



District of Columbia
Breastfeeding
NEEDS ASSESSMENT
REPORT

August 2025

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Executive Summary

The DC Breastfeeding Coalition and DC Health collaborated to conduct a breastfeeding needs assessment for the District of Columbia. We evaluated the breastfeeding experiences of 224 parents through surveys and focus groups and surveyed 68 healthcare providers (hospital, primary care, obstetric, lactation and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) providers about their experiences supporting the breastfeeding dyad.

Key Findings:

- There is a clear need for education about common breastfeeding challenges, not just for parents, but also for families and support networks.
- Fewer than one in three parents (29%) reported that their obstetric provider discussed breastfeeding during prenatal care. Obstetric providers cited several barriers to offering breastfeeding education and support, including limited time, lack of reimbursement, insufficient knowledge, and inadequate access to lactation specialists.
- Nearly half of respondents said their child received formula in the hospital. The most common reasons included poor latch, concerns about milk supply, and personal preference.
- After hospital discharge, almost 40% of participants experienced breastfeeding difficulties.
- One-third of respondents stopped breastfeeding earlier than they intended. The top reasons were returning to work or school and not receiving timely support.
- Primary care providers reported that they often lack the time and expertise needed to provide breastfeeding education and support. DC WIC staff shared that many mothers returned to work early to financially support their families and did not have access to breast pumps or adequate breastfeeding assistance.



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Key Recommendations DC Health – Title V Maternal and Child Health Services & WIC Breastfeeding Needs Assessment:

➤ Family-level Strategies

- Provide families with prenatal breastfeeding education tailored to their learning needs.
- Establish closed-loop referral systems that connect families to lactation support across clinical and community settings.
- Support adequate paid parental leave for all working parents to support sustained breastfeeding.

➤ Hospital-level Strategies

- Strengthen breastfeeding education for hospital staff, with emphasis on practical support and competence.
- Expand access to donor milk within hospital settings, especially for infants with medical or nutritional needs.
- Ensure birth parents at risk for breastfeeding challenges are identified early and referred to lactation support services upon discharge.

➤ Provider-level Strategies

- Enhance provider education with hands-on training in breastfeeding support and counseling.
- Convene a task force led by obstetric providers to develop efficient, comprehensive models for prenatal breastfeeding education.

➤ WIC-level Strategies

- Provide hands-on breastfeeding training for all WIC staff who counsel families on infant feeding.
- Increase prenatal enrollment of birth parents in WIC to ensure early access to support.
- Improve distribution systems for breast pumps to ensure timely access for eligible families.
- Educate families about paid parental leave and workplace laws that protect time and space for milk expression.

➤ Policy-level Strategies

- Ensure all working parents have access to adequate paid parental leave.
- Educate employers, employees, and families about breastfeeding support laws and improve enforcement, including workplace accommodations for milk expression.
- Collaborate with Medicaid and other insurers to improve reimbursement for outpatient lactation services.
- Support and develop workforce strategies to integrate more lactation specialists into outpatient care settings, with priority on those that serve the greatest number of families residing in Wards 5, 7, and 8.

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The District of Columbia Breastfeeding Coalition (DCBFC) is a 501(c)(3) organization that is primarily volunteer-driven and was established in 2004 to increase the breastfeeding rates of all infants living in the District of Columbia. Working in partnership with maternal and child health professionals, community health organizations, and mother-to-mother support groups, the DCBFC seeks to promote, protect and support culturally sensitive programs and activities that build awareness and understanding of the preventive health benefits of breastfeeding. Through its breastfeeding research, advocacy and educational activities, the Coalition seeks to reduce health disparities—particularly among the most vulnerable infants and children living in our communities.



Inclusivity Statement

The authors use the term breastfeeding in this report but acknowledge that not all people who feed their infant human milk identify as women or mothers and/or use she/her pronouns. This report uses human milk preferably over breast milk.

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Background

In the United States, breastfeeding is considered the gold standard for infant nutrition, offering well-documented immunological and neurodevelopmental benefits that support both short- and long-term health outcomes. Infants who are breastfed have lower rates of asthma, obesity, type 1 diabetes, severe lower respiratory disease, acute otitis media, Sudden Infant Death Syndrome (SIDS), gastrointestinal infections and premature infants have a lower risk of necrotizing enterocolitis (NEC).¹ Low breastfeeding rates in the U.S. may contribute to our nation's higher maternal and infant mortality rates compared to other high-income countries. In fact, one recent study reported that US infants who are breastfed are 33% less likely to die in the first year of life compared to formula-fed infants.² The birth parent also experiences benefits from breastfeeding including a lower risk of breast cancer, ovarian cancer, type 2 diabetes and hypertension. Accordingly, the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the World Health Organization (WHO), recommend that infants be exclusively breastfed for the first 6 months with continued breastfeeding while introducing appropriate complementary foods for 2 years or longer.³⁻⁵

The US Department of Health and Human Services' Healthy People 2030 breastfeeding objectives are to increase the proportion of infants who are exclusively fed human milk from birth through 6 months to 42% and the proportion of infants receiving any human milk at 1 year to 54%.⁶ The District of Columbia (DC) has high rates of breastfeeding initiation (90.2%) and meets one of the US Department of Health and Human Services' Healthy People 2030 breastfeeding objectives with 30.1% of the residents exclusively breastfeeding at 6 months. However, DC's 12-month breastfeeding rate (43.8%) falls below the 2030 objectives.¹ These initiation rates are much higher than those published in the Fiscal Year 2023 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Breastfeeding Data Local Agency Report, which showed that 45% of DC WIC participants initiated breastfeeding.⁷

Breastfeeding is a complex paradigm that encompasses socioeconomic, demographic and cultural factors. According to the Centers for Disease Control and Prevention (CDC), only 27.2% of US infants born in 2021 were exclusively breastfed at 6 months.¹ When stratified by race/ethnicity, both rates of breastfeeding initiation and continuation are disparately lower in non-Hispanic Black populations. For example, women in lower economic brackets (as evidenced by their enrollment in WIC) have significantly lower breastfeeding rates compared to the general population.¹ This data is mirrored in DC where rates vary widely along socioeconomic lines.

There is inconsistent and incomplete data on the District's breastfeeding rates stratified by socioeconomic and racial demographics. One source is the Pregnancy Risk Assessment Monitoring System (PRAMS) which was a partnership between the DC Department of Health (DC Health), the Centers for Disease Control and Prevention (CDC) and Bloustein Center for Survey Research of Rutgers University. PRAMS is a population-based survey of residents who delivered a live-born infant; 100 women who recently gave birth are randomly chosen from the DC birth certificate registry to take the survey. According to the PRAMS 2021 data for initiating breastfeeding, 98.4% of District parents with commercial insurance and 93.0% of parents with Medicaid ever breastfed. In addition, 98% of White parents and 95% of Black and Hispanic parents ever breastfed. Breastfeeding initiation across the wards ranged from 93% in Ward 6 to 100% in Ward 1.⁸

Another source for breastfeeding data is the CDC National Immunization Survey. However, because the surveillance data relies on small sample sizes, they are limited in their ability to detect disparities at the state or territorial level. To address this gap, the CDC analyzed 2019 National Vital Statistics System birth certificate data and published state-level breastfeeding rates stratified by race. These results revealed a greater racial disparity in DC breastfeeding initiation rates with 97.1% of White parents initiating breastfeeding compared to 83.8% of Hispanic and 71.2% of Black parents.⁹

In the PRAMS 2021 data, there was greater disparity in breastfeeding duration along racial lines with 95% of White respondents breastfeeding for 8 weeks or more as compared to 82% of Hispanic and 70% of Black parents.⁸ Moreover, within the WIC population, Black individuals have significantly lower breastfeeding rates.¹⁰ There are also disparities in breastfeeding duration rates along other sociodemographic lines. DC is divided by eight wards. Each of DC's wards differ by racial and socioeconomic demographics as shown in Table 1. The highest poverty rate exists in Wards 7 and 8 which also have the greatest percentage of Black residents.¹¹ Additionally, breastfeeding duration varied by ward with 85% or more of parents in Wards 1 through 6 breastfeeding for at least 8 weeks and 74.2% and 71.0% of parents in Wards 7 and 8, respectively. There was also a disparity in breastfeeding duration based on insurance type with 93.7% of parents with commercial insurance breastfeeding for 8 weeks or more as compared to 68.3% of parents with Medicaid.⁸

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Table 1: DC Wards Compared By Racial and Socioeconomic Demographics *

Ward	% of DC population	% Black	% Hispanic	% White	Median income for family with children	Poverty Rate
1	12%	29%	35%	23%	\$181,127	12%
2	12%	17%	24%	39%	\$250,000+	11%
3	12%	5%	13%	66%	\$250,000+	7%
4	13%	37%	23%	30%	\$200,268	9%
5	13%	58%	16%	17%	\$144,922	15%
6	12%	30%	12%	43%	\$223,794	11%
7	14%	81%	12%	4%	\$66,900	22%
8	12%	84%	6%	5%	\$50,653	27%

*Source: DC Kids Count 2025 Ward Snapshots¹¹

To even begin to brainstorm strategies to propel us toward the Healthy People 2030 breastfeeding objectives and improve breastfeeding disparities, we must first identify the needs of our community in regard to breastfeeding support, barriers and resource gaps, especially in those populations where breastfeeding initiation and continuation rates are the lowest.

With this goal in mind, the DC Breastfeeding Coalition collaborated with DC Health to conduct a breastfeeding community needs assessment of the District of Columbia. To ensure the needs assessment was comprehensive and reflected different groups within the community, we gathered input from a broad range of participants including DC parents via a survey and focus groups and key interested parties such as maternity care providers, WIC staff, lactation support providers, and obstetric and pediatric primary care providers. This report describes the barriers and facilitators to breastfeeding reported by these groups and provides recommendations to improve breastfeeding support in the District of Columbia.

Study Overview

The Breastfeeding Needs Assessment was conducted by the DC Breastfeeding Coalition (DCBFC) in Washington, DC, with funding from DC Health, Title V Maternal and Child Health Services. This initiative aligns with Title V’s Maternal and Child Health priority to improve breastfeeding support and outcomes, particularly within the domain of Women’s/Maternal Health. A mixed-methods design was employed, incorporating quantitative online surveys of parents and healthcare providers alongside qualitative focus groups with parents. Institutional Review Board (IRB) approval was secured from Children’s National Hospital (STUDY00000920) and the DC Department of Health (IRB 2024-9).

Table 2. Frequencies of Social Drivers of Health and Other Characteristics of Respondents Compared To Washington, DC's General Population (n=224), 2024			
	Total	Percent of Total (95% Confidence Interval)*	DC Women**
SOCIAL DRIVERS OF HEALTH			
Mother's Age (years)***	n	% (CI)	%
18-24	17	7.7 (4.8-12.1)	13.4
25-30	89	40.3 (34.0-46.9)	16.9
31-35	84	38.0 (31.8-44.6)	32.8
>35	31	14.0 (10.0-19.3)	36.9
Race/Ethnicity			
Non Hispanic White	126	58.0 (51.2-64.5)	31.7
Non-Hispanic Black	59	25.9 (20.5-32.3)	41.9
Hispanic	17	7.6 (4.7-12.0)	18.4
Other	22	8.5 (5.4-13.1)	8.0
Education			
HS degree or less	37	16.6 (12.2-22.1)	33.3
Associate degree, Some College, Completed College	84	37.7 (31.5-44.2)	32.3
Graduate Degree	102	45.7 (39.3-52.4)	34.4

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Medicaid Insurance			
Yes	119	52.4 (45.6-59.0)	52.0
No	105	47.6 (41.0-54.4)	48.0
Language spoken at Home			
English	204	91.1 (86.5-94.2)	
Spanish	16	7.1 (4.4-11.4)	
Other	4	1.8 (0.7-4.7)	
WIC participation			
WIC enrolled	105	46.2 (39.6-53.0)	61.1
Not in WIC and not eligible	63	28.1 (22.6-34.4)	
WIC Eligible but not in WIC	56	25.0 (19.7-31.1)	
Ward of residence			
1	33	15.6 (11.3-21.1)	12
2	31	14.6 (10.5-20.1)	12
3	38	17.9 (13.3-23.7)	12
4	30	14.2 (10.1-20.0)	13
5	22	10.3 (6.9-15.3)	13
6	10	4.7 (2.5-8.6)	12
7	21	10.0 (6.5-14.7)	14
8	27	12.7 (8.9-18.0)	12
Worked or volunteered when baby was <1 year			
No	119	53.8 (47.2-60.4)	
Yes	102	46.2 (39.6-52.8)	

*Denominator may be lower than 224 due to missing data.

**Race/ethnicity, age and education data for Washington, DC was retrieved from¹², for Medicaid,¹³ and for Ward.¹¹

***Age ranges for DC women is based on what is available on CDC Wonder: 18-24, 25-29, 30-34, and 35-44

Results

Parent Survey

Study Sample and Characteristics

The total sample included 224 eligible individuals (Table 2). Most participants were between 25-35 years of age (77.2%), with half of those being between 25-30 years (39.7%) and the other half between 31-35 years (37.5%). The majority had completed some higher education (Table 1a). More than half were non-Hispanic White (56.3%) and about a quarter were Non-Hispanic Black (26.3%). Approximately half of the infants received Medicaid insurance (53.1%) and were enrolled in WIC (46.9%). Nearly half of the participants worked or volunteered when their infant was less than one year old (45.5%). Across study sample sources, significant differences emerged in every SDoH variable except Medicaid. There were no differences in prenatal care behaviors and intention to breastfeed by study sample source (see Survey Appendix Supplemental Table 2 Panel vs Non-Panel). The needs assessment was not designed to yield a sample that was representative of the DC population, however it generally did reflect the sociodemographic characteristics of the general DC population with a couple of exceptions. Non-Hispanic White individuals were over-represented in the total pooled sample, and this is because Qualtrics panels draw from a sample that is biased towards Non-Hispanic White individuals and those with higher education. In contrast, the non-panel sample reflected the demographics of the DC population (see Survey Appendix Supplemental Table 2 Panel vs Non-Panel).

Prenatal Characteristics

The majority of women received prenatal care (85.7%) and more than half (56.3%) began care in the first trimester (Table 3a).

Table 3a. Pregnancy Characteristics	Total	Percent of Total (95% Confidence Interval)	DC population
Received prenatal care	n	% (CI)	%
Yes	192	85.7 (80.5-89.7)	91.4
No	32	14.3 (8.0-9.0)	8.6*
Trimester began care			
1st	126	65.6 (58.6-72.0)	73.0
2nd	57	29.7 (23.6-36.6)	18.6
3rd	9	4.7 (2.4-8.8)	

*Received late or no prenatal care per March of Dimes Peristats for Washington, DC14

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Breastfeeding Education During Pregnancy

Respondents identified the top five sources of breastfeeding conversations during pregnancy as family (57.1%), friends (42.9%), nurses (30.8%), pediatric providers (29.0%), and obstetric providers (27.2%). Among WIC-enrolled participants, 45.7% reported receiving breastfeeding guidance from WIC during pregnancy (Table 3b). When asked where they received breastfeeding information prior to birth, respondents most frequently cited family (51.8%), friends (35.7%), online/social media platforms (28.6%), and pediatric offices (27.7%). Again, 45.7% of WIC-enrolled respondents reported receiving prenatal breastfeeding information directly from WIC.



Table 3b. Breastfeeding Education During Pregnancy		
	Total	Percent of Total (95% Confidence Interval)
Who spoke with you about breastfeeding when you were pregnant	n	% (CI)
Family	128	57.1 (50.5-63.5)
WIC*	48	44.8 (35.4-54.5)
Friends	96	42.9 (36.5-49.5)
Nurse	69	30.8 (25.1-37.2)
Pediatric provider	65	29.0 (23.4-35.3)
Obstetric provider	61	27.2 (21.8-33.5)
Lactation specialist	55	24.6 (19.3-30.6)
Midwife	38	17.0 (12.6-22.5)
Classes	38	17.0 (12.6-22.5)
Doula	20	8.9 (5.8-13.5)
No one	17	7.6 (4.8-11.9)
Where did you receive information about breastfeeding before your child was born		
	n	%
Family	116	51.8 (45.2-58.3)
WIC office*	53	45.7 (36.3-55.4)
Friends	80	35.7 (29.7-42.2)
Online/Social Media	64	28.6 (23.0-34.9)
Pediatric office	62	27.7 (22.2-33.9)
Obstetric office	58	25.9 (20.6-32.1)
Birthing center	56	25.0 (19.7-31.1)
Classes	43	19.2 (14.5-24.9)
No where	19	8.5 (5.5-12.9)

*Denominator = 105 WIC enrolled participants

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Overall Breastfeeding Behaviors

The majority of participants (96.4%) ever provided their child with human milk, and 49.6% reported exclusive breastfeeding (i.e., “breastfed only”).

At the time of the survey, 71.0% (n=159) of respondents were actively breastfeeding. Among those, 76.1% were feeding infants older than three months.

Participants who had stopped breastfeeding by survey completion (n=62) reported the following durations:

Duration of Breastfeeding Percentage (n)

Less than 1 month 9.7% (6)

1–3 months 11.3% (7)

4–6 months 22.6% (14)

7–9 months 17.7% (11)

10–12 months 29.0% (18)

More than 12 months 9.7% (6)

Breastfeeding in the Hospital

The majority of respondents reported that their child received their mother’s own breast milk in the hospital (89.7%). Of those who reported that their child did not receive their milk in the hospital, 73.9% (n=17) reported that they wanted to breastfeed. Nine percent (n=20) of respondents reported that their child received donor milk in the hospital. There were no statistically significant differences in the association of receiving donor milk with WIC eligibility status or with Medicaid insurance. There were also no statistically significant associations between this behavior and race/ethnicity or education.

About half of respondents (54.0%) reported that their child received formula in the hospital. Those who were enrolled in Medicaid were significantly more likely to report that their child received formula in the hospital (66.4% of those enrolled in Medicaid compared to 40.0% of those not enrolled in Medicaid). There were no statistically significant associations between this behavior and WIC eligibility status, race/ethnicity or education. The top reasons given for the child receiving formula in the hospital were that the child would not latch well, the respondent felt they did not have enough breast milk, they wanted to give their child formula, and breastfeeding was painful (Table 4a).

Breastfeeding Difficulty and Support in the Hospital

More than a third of respondents (38.3%) reported difficulty breastfeeding while in the hospital. The majority of respondents reported that nurses provided help with breastfeeding (73.2%) two-fifths reported receiving help from lactation specialists (42.9%) and one-fifth reported receiving help from pediatric providers (19.6%) (Table 4a). There were significant differences in experiencing difficulty breastfeeding according to the study sample source (see Appendix Table Panel vs Non Panel).

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Table 4a. Breastfeeding in the Hospital		
Medical condition making breastfeeding difficult		
	n	%
Yes	25	11.2
What is the condition?		
C-section	12	48.0
Premature delivery	18	72.0
Child received respondent's milk in the hospital		
Yes	201	89.7
No but I wanted to breastfeed	17	7.6
No I chose not to breastfeed in the hospital	6	2.7
Child received donor milk in the hospital	20	8.9
Child received formula in the hospital	121	54.0
Why did child get formula in the hospital* (Check all that apply)	n	%
My child would not latch well	39	32.2
I felt I did not have enough milk	37	30.6
I wanted my child to get formula	33	27.3
Breastfeeding was painful	22	18.2
Infant was premature	22	18.2
I was too tired to breastfeed	21	17.4
A medical provider recommended it	17	14.0
I was too sick to breastfeed	7	5.8
Not sure, formula was given without my permission	2	1.7
Difficulty breastfeeding while in hospital	n	%
Yes	77	38.3
No	124	61.7
Who helped you with breastfeeding in the hospital (Check all that apply)	n	%
Nurses	164	73.2
Lactation specialist	96	42.9
Pediatric provider	44	19.6
Obstetric provider	31	13.8
No one	16	7.1
Partner	1	0.4

*Denominator = 121 children who received formula in the hospital

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Breastfeeding Difficulty and Support After Participants Left the Hospital

More than a third of respondents reported that they had difficulty breastfeeding after leaving the hospital (39.7%). Of those that reported difficulty, 84.7% indicated that the difficulty occurred in the first four weeks of the baby's life. Almost half of all respondents reported that they received help with breastfeeding from family (46.4%), almost one-third reported receiving help from friends (30.8%), or lactation specialists (28.2%), almost one fifth received help from nurses (19.6%), or pediatric providers (18.3%), and less than one-tenth received help from obstetric providers (8%). Among those enrolled in WIC, one-quarter (27.6%) reported that they received help from WIC. Only 9.8% (n=22) reported that they received online support with breastfeeding and the majority reported using social media (n=16) followed by Pacify, a smartphone app that provides on-demand access to 24/7 lactation and infant feeding support (n=6). More than half of respondents (58.0%) reported that it was not difficult to get breastfeeding support. The primary reasons participants had difficulty accessing support were the cost of services, geographic location, and childcare constraints.

When specifically asked about whether their child's pediatrician/pediatric provider helped with breastfeeding, 50.9% said yes. In addition, 26.8% said that another person in the pediatric office helped with breastfeeding; 51.7% of them reported that it was a nurse and 43.3% reported that it was a lactation specialist in the pediatric office that helped them with breastfeeding.

When respondents were asked to select all of the ways they would have liked to receive breastfeeding education and support, 49.6% selected virtually, 44.6% selected home visits, 32.1% selected in-person groups and 30.4% selected individual counseling in a clinic (Table 4b).





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Table 4b. Breastfeeding Experience After Hospital Discharge		
Did you have difficulty breastfeeding after leaving the hospital?	n	%
Yes	85	39.7
No	129	60.3
Age of infant when you had difficulty after leaving the hospital?*	n	%
Less than 1 week old	23	27.1
1 to 2 weeks	27	31.8
3 to 4 weeks	22	25.9
2 months and up	13	15.3
Who helped you with breastfeeding after you left the hospital (check all that apply)	n	%
Family members	104	46.4
Friends	69	30.8
Lactation specialist	63	28.1
WIC*	29	27.6
Nurses	44	19.6
Pediatric provider	41	18.3
No one	38	17.0
Home visit	30	13.4
On-line support	22	9.8
Breastfeeding clinic	19	8.5
Obstetric provider/midwife	18	8.0

*Denominator = 105 WIC enrolled participants

** Denominator = 85 who reported difficulty breastfeeding after leaving the hospital

***Denominator = 60 who responded that someone else in the pediatric office helped with breastfeeding



Which on-line support resources did you receive help from (check all that apply)	n	%
Social Media	16	72.7
Pacify	6	27.3
Did any of the following make it difficult to get support (check all that apply)	n	%
Not applicable/I did not have any difficulty	130	58.0
Cost of support	36	16.1
Location	35	15.6
Childcare	29	12.9
Transportation	26	11.6
Hours of operation	11	4.9
Did your child's pediatrician/pediatric provider help you with breastfeeding?	n	%
No	107	47.8
Yes	114	50.9
Did another person in the pediatric office help you with breastfeeding?	n	%
No	161	71.9
Yes	60	26.8
What was their role in the clinic?***	n	%
Nurse	31	51.7
Lactation Specialist	26	43.3
How would you have liked to receive breastfeeding education and support? (select all that apply)	n	%
Remotely (for example Zoom or Pacify)	111	49.6
Home visits	100	44.6
In-person groups	72	32.1
Individual counseling in a clinic	68	30.4
By phone	53	23.7

Breastfeeding Intention and Reasons For Not Following Original Plan

The majority of respondents, 70.5%, intended to breastfeed only. A quarter of respondents intended to both breastfeed and formula feed (referred to as mixed feed) and 4.5% intended to only formula feed. Among those who intended to breastfeed only, the odds of breastfeeding only in the first year of life was 11.41 (95%CI, 5.02-25.93).

Of those who intended to breastfeed only, 63.9% breastfed only, 32.9% mixed-fed, and 3.2% only fed their infant formula (Table 5a). Top reasons for changing the breastfeeding only plan was perception of not enough milk (38.3%), pain with breastfeeding (35.1%), difficulty with latch (35.1%), and that they had to return to work or school (24.5%; Table 5b).

Table 5a: Original Feeding Plan and Actual Feeding Behavior						
		Original Feeding Plan				
			Both breastfed and formula	Breastfed only	Formula fed only	Total
Actual Feeding Behavior	Both breastfed and formula	n	47	52	4	103
		%	83.9	32.9	40.0	46.0
	Breastfed only	n	8	101	2	111
		%	14.3	63.9	20.0	50.0
	Formula fed only	n	1	5	4	10
		%	1.8	3.2	40.0	4.5
	Total	n	56	158	10	224
	%	100	100	100	100	

Of those who intended to mix-feed, 83.9% did and 14.3% breastfed only (Table 5a). Only 10 respondents intended to formula feed and six of them mixed-fed (n=4) or breastfed only (n=2) (Table 5a). Top reasons for changing from the plan to breastfeed were not enough breast milk (38.3%), pain with breastfeeding (35.1%), difficulty with latch (35.1%), and that they had to return to work or school (24.5%). Top reasons for changing from the plan to mix feed were that they had to return to work or school (37.5%), perception of not having enough breast milk (30%), decided breastfeeding was healthier (32.5%), pain with breastfeeding (27.5%), and difficulty with latch (27.5%) (Table 5b).

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Table 5b. Breastfeeding Intention		
What was your original plan for feeding your child before your child was born?	n	%
Breast only	158	70.5
Both Breastfeeding and formula	56	25.0
Formula only	10	4.5
Changed breastfeeding only plan	n	%
No	64	40.5
Yes	94	59.5
Changed breastfeeding only plan because (check all that apply)*	n	%
Not enough milk	36	38.3
Pain when breastfeeding	33	35.1
Difficulty with latch	33	35.1
Had to return to work/school	23	24.5
Did not get help when I needed it	7	7.4
Changed mixed feeding plan	n	%
No	16	28.6
Yes	40	71.4
Changed mixed feeding plan because (check all that apply)**	n	%
Had to return to work/school	15	37.5
Decided it was healthier	13	32.5
Not enough milk	12	30.0
Pain when breastfeeding	11	27.5
Difficulty with latch	11	27.5
Breastfeeding easier than I thought it would be	7	17.5
Discussion with Family/Friend	6	15.0
Discussion with HCP	5	12.5
Did not get help when I needed it	4	10.0

*Denominator = 94 who changed breastfeeding only plan

**Denominator = 40 who changed mixed feeding plan

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Employment and Childcare Support For Breastfeeding

Under half of respondents (45.5%) had a paid or volunteer job when their child was less than one year old. Of these, 93.1% reported that their workplace was supportive of breastfeeding and 85% reported that their childcare provider was supportive of breastfeeding (Table 6).

Table 6. Employment and Childcare Support		
Did you have a paid or volunteer job when your child was less than 1-year-old?	n	%
Yes	102	45.5
No	119	53.1
Was your workplace supportive of breastfeeding?*	n	%
Yes	95	93.1
No	7	6.9
Was your childcare provider supportive of breastfeeding?	n	%
Yes	147	85.0
No	26	15.0
Not applicable	48	-

Reasons For Stopping Breastfeeding Earlier Than Participants Wanted To

A little more than one quarter (28.6%) of respondents stopped breastfeeding earlier than they wanted to. Of those who stopped breastfeeding earlier than they wanted to, the top reasons were pain when breastfeeding (50.0%), not enough breast milk (35.9%), had to return to work or school (31.3%), and did not get help when they needed it (29.7%). Respondents reported that the following would have helped them breastfeed longer: more help in the pediatric clinic (45.3%), better access to breastfeeding support (42.2%), more support at work (29.7%), and home visits (28.1%) (Table 7)



Table 7. Stopping Breastfeeding Earlier Than Desired		
Did you stop breastfeeding earlier than you wanted to?	n	%
Yes	64	28.6
No	157	70.1
What was the reason you stopped breastfeeding earlier than you wanted? (select all that apply)*	n	%
Pain when breastfeeding	32	50.0
Not enough milk	23	35.9
Had to return to work/school	20	31.3
Did not get help when I needed it	19	29.7
Discussion with Healthcare provider	4	6.3
What would have helped you breastfeed longer? (select all that apply)	n	%
More help in the pediatric clinic	29	45.3
Better access to breastfeeding support	27	42.2
More support at work	19	29.7
Home visit to help with breastfeeding	18	28.1
Help in the WIC clinic	6	9.4



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Parent Focus Group

Sixty-four parents participated in the focus groups (both in English and Spanish). Three participants did not complete a pre-group survey, so they are not included in the descriptive statistics but may have quotes included. The focus group participants ranged in age from 18-35 years of age. About a quarter of participants identified as Hispanic/Latina and more than half identified as African American/Black. More than a quarter of participants had education at the high school level or less while more than half had some college education or beyond (Table 8).

Table 8: Demographic Table For Focus Group Participants, n=61

Category	Sub-category	n	%
Age			
	18-24	5	8.2
	25-30	17	27.9
	31-35	15	24.6
	35-greater	24	39.3
Ethnicity			
Hispanic or Latino/a	Yes	15	24.6
	No	46	75.4
Race			
	African American/Black	35	57.3
	Caucasian/White	13	21.3
	Prefer not to say	7	11.4
	Other	6	9.8
Education			
	Some high school	3	4.9
	High school	15	24.6
	Some college	11	18.0
	College graduate	17	27.9
	Post-graduate	15	24.6

Focus Group Breastfeeding Behavior

Forty six percent of participants reported that they only breastfed, 44% used a combination of breastfeeding and formula and approximately 10% used formula only. Of the 52 respondents who breastfed, 67% of them were still breastfeeding. For those who had stopped breastfeeding, the majority stopped before the baby was three months. Tables 9 and 10 summarize the infants' age who were still being breastfed and the age of infants when breastfeeding ended.

Table 9: Age of Infants Who Are Still Being Breastfed, n= 35		
Age of Infant	n	%
Less than 1 month	5	14.3
1 to 3 months	8	22.9
4 to 6 months	11	31.4
7 to 9 months	3	8.6
10 to 12 months	1	2.9
More than 12 months	7	20.0

Table 10: Age of Infant When Breastfeeding Ended, n= 17		
Age of Infant	n	%
Less than 1 month	2	11.8
1 to 3 months	6	35.3
4 to 6 months	2	11.8
7 to 9 months	2	11.8
10 to 12 months	4	23.5
More than 12 months	1	5.9

Focus Group, Section I: Major Themes

Breast Is Best

Participants believe that breastfeeding is the best way to feed an infant because it is natural and has many health benefits, including preventing illnesses (i.e., increasing immunity) and promoting healthy weight gain for babies. Breastfeeding is also seen as promoting a deep bond between mother and baby.

Illustrative quotes

§ I feel the nurturing aspect. It took me two months to get my son latched, I really struggled the first time, so I was pumping for two months before we latched. I didn't give up. I think also, when I was finally able to get him on the breast, we had a lot of really deep connections.

§ I wanted to do it for the immunity, being able to pass on some immunity.

§ The [breastfeeding] experience was amazing. It was good. When it was good, it was good when it was not good, it was not good. I missed it, because for me... it really is an attachment, and so it really is ... you bringing that child closer to you, ...the bond is stronger because you're producing for ... this human.

§ They told me about this book about breast milk having all these nutrients. My baby is so big, and I think that his growth has been spurred or helped by the breast milk, and that's why I'm happy about his growth and his size, and people comment on that.

§ They asked me if I plan to breastfeed, and my choice was always yes, like I want to breastfeed. I think it's the most natural thing you can do, and the breast is best, you know.

§ I had both of my kids through IVF, and had to use an egg donor for both of them. And I think for me, it was like it was especially the bonding, because I felt that it would provide a stronger connection, since I didn't have the genetic connection. And also ... felt like it was the one thing I could do since I couldn't have kids.

Breastfeeding: Roses and Thorns

Participants had opposing thoughts about breastfeeding. Participants noted that breastfeeding is easier, quicker, and more economical (i.e., less expensive than formula) and enabled them to rest as it could be done while lying down.

Illustrative quotes

§ For me, breastfeeding... it's just quicker, ... the baby isn't crying as long or you're not spending money on formula. I exclusively breastfeed, so I don't really pump that much. I only pump if she's going to be at her grandma's It was just easier for me to just breastfeed."

§ I love the side breastfeeding [position], laying in the bed and breast. That's my favorite. That's the top reason I encourage any woman to breastfeed is because you can do it lying down.

On the other hand, participants overwhelmingly noted that breastfeeding is hard, painful, "exhausting," and requires extra effort. Women noted that they had to breastfeed "a lot" and mentioned that pumping and cluster feeding were sources of stress. Across all groups, participants expressed a lack of knowledge about managing common breastfeeding challenges such as preventing clogged ducts, maintaining milk supply, and knowing whether or not the infant was getting the proper amount of milk.

Illustrative quotes

§ There were a couple of nights of cluster feeds, and ..., then that's another night where you wake up and you're completely in pain because you're like, literally, your nipples are raw.

§ I wish I had more knowledge on how to balance life while breastfeeding or pumping. My experience at the time felt so overwhelming because I just felt like I couldn't get enough sleep. I couldn't get anything done. I couldn't do anything for myself without having, ..., breast pain or needing to run to the baby, do something related to pumping, make sure I'm eating the right foods, drinking enough water. ... your life revolves around breastfeeding, pumping, making sure that you have enough of a supply. It really drained me, mentally, emotionally, in all senses. And so, I wish that I had some guidance around how to manage expectations better, manage my time better, or what were some things I could be doing.

Good Information Is Hard To Find

Many women reported that they didn't get their questions answered by obstetric healthcare providers. While some reported that they were given a pamphlet on breastfeeding, others noted that their obstetric providers asked the question about whether or not they planned to breastfeed as part of a checklist with no further discussion. Many women, however, had positive experiences getting information from their child's pediatrician.

Illustrative quotes

§ At the hospital, I didn't receive any assistance on how to breastfeed the baby.

§ I don't feel like I got that much education on breastfeeding, at least from my OB besides, like a pamphlet, ... and letting me know, ... how to get insurance to cover my breast pump. (that was) the extent of the education.

§ My pediatrician recommended it as a referral because the baby was struggling to gain enough weight as I was breastfeeding. She had referred me to a specialist to make sure that I was latching properly and getting enough supply into the baby.

§ I'm so grateful for pediatricians. She kind of tweaked what I was taught in the hospital. ...The lactation consultant was really helpful with ...the latch itself. And then my pediatrician kind of recommended a change of how long to nurse on each side, and that worked. The weight loss that he had improved since we did that.



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Complications/Pain Interrupted the Breastfeeding Journey

For many participants, their breastfeeding plans and/or journeys were interrupted by the trauma during and after the birthing experience. Across all of the focus groups, moms detailed experiences with emergency C-sections, preterm births, babies spending weeks in the NICU, and post-delivery hospitalization. Participants talked about their babies being given formula without their permission. While some women were offered donor milk others were not. Most significantly, focus group participants struggled with wanting to breastfeed while trying to recover from difficult deliveries. For many participants, the ability to maintain their milk supply and continue breastfeeding over a long period was impacted by medical complications and prolonged hospital stays. Participants mentioned preeclampsia, and bleeding issues as some of the reasons their milk supply decreased and/or they had to start formula feeding.

For other women, breastfeeding was a painful experience. Participants often didn't know how to stop or minimize the pain related to cracked nipples or painful latching. Without knowledge about how to manage their pain, many women stopped breastfeeding within the first 3 months.

Illustrative quotes

§ The first time my boobs got engorged, I was ... Googling it. I was like, what do I do? How do I make this stop? It hurt so bad. I didn't really have knowledge on what to do or even how to best support it.

§ I chose to stop this time around because I didn't know what else to do to stop the pain. I felt like I was failed by those medical providers.

§ This last pregnancy was a little bit different. ...I had him, and then it was ...my third time going back in the hospital for ... postpartum preeclampsia. He was home with my mom, so he was getting bottle-fed with nothing but formula. By the time I tried to breastfeed him at home, I ended up getting sick. We just kind of turned into exclusively breast pumping, which was okay, but it was different. I don't really like pumping.

Focus Group, Section II: Major Discussion Points By Topic

Prenatal Education

During the prenatal stage, participants had different experiences with breastfeeding education from their healthcare providers. Some women said that they were asked about whether or not they plan to breastfeed by a healthcare provider but were not asked additional follow-up questions. The lack of questions by providers led some women to seek out information on their own.

The majority of women stated that they had to educate themselves about breastfeeding via different social media sources with Google or Tik Tok mentioned most often as well as unspecified books. A couple of women went to the Breastfeeding Center for Greater Washington website and while several others received education from Mamatoto Village in DC.

Illustrative quotes:

§ I just got asked by the OB, you know, whether I was planning on breastfeeding, and that was in Alabama and in DC, both. I didn't really get a lot of education from any of the doctors. We had a visit from the lactation consultant in the hospital. ... I had some stuff from the doula, but mostly it was just reading that we did on our own, like the prenatal books and Google and that kind of thing.

§ So, they asked. But I think, ..., once you give them what your decision is. They don't ... pry. They don't try to sway you or anything. ..., they're not giving you much more information unless you're breastfeeding. Well for me personally, anyway, ... once I told them I was going to formula feed that kind of was the end of the conversation.

§ I'm pretty sure I had no conversations whatsoever about it (with a provider), ... I'd done a prenatal class through my synagogue, which was just kind of three classes with a woman who works at the synagogue in their child education area, but then also happens to be a doula, and as part of that, she definitely focused one of the classes in terms of, just like preparing to breastfeed for those who were planning on it.

§ I don't think that my OB and I ever talked about breastfeeding once. So yeah, as if you're only talking about the prenatal period, then yeah, zero, absolutely zero. But I, I think that also could be because, you know, this is my third kid, so maybe they're like, oh, we don't need to talk about it. And maybe they would have if I had been a first-time mom.

§ ... my prenatal experience was that I was asked about my plans to breastfeed or formula feed as kind of part of a checklist, usually by ..., a tech before my actual appointment ... I also saw midwives, ..., I never had a conversation about breastfeeding with anyone in the prenatal stage.

Post-Delivery and Hospital Assistance with Breastfeeding

With a lack of prenatal education, many women discussed the education they received post-delivery. Women reported widely different experiences with getting breastfeeding assistance post-delivery. A couple of mothers discussed receiving information from WIC while other women had access to lactation consultants and/or doulas for assistance.

Illustrative quotes:

§ Before I left the hospital, right after I had my baby, the WIC program. They helped with everything, they walked me through everything, even from latching on, they reached out a lot from the hospital

§ I didn't get any information during my prenatal process about breastfeeding. I didn't get information until I had her, and that's when the lactation consultants came in.

§ I had a lactation consultant come to visit me on,...the second day of his life, and then another came on the third day. [...] She helped me with finding comfortable positions, which actually made a huge difference. ...Before that I hunched over, my incision was really sore. I was doing hunchback of Notre Dame style positions, and it was... so uncomfortable that I couldn't feed him for as long as he needed. She was really good. Since then, I got a lactation consultant. She came when he was five days old, and she came again two weeks after that.

§ The nurses were helping me out and teaching me different techniques, until the lactation consultant was able to see me. And even after that, they still assisted me when the lactation consultant came, I think it was ...my second day in the hospital, and she helped me with positions, ... ways to get my ...nipples to come out, stimulate my nipples more, and basically, different techniques and things to make it easier for me.

Social Support and Influence of Family and Friends

While support in the hospital and from healthcare providers was inconsistent, many women discussed relying on family and friends for support during their breastfeeding journey. Moms talked about getting information from their mothers and other relatives with breastfeeding experience.

Illustrative quotes:

§ Women in my family and my friends, so my experience was similar to what a couple of other people have said. I honestly don't recall getting any specific information or education about breastfeeding more, just sort of asked which I was planning to do, and I was lucky, I didn't really have any issues with it for either of my children. I didn't go to look for or need ... outside support. But I think when I just assumed, when I was pregnant with my first child, that I would breastfeed if I could, and because that's ... what my mom did. That's what my sister, who has two kids who are now teenagers, had done, so what a lot of my friends had done.

§ I think for me, it was similar, ... family and friends, and also just I know that ...the CDC guidelines, or our recommendation is to feed, or exclusively breastfeed for six months. So that was kind of my goal based on that.

Reasons Provided For Not Breastfeeding

Several focus groups included mothers who chose to formula-feed their infants. Some reasons cited include:

- **Lifestyle limitations**
 - One or two participants indicated that they chose not to breastfeed because they wanted to smoke or drink.
 - Some younger mothers said they wanted to “get back” to their life postpregnancy
- **Baby's preference for formula**
 - Some suggested that the baby had a preference for formula.
 - Some mentioned that the baby wouldn't latch so they turned to formula.
- **The age of the mother**
 - Some participants cited their youth as a reason for not wanting to breastfeed.

Focus Group, Section III: Spanish-Language Participants

There were three focus groups with women whose primary language was Spanish. The total number of Spanish-speaking participants was, n=7. Across all Spanish-language focus groups, participants discussed:

Strong Beliefs and Norms Around Breastfeeding

- They all said that breast is best, and helps with the baby's growth.
§ Quote: "It is normal to breastfeed your babies. So, in my country, babies are only raised with mother's milk."

Challenges of Immigrant Mothers Alone in the United States

- Being alone without some family members for social support
§ Quote: I had to give birth to this baby down here (in the US), and I did not have any family member that could assist me. I'm only here by myself in this country, so that's really hard.
§ Quote: Yes, I'm by myself here in this country. So, it's a really hard experience because you don't have, I don't have my mom or dad or siblings that could assist you somehow.
§ Quote: I have the same belief in my country as with the rest, but as a first-time mother, it's a challenge because you are completely lacking experience. So even if you have nurses helping you, doctors helping you, it is hard, because in this country, we are alone and we don't have any family members around. That is a cause of stress, and I consider that affects your milk production when you're when you're a first timer, and you have no external help.

Did Not Discuss Breastfeeding As Beneficial for the Mom

- In the three Spanish-speaking focus groups, none of the mothers mentioned the maternal benefits of breastfeeding.

There were only seven Spanish-speaking focus group participants. While it may be difficult to draw many conclusions about the challenges experienced by breastfeeding mothers in DC whose primary language is Spanish, it may be worth exploring this population further.

Focus Group, Section IV: Needs of the DC Community (Solutions)

The focus groups concluded with participants giving ideas about the kinds and types of resources that might be useful in their communities. Moms had many different ideas for potential helpful resources. These are the solutions that were suggested by multiple participants across the focus groups:

1. Supplies for milk storage

- a. A couple of women mentioned that having supplies like freezer bags to help with the storage of breastmilk would reduce some of the economic burden.

2. More childcare options

- a. Childcare options that are closer to their residences with flexible hours for working moms who are returning to work.

3. Longer parental leave

- a. Generally, participants believed that more time at home with the baby would be beneficial for both the parent and the child, particularly for moms who want to breastfeed for longer.

4. More education or a greater explanation about breastfeeding challenges

- a. Women wanted more education and resources that would help mothers understand how difficult breastfeeding can be. The difficulties of breastfeeding were discussed by almost all of the breastfeeding moms, particularly first-time birthing parents. Many suggested that they weren't prepared for the difficulties and wished that healthcare providers would have told them more. One participant suggested that healthcare providers give a "lactation plan" for parents so that breastfeeding parents might be more prepared to handle challenges.
- b. More education and community understanding that breastfeeding does not work for everyone. Participants wanted to de-stigmatize not being able to breastfeed.

5. Culturally competent healthcare providers

- a. Some participants mentioned having more healthcare providers (lactation consultants and doctors) that are culturally aware would help mothers who are distrusting of medical institutions.

6. Financial assistance for new moms

- a. Focus group participants mentioned that financial assistance could be helpful to breastfeeding moms to help them stay home longer while breastfeeding.

7. Home visits from a healthcare professional

- a. Participants suggested that home visits from a healthcare provider in the first few weeks postpartum would be helpful to avoid the added stress of going outside with a new baby.

8. Breastfeeding products covered by insurance

- a. For some women, insurance covered the cost of a breast pump. Several participants mentioned that it would be helpful if insurance covered additional breastfeeding-related costs.

Provider Survey

In total, 68 providers completed the survey. Each provider received a survey tailored to their specialty, for a total of five surveys used. Table 11 shows the characteristics (medical specialty, lactation support or WIC) of the providers who completed the survey. Because the sample size by provider type is small, descriptive results are presented to highlight general trends.

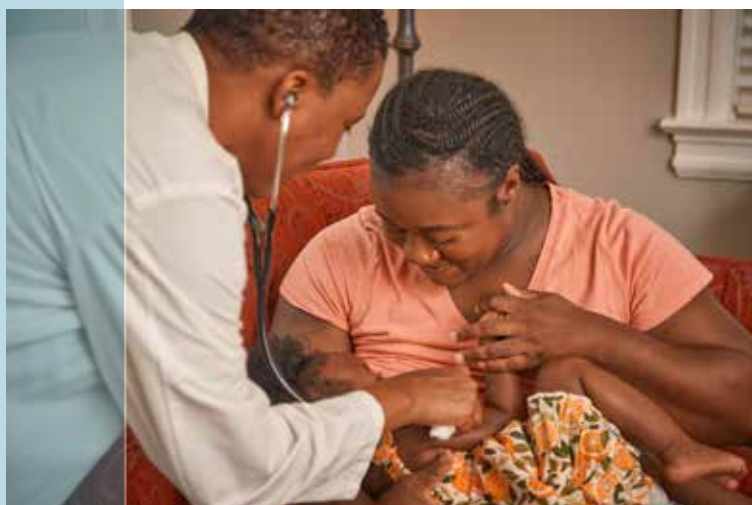


Table 11: Provider Survey Characteristics

Provider type	Number who completed the survey
Hospital provider	3
Primary and other healthcare provider	28
Obstetric clinic provider	12
Lactation support provider	11
WIC employee	14
TOTAL	68

Hospital Provider

All three hospital providers worked in a certified Baby-Friendly facility. Challenges they noted in becoming certified as Baby-Friendly included the time commitment and cost. All providers reported that their facility had an IBCLC on staff. Two out of the three respondents reported that an IBCLC is available in the evenings and two out of the three said they were not sure if one was available on weekends. When asked what support is provided to birthing parents in the hospital postpartum two reported that they were not sure.

Primary and Other Healthcare Provider

The majority of primary and other healthcare providers were female (n=23/28; 82.1%), 23 (82.1%) were pediatricians, four (14.3%) were family practice providers, and one (3.6%) was a psychologist. Fifteen (53.6%) reported that they worked for Children's National Hospital Primary Care. The majority reported that they were educated about breastfeeding through didactic lectures (n=23;82.1%), online classes (n=10;35.7%), hands-on classes (n=8;28.6%), by shadowing (n=4;14.3%), and/or their own personal experience (n=4;4.3%). When asked who assists patients with breastfeeding challenges, 22 (78.6%) reported a lactation specialist, and 21 (75.0%) reported a provider. Around half reported that their practice had staff members with specific training in breastfeeding to assist families, eight (28.6%) reported IBCLC, and six (21.4%) reported a lactation specialist. Twenty (71.4%) said that they refer to outside groups for breastfeeding support and of those 11 (55.0%) referred to East of the River Lactation Support Center and 12 (60.0%) to the Breastfeeding Center for Greater Washington. When asked if they knew if outside breastfeeding support resources were paid for by insurance, all said they were not sure, when asked if Medicaid covers support resources 13 (46.4%) said they were not sure, and when asked if their practice tracks breastfeeding rates 12 (42.9%) said they were not sure. Eleven (55.0%) reported that they did not have enough time to provide adequate breastfeeding support and 18 (64.3%) reported that their practices did not have adequate expertise in house. Of the 22 pediatric providers who answered how often they provide direct assistance to the breastfeeding dyad, nine (40.9%) said once a month, six (27.3%) said once or twice per year, four (18.2%) said once every three months, and three (13.6%) said once a week or more.

Obstetric Clinic Provider

Six out of the 12 respondents were obstetricians, five were nurse midwives, and one was an obstetric resident. When asked how they were educated about breastfeeding, six said online classes, 11 said didactic lectures, and five said hands-on classes. When asked how families were educated about breastfeeding prenatally, seven said through classes, nine said individual discussions with obstetric providers, seven said individual discussions with nursing staff, and seven said through classes. Five reported that their practice provides breastfeeding classes and 10 reported that they refer to outside groups to educate families on breastfeeding. Ten said they have staff members with specific training to assist families with breastfeeding. Nine reported that they discussed breastfeeding at least once with every patient and three reported with 75 to 99% of patients. All 12 reported that they document that they discussed breastfeeding with the patients in the medical record. Two reported that they never provide direct assistance to the breastfeeding dyad. When asked about frequency of providing direct assistance to the dyad, five said once every three months or less frequently, and five said once a month or more frequently. When asked what the challenges were with educating families about breastfeeding, most reported that they had little time, they had no experts in house, or they had limited training for breastfeeding. When asked what they would suggest improving breastfeeding support in their office, most responded that they need longer appointments or embedded breastfeeding support staff. All of the respondents were female. Eight reported that they had children and all eight reported that they had breastfed them.

The following quote was selected to summarize the general sentiments of the providers surveyed:

“Reimbursement for lactation consultants needs to be sufficient to support their salary. There should be lactation consultants in every large health center in the District providing newborn care. They should see patients full time Mon- Fri. Patients should be given a newborn appt and a lactation appointment within 3 days of leaving the hospital. There should be free lactation education (English/Spanish at minimum) on demand for patients that providers can promote and MCOs should incentivize - complete the education and get a gift card.” -Nurse midwife, 20+ years’ experience in practice

Lactation Support Provider

Six of the 11 (54.5%) lactation support providers who completed the survey reported that they work in a private clinic. Eight (72.7%) said that they get insurance payments and 10 (90.1%) reported that they provide services for families receiving Medicaid. The challenges lactation support providers reported providing services to families receiving Medicaid included difficulty obtaining breast pumps and finding providers who perform frenectomies and accept Medicaid. Challenges that they've noticed for breastfeeding families receiving Medicaid include complex medical needs, inadequate housing and nutrition, and low reimbursement rates. Five reported that they provide services on the weekend and three provide them in the evening hours. When asked about challenges and what they would recommend several themes emerged and are summarized well by the following quote:

“Most moms do not have the time and support they need to continue breast-feeding longer. Most moms stop after a couple months due to having to go back to work because they need money. Some do not have help from anyone and tend to stop because they have to care for their other children. Other moms have mental/emotional issues and need a break because they feel tied down. It seems much easier for them to formula feed when they have no one else that could help them. Some moms complain of how painful it can be daily and not having anything to calm the pain down. Breastfeeding is stressful for some if they do not have any support.”

WIC Employees

Twelve WIC employees completed the survey. Six (50.0%) were nutritionists, two (16.7%) were peer-counselors, two (16.7%) were clinic assistants, and two (16.7%) were nutrition counselors. Out of the ten (83.3%) who reported that they received specific breastfeeding training, seven (70.0%) reported that they received specific breastfeeding training through online classes, and four (40.%) said through hands-on classes. When asked to identify the biggest unmet needs for breastfeeding, respondents reported that patients had to return to work quickly for financial support, did not have help when needed, and they did not have access to breast pumps.

Recommendations

Overview: The literature is clear that birth parents who receive information about breastfeeding during pregnancy are more likely to initiate breastfeeding.^{15, 16} Breastfeeding education is needed throughout pregnancy, after delivery and during the first year of life. This education should extend to family and friends who are providing support to the birth parent. The role of the healthcare system is critical in providing education and support prenatally and for the breastfeeding dyad. Recommendations are presented below by structural level (family, community and healthcare).

Family-Level

Family and friends are the top two groups respondents spoke to about breastfeeding prenatally. After the breastfeeding dyad leaves the hospital, family and friends continue to be an important source of breastfeeding information and support. Therefore, we recommend that these groups are prioritized to receive breastfeeding education to ensure they are providing accurate information to pregnant individuals and to new parents. Furthermore, studies have shown that mothers who receive breastfeeding support from family and peers have more breastfeeding success.¹⁷ Social media is ubiquitous in our society and more than half of respondents reported that social media is a preferred way to receive information. Future research is needed to understand what sources of online/social media parents use and the quality of the information those sources provide. We recommend that DC Health and its community partners update their websites to ensure the breastfeeding information is accurate, high quality and easily accessible. We recommend targeted social media campaigns with discrete and concrete information that is easily digestible for mothers, families and friends to understand.



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Community-Level

The results show that nearly one-third of respondents stopped breastfeeding earlier than they wanted to and the top reasons were returning to work or school and not getting help when they needed it. DC's paid parental leave is an important intervention to allow mothers to delay reentry into the workforce and breastfeed longer.¹⁸ A national study showed that parents living in states with paid parental leave had longer breastfeeding duration than states without this law.¹⁹ Additionally, a systematic review of the literature showed that parents breastfeed longer if they have longer parental leave.²⁰ Since family members are an important source of breastfeeding support during the first months of life, it is also important to ensure the non-birthing parent/partner also receive parental leave as this has been shown to increase breastfeeding duration.²¹

Support in the workplace has been found to improve breastfeeding duration.^{22, 23} This support includes providing designated spaces for milk expression and support from co-workers and managers. DC and federal laws require employers to provide time and space for employees to express milk.²⁴⁻²⁶ Almost 30% of employees said that more support at work would have helped them breastfeed longer. We recommend educating employers and employees about these laws and enforcing the laws. It is recommended employers and colleagues are educated about the importance of supporting breastfeeding employees. Strengthening education about paid family leave benefits and federal and local mandates about lactation accommodations can be tools to empower mothers to continue and to access breastfeeding support in the workplace.

Expanding breastfeeding support at home and in the community is critical to help with breastfeeding success. Given that parents reported not getting help when needed, expanding home visitation programs with lactation experts could identify concerns early and improve breastfeeding duration. In addition, we recommend increasing access to support outside of regular work hours by having lactation specialists available through virtual platforms like Zoom or Pacify, creating more WIC breastfeeding support groups and increasing doula support programs in the District.



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WIC-Level


WIC can be an important source of information about breastfeeding. WIC encourages and supports breastfeeding through expanded packages for breastfeeding parents, peer counselor support, breastfeeding classes, texts and breast pumps. Most WIC providers said they received specific breastfeeding training, although only 40% received hands-on training. We recommended all WIC employees who counsel parents about feeding receive hands-on breastfeeding training.

WIC employees reported that mothers often had to return to work early to financially support their families, did not have access to breast pumps and were unable to get help when needed. We recommend identifying ways to increase the percentage of birth parents enrolled in WIC prenatally, the distribution of breast pumps through WIC when indicated, and the education of families enrolled in WIC about paid parental leave and laws requiring employers to provide time and places to express milk at work.

Healthcare-Level

Healthcare providers are a trusted source of breastfeeding information for families. Many parents in this study reported that providers helped them with breastfeeding challenges, but there also reported gaps in breastfeeding support. Our recommendations are grouped by provider type.

Hospital Providers: Hospital providers are ideally situated to ensure breastfeeding starts well and that infants are exclusively breastfed in the hospital. About half of respondents reported that their child received formula in the hospital with the top reasons being poor latch, perceived insufficient milk and wanting their child to get formula. The first two reasons could be easily remedied by assistance from a knowledgeable provider. A small percentage of participants' infants received donor milk in the hospital. We recommend ongoing support of breastfeeding education for hospital staff and identifying ways to make donor milk more easily available in the hospital. We also recommend ensuring birth parents at risk for breastfeeding problems are identified and referred to lactation support services after hospital discharge.



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Obstetricians: Obstetric providers have a prime opportunity to provide needed prenatal breastfeeding education to families. Obstetric providers include family practice providers and midwives who provide peripartum care and obstetricians. ACOG recognizes the importance of prenatal breastfeeding education.²⁷ Our results show different perspectives about whether families receive adequate prenatal breastfeeding education in the obstetric clinic. Only a minority of parents (29%) reported that their obstetric providers spoke with them prenatally, but 9 out of the 12 (75%) of obstetric providers said they discuss breastfeeding with every patient. This may reflect selection bias in that obstetric providers interested in breastfeeding promotion may have completed the survey. Obstetric providers are positioned to help families prenatally as they have continuity with families, may be the only medical provider birth parents see prenatally, and are a trustworthy source. The sentiments expressed during the focus groups and the data from the survey show that parents miss this prenatal education from obstetric providers. We recommend families receive more consistent, comprehensive prenatal breastfeeding education targeted to the parents' specific needs during their obstetric visits. Ideally this education should include the birth parents' partner or support person as this has been shown to increase breastfeeding initiation and duration.²⁸

The obstetric providers identified barriers to providing this education including lack of time, reimbursement, knowledge and lactation support. We recommend creating a task force led by obstetric providers to determine the best ways to provide accurate information in a timely manner. Some suggestions include encouraging breastfeeding education for obstetric providers, following recommendations in the Academy of Breastfeeding Medicine clinic protocol #19 Breastfeeding Promotion in the Prenatal Period and/or incorporating WIC breastfeeding peer counselors or paraprofessional educators to ensure every parent receives breastfeeding education prenatally.²⁹ Brief breastfeeding education of obstetric residents has been found to increase their breastfeeding counseling and brief prenatal education by a WIC breastfeeding counselor in Washington, DC was shown to increase WIC clients' breastfeeding efficacy.³⁰ We recommend working with insurance companies to enable adequate payment for prenatal breastfeeding education and support.



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Pediatric Providers: Pediatric providers are the first health professionals families encounter after hospital discharge and are an essential source for breastfeeding education and support. When specifically asked whether their child's pediatrician/pediatric provider helped with breastfeeding, half said yes. Pediatric providers reported barriers to helping the breastfeeding dyad include time limitations, lack of payment by insurance companies and not having a lactation specialist in the clinic. Some recommendations to mitigate these barriers include increasing pediatric provider breastfeeding hands-on education to enable them to provide accurate breastfeeding help in a more efficient manner. It is possible that with adequate payment for services, more providers would be able to incorporate lactation specialists into their outpatient clinics.

Lactation Providers:

Almost 40% of the participants mentioned experiencing breastfeeding difficulties after hospital discharge. Most of these problems could be managed by a pediatric or WIC provider, yet lactation providers are experts trained to help those with more complex breastfeeding challenges. We recommend ongoing support of lactation support programs. Lactation providers mentioned low reimbursement rates for Medicaid providers as a barrier to providing care to these families. We recommend ensuring Medicaid reimbursement rates are sufficient to enable lactation providers to help these families.



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Special Considerations

Based on national data, we know that Hispanic families and Black families breastfeeding duration is significantly shorter than that of other ethnicities and these trends are similar in the District of Columbia.¹ Given the small sample size of Spanish-speaking patients in our focus groups, we are not able to make concrete recommendations for this community based on our results. As such, we recommend that additional efforts be made to explore the experience of immigrant families in the District and their unique challenges. Key areas to explore include where these families seek support, what type of support they receive in the workplace, and the availability of education in their primary language.

While direct recruitment for the parent surveys and focus group study was conducted in targeted areas to ensure participation from key demographics, the study was not designed to generate results representative at the ward level. Many, but not all, participants from Ward 8 were recruited by the investigators at a health center with enhanced breastfeeding support services while those from Wards 3, 6, and 7 were all recruited by posted flyers or by the paid panel, thus their access to such support services is unknown. For many of the variables in the study, the cell sizes were too small to allow analysis at the ward level, even after combining those recruited through all methods. These are just three reasons that examining breastfeeding outcomes by ward would not be appropriate. Future research is recommended to generate results that are representative at the ward level, including a survey with a larger sample size and a sampling strategy to ensure unbiased sampling.



In summary, the District of Columbia should continue to position itself and aim to provide evidence-based and culturally congruent breastfeeding support to families and infants. This needs assessment enabled us to listen to DC parents and healthcare providers to better understand barriers and identify solutions to improve breastfeeding support in the District of Columbia. Implementation of our recommendations could increase breastfeeding education and support and help eliminate breastfeeding inequities in the District of Columbia.

Methods

Study Population

Survey of parents: The study population for the survey was drawn from two sources. The survey was distributed to 100 DC residents using a paid survey panel. For this report, the group of respondents who completed the online survey after it was distributed using the paid survey panel are referred to as “Panel”. Study team members also aimed to directly recruit 100 residents from Wards 5, 7, and 8 to ensure adequate participation from these priority areas which were the focus of the project. Recruitment was conducted at various clinics and community locations across DC (Survey Appendix Supplemental Table 1). Survey recruitment flyers were also posted on DC-specific social media sites. All parents recruited from sources other than the paid survey panel are referred to as “Non-Panel” for this report. The total recruitment goal for the survey was 200 parents.

Parents were eligible to participate if they did not have a contraindication to breastfeeding, lived in the District of Columbia, gave birth to a child who is still living in the two years prior to the survey, and spoke English, Spanish, French, or Amharic. Survey respondents received a \$20 gift card incentive upon completion of the survey. The parent survey was administered between April 29, 2024, and December 10, 2024, to individuals who met the inclusion criteria.

Focus group of parents: Eligible parents were recruited using the same strategy outlined for the direct parent survey, ensuring participation from communities with priority demographics. Inclusion criteria mirrored those previously described, with recruitment limited to Spanish- and English-speaking participants. All focus groups were facilitated by a trained qualitative researcher, recorded, and transcribed verbatim. Participants received a \$100 gift card incentive upon completion. Fifteen one-hour focus groups were conducted via Zoom. Each focus group included between two and seven participants. Twelve of the 15 groups were conducted in English, the remaining three were conducted in Spanish. Seven people participated in the Spanish-language focus group. There were a total of 64 focus group participants.

Survey of providers: Providers were eligible to participate if they practiced in Washington, DC, and were members of one of the target groups:

- Birthing facility providers: neonatal provider, IBCLC, and obstetric providers
- Clinic providers: pediatricians, family practice providers, nurse practitioners, obstetric providers, and midwives.
- Lactation Support Providers: peer and professional lactation support personnel from DC hospitals/birthing facilities and private practices.
- WIC employees: employed by DC WIC.

Providers did not receive an incentive for completion of the survey. The provider survey data was collected between August 12, 2024 and December 16, 2024. Surveys were sent to five types of providers (hospital-based maternal and child health providers, primary care providers, obstetric clinic providers, lactation support providers, and WIC employees). The survey was tailored for each type of provider and thus five survey instruments were used. WW

Pediatric providers were recruited via flyers sent electronically to faculty at the five Children’s National Hospital Primary Care sites (Anacostia, THEARC, Columbia Heights, Shepherd Park, and Shaw Metro), or via flyers sent to the medical directors at Children’s National Pediatricians & Associates (CNPA) Foggy Bottom, Kaiser Permanente (Kaiser), Unity Health Care (Unity), Mary’s Center , Community of Hope, as well as through the DC Chapter of the American Academy of Pediatrics newsletter. Obstetric providers were recruited through flyers sent electronically to the Perinatal Committee of the DC Chapter of the American Academy of Pediatrics, members of the DC American College of Obstetricians and Gynecologists, and obstetric medical directors of all DC birthing facilities, Kaiser, Unity and Mary’s Center. Lactation support providers were recruited through emails sent to directors of the Children’s National East of the River Lactation Support Center, The Breastfeeding Center for Greater Washington and to the listserv for The Lactation Consultants Association of Greater Washington. DC WIC employees were recruited through flyers sent electronically to all the WIC directors.



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Data Collection

Survey Tools

The survey instruments were developed by study team members with demonstrated expertise in lactation practice and research. Prior to IRB submission, all tools underwent review and approval by the DC Health grant project officer and program manager to ensure alignment with programmatic and scientific standards. Final survey instruments are available upon request.

Study Variables-Parent Survey

Social Drivers of Health. See Table 1. Sociodemographic and economic status variables included age of respondent, race/ethnicity, education, language spoken at home, WIC enrollment and eligibility, employment during infant's first year of life, and ward of residence.

Prenatal care. Participants were asked if they had received prenatal care (dichotomous) and which trimester care began (categorical). They were also asked where they had given birth to their infant (additional data on the facility level comparisons not shown as they may not be reflective).

Breastfeeding support and education overall and during pregnancy. Participants were asked to select who encouraged them to breastfeed in general, who spoke with them about breastfeeding during their pregnancy, and where they received information about breastfeeding before their child was born.

Breastfeeding experience in the hospital: Individuals were asked how their infant was fed in the hospital and why that decision was made. They were asked if they had difficulty breastfeeding in the hospital and who helped them with breastfeeding in the hospital.



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Breastfeeding practices and intention: Participants were asked how they fed their infant in the first year of life (categorical: formula only, breastfed only, or both), and asked if they had ever breastfed or given human milk to their infant. Participants were also asked how they intended to feed their infant during the first year of life (categorically: formula only, breastfeeding only, or a combination of both). If their plans changed, they were asked to explain the reason for the change.

Breastfeeding experience after hospital discharge:

Respondents were asked whether they experienced any breastfeeding difficulties after leaving the hospital, the infant's age at the time of the difficulty, and who provided breastfeeding support once they were home.

Difficulty with breastfeeding: Participants were asked what made it difficult to get breastfeeding support and who helped them.

Support for breastfeeding: Participants were asked how they would have liked to receive breastfeeding education and support.

Helpful experiences: Participants were asked an open-ended question about the experiences that were helpful with breastfeeding.

Study Variables-Provider Survey

The provider survey assessed multiple dimensions of breastfeeding support within clinical practice. Key variables included:

- Providers' prior education and training in breastfeeding support
- Types of breastfeeding support routinely offered to parents
- Perceived strengths and challenges within their practice settings
- Recommendations to enhance breastfeeding support systems across Washington, DC

Focus Group Guide Development

The focus group guide was developed collaboratively with representatives from the DC Breastfeeding Coalition. The guide featured open-ended questions addressing breastfeeding initiation, duration, sources of support, barriers encountered, and interactions with healthcare systems. The collaborative development process ensured that the guide was both culturally responsive and aligned with local public health priorities.

Data Analysis

Parent survey data. There were 224 eligible individuals who completed the survey. Descriptive statistics were produced for all variables that had more than five responses. Bivariate analyses were then conducted to examine differences between (1) each social driver of health (SDoH) and the study sample source, and (2) each SDoH and the support-related variables. Chi-square and unadjusted odds ratios and 95% confidence intervals were conducted to identify statistically significant associations. Thematic analysis of the three open-ended questions was also performed. Finally, we compared the distribution of sociodemographic and related variables in our sample with those of the general DC population when possible, to better understand differences between our sample and the general DC population. All analyses of survey data were conducted using Stata version 17 (College Station, TX).

Provider survey data. Due to the small sample a bivariate analysis was not performed rather a descriptive analysis was conducted. Frequencies of key variables were generated according to type of provider. A preliminary thematic analysis of the open-ended questions was also performed.

Parent focus group data. Data analysis was conducted in two phases using an iterative, multi-stage approach. In the first phase, transcripts from the initial seven focus groups were coded using an open coding process to identify emerging themes. In the second round of this phase, the researcher conducted cross-group comparisons to refine thematic categories and used communication and behavioral science frameworks to contextualize and interpret the data.

After all 15 focus groups were completed, a second phase of analysis was conducted. This involved re-examining and updating the initial coding framework to incorporate data from all sessions. Emerging themes were refined and expanded to reflect the full dataset, ensuring analytical consistency and theoretical saturation across both English- and Spanish-language groups.

The qualitative (focus group) data were thematically coded for analysis using MAXQDA, a qualitative data management and analysis software tool.

Appendix Survey

Supplemental Table 1: Direct Recruitment Locations

Organization	Ward
Children’s National Pediatricians & Associates Foggy Bottom	2
Children’s National Primary Care at Anacostia	8
Children’s National Primary Care at Columbia Heights	1
Children’s National Primary Care at Shepherd Park	4
Children’s National Primary Care at THEARC	8
DC Department of Human Services at Anacostia	8
DC Department of Human Services at Fort Davis	5



Supplemental Table 2: Comparing Demographic Characteristics Between Panel and Non-Panel Respondents

CHARACTERISTICS	Total SAMPLE		NON-PANEL		n	%	Significant Difference between Panel and Non Panel	DC adult percentage (when available)
	n	%*	n	%				
SOCIAL DRIVERS OF HEALTH								
Total survey	224	100		53.6	104			
Mother's Age (years)	n	%	n	%	n	%		
18-24	17	7.6	15	12.5	2	1.9		13.3
25-30	89	39.7	30	25	59		Pearson chi2(4) = 36.59 p-val<.001	16.8
31-35	84	37.5	46	38.3	38			32.6
>35	31	13.8	27	22.5	4	3.8		37.3
Race/Ethnicity	n	%	n	%	n	%		%**
Non Hispanic White	126	56.3	31	25.8	95			36.6
Non-Hispanic Black	59	26.3	56	46.7	3	2.9	Pearson chi2(3) = 98.97 p-val<.001	43.3
Hispanic	17	7.6	13	10.8	4	3.8		11.6
Other	22	9.8	20	16.7	2	1.9		N/A
Education	n	%	n	%	n	%		%
HS degree or less	37	16.5	36	30	1	1		13.1
Associate degree, Some College, Completed College	84	37.5	44	36.7	40		Pearson chi2(3) = 39.00 p-val<.001	40.6
Graduate Degree	102	45.5	39	32.5	63			39.0
Medicaid Insurance	n	%	n	%	n	%		%***
Yes	119	53.1	53	44.2	52	50		52.0
No	105	46.9	67	55.8	52	50	Pearson chi2(1) = .763 p-val=.383	48.0
Language spoken at Home	n	%	n	%	n	%		
English	204	91.1		83.3	104	100		

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Spanish	16	7.1	16	13.3	0	0	Pearson chi2(2) = 19.03 p-val< .001	
Other	4	1.8	4	3.3	0	0		
WIC participation	n	%	n	%	n	%		
Not in WIC and not eligible	63	28.1	46	38.3	17			
WIC Eligible but not in WIC	56	25	13	10.8	43		Pearson chi2(2) = 31.19 p-val<.001	
WIC enrolled	105	46.9	61	50.8	44			
Ward living in	n	%	n	%	n	%		%**
1	33	14.7	24	20	9	8.7		12
2	31	13.8	10	8.3	21		Pearson chi2(8) = 56.43 p-val<.001	12
3	38	17	5	4.2	33			12
4	30	13.4	15	12.5	15			13
5	22	9.8	15	12.5	7	6.7		13
6	10	4.5	5	4.2	5	4.8		12
7	21	9.4	12	10	9	8.7		14
8	27	12.1	25	20.8	2	1.9		12
Worked or volunteered when baby was <1 year	n	%	n	%	n	%		
No	119	53.1	54	45	65			
Yes	102	45.5	63	52.5	39		Pearson chi2(2) = 8.56 p-val=.014	
Key pregnancy care behaviors								
Received prenatal care	n	%	n	%	n	%		
Yes	192	85.7		95.8	77			
No	32	14.3	5	4.2	27		Pearson chi2(1) = 21.61 p-val<.001	
Trimester began care	n	%	n	%	n	%		
1st	126	56.3		84.2	25			
2nd	57	25.4	10	8.3	47		Pearson chi2(2) = 65.00 p-val< .001	
3rd	9	4	4	3.3	5	4.8		
Difficulty breastfeeding while in hospital	n	%	n	%	n	%		
Yes	77	38.3	53	49.1	24			
No	124	61.7	55	50.9	69		Pearson chi2(1) = 11.45 p-val=.001	

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Difficulty breastfeeding while in hospital	n	%	n	%	n	%		
Yes	77	38.3	53	49.1	24			
No	124	61.7	55	50.9	69		Pearson chi2(1) = 11.45 p-val=.001	

*224 is the denominator, % does not add up to 100% due to missing responses

Sources: **DC Kids Count Ward Snapshots,¹¹ ***DC Medicaid State Fact Sheet¹³

Appendix Focus Group

Table FG 1: Description of Each Focus Group Including a Listing of Conducted Date, Language, Number of Participants, n= 64

2024			
1	August 27th	English	5
2	September 11th	English	2
3	September 19th	English	5
4	October 3rd	English	6
5	October 12th	Spanish	2
6	October 14th	English	7
7	November 7th	English	7
8	December 20th	English	4
2025			
9	January 15th	English	2
10	January 17th	English	3
11	January 31st	English	6
12	February 12th	Spanish	3
13	February 24th	English	5
14	February 28th	Spanish	2
15	February 28th	English	5

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