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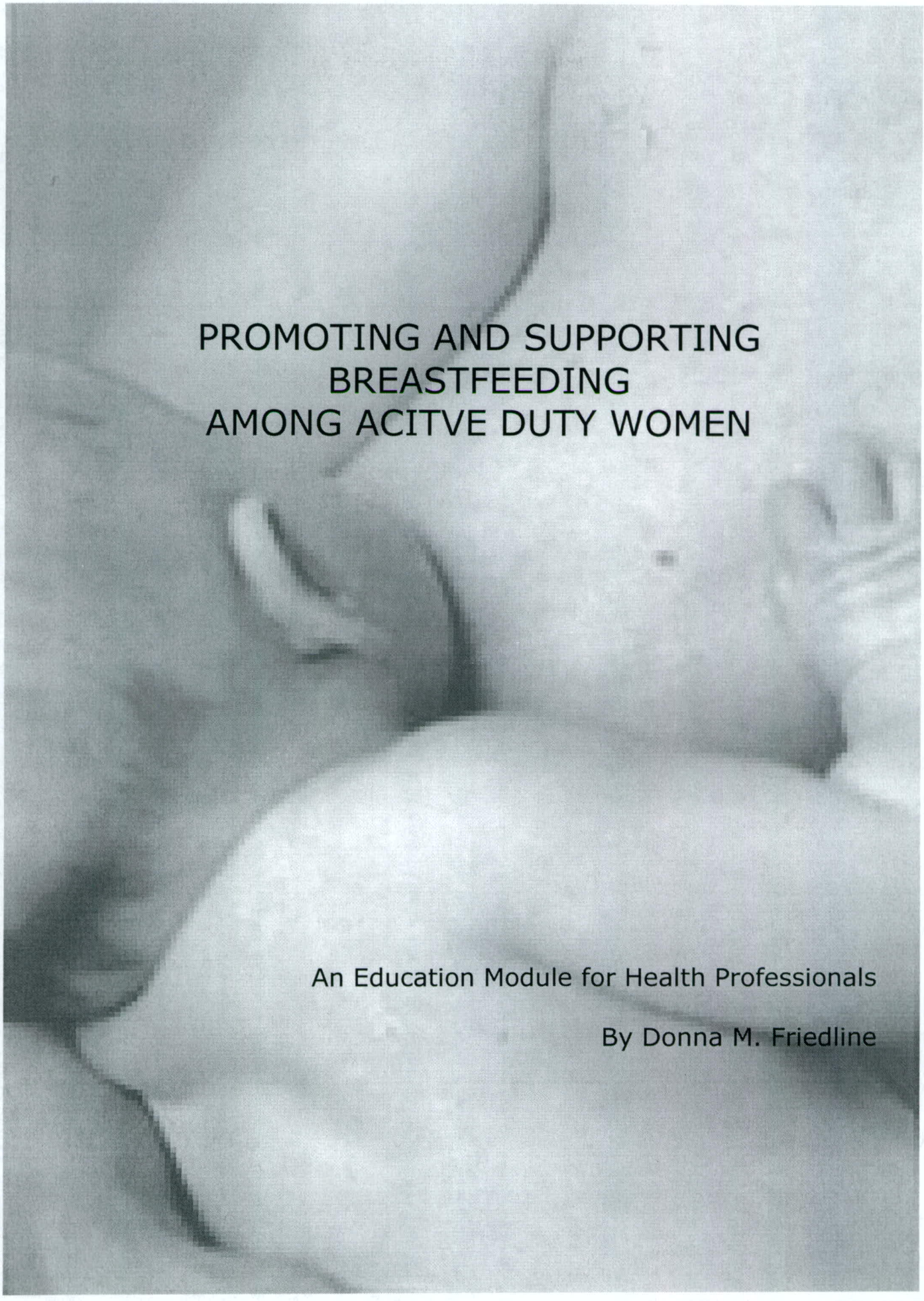

PROMOTING AND SUPPORTING BREASTFEEDING AMONG ACITVE DUTY WOMEN

An Education Module for Health Professionals

By Donna M. Friedline

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In recent years, there has been a steady increase in the number of women serving in the United States military. Most women serving on active duty are of childbearing age. The decision to breastfeed while remaining on active duty is an area of potential conflict. While it is well known that full-time employment decreases the incidence and duration of breastfeeding, active duty women may face additional obstacles such as potential deployment, body weight requirements, and hazardous workplace exposures, in addition to problems faced by their civilian counterparts.

For decades, research has shown that breastfeeding provides numerous health and economic benefits for newborns, mothers, and society. The American Academy of Pediatrics [2] describes breast milk as "uniquely superior" form of infant feeding and recommends "breastfeeding continue for at least 12 months, and thereafter for as long as desired" [p. 1037]. Numerous other professional organizations, including the American College of Nurse-Midwives [3], the American Dietetic Association [5], the Association of Women's Health, Obstetric, and Neonatal Nurses [7], the American College of Obstetricians and Gynecologists [4], the American Academy of Family Physicians [1], and the International Lactation Consultant Association [29], have made similar statements in support of breastfeeding.

In the United States, the Healthy People 2010 initiative set goals to increase breastfeeding rates to 75 percent at hospital discharge, to 50 percent at six months, and to 25 percent at 1 year of life [48]. In reality, these goals are ideals and despite the known benefits of breastfeeding and support from health care professionals breastfeeding rates continue to fall short of these Healthy People 2010 goals. To meet these goals barriers to breastfeeding must be identified and minimized.

The purpose of this education module is to help educate health care professionals in identifying and reducing the potential barriers for active duty women choosing to breastfeed.

Breastfeeding in the Military

Women comprise 13.4 percent of today's military force and work in a variety of jobs; making them key to the U.S. military. Of the 193,099 women in the U.S. military in 1997, more than 75 percent were under the age of thirty-five [19]. Military women are strongly representative of the populations in which the lowest breastfeeding rates are found, such as low income, minority, and those with less than a college education [19 & 33]. As the

Table 1: Comparison of breastfeeding rates and goals

Breastfeeding at Specific Time	Healthy People 2010 Goals[47]	Full-time Employed Civilians (2002) [39]	Unemployed Civilians (2002) [39]	Active Duty Army (1990)[48]	Active Duty Army (2002)[30]	Active Duty Air Force (1997)[21]
Initiation	75%	69%	69%	100%	89%	85%
2 weeks	NR*	NR*	NR*	73%	NR*	67.9%
2 months	NR*	NR*	NR*	37%	42.1%	35.7%
6 months	50%	27.5%	35.2%	10%	NR*	21.4%
12 months	25%	12.6%	23.8%	10%	NR*	NR*

*NR: Rate not specified for group at specified time

percentage of childbearing women in the military increases greater emphasis must be placed on breastfeeding support. Despite the large number of childbearing women in the military, research on breastfeeding and active duty women is limited and most remains unpublished. Available research has shown that active duty women initiate breastfeeding at higher rates than their civilian counterparts, but often discontinue breastfeeding before or soon after returning to work [10, 18, 25, 31, & 49]. By eight weeks post partum, breastfeeding rates among active duty women are already less than the six month goal of Healthy People 2010. The breastfeeding rates of active duty women, employed civilians, unemployed civilians, and Healthy People 2010 goals are compared in Table 1.

Several studies have looked at the experiences, attitudes, and barriers to breastfeeding for active duty women, but only one qualitative study is published. Stevens [43] was the first published study to examine the breastfeeding experiences of military women. This small study (N=9) identified military specific issues such as deployment, rank, and weight standards in addition to issues with pumping, commitment, and work place support which were similar to employed civilian women. The similar findings of other studies of breastfeeding with military populations are summarized Table 2.

Military Breastfeeding Policies

The Department of Defense (DoD) has no formal policies on breastfeeding within the military. All services provide 42 days of post partum convalescent leave and deferment from deployment until 4 months post partum with the exception of the Coast Guard which allows 6 months deferment from deployment [10, 28]. The United States Navy is the only service with written policy that addresses breastfeeding. This policy allows time for breaks and meals with their commanders'

TABLE 2: Research on Breastfeeding and Active Duty Women

Author	Date	N=	Type of Study	Population	Results	Strengths / Weaknesses
Bristow [15]	1999	4	Qualitative, semi-structured interviews	Active duty officers, primiparous, age 28-42, East Coast medical facility	Women reported husband as most support person, lack of work place support, a strong desire for increased maternity leave and positive reinforcement for health care providers	Described factors that influenced feeding decision and barriers to breastfeeding; small purposeful sample of highly educated professionals
Harlow [25]	2000	64	Descriptive, questionnaires and/or interview	Active duty Air Force & dependents, mid-size Northwest hospital	65% stated health care provider recommended breastfeeding; barriers identified were active duty status, lack of pre-pregnancy counseling, lack of family support, frequent moves, no time to pump, formula gift packs, & supplementation in hospital; facilitators were rooming-in, feeding on demand, & positive breastfeeding experience in hospital	Response rate 71%; explored barriers and facilitators at military facility; provided information on system-level influences; possible interviewer bias with data collection methods; sample not exclusively active duty; few ethnic minorities
Krueger [31]	2002	126	Prospective cohort, sequential surveys	Active duty, Tri-service, Madigan Army Medical Center, ages 19 to 37, 93% enlisted	88.9 % of officers vs. 33.3% of enlisted breastfeeding at 8 weeks; factors associated with not breastfeeding at 8 weeks- enlisted, return to duty <6weeks PP, heavy field duty, difficult work schedules, lack of command and co-worker support, and deployment	First to explore attitudes, social norms, and perceived control in Army women; Sample younger with lower education levels than general Army population; Few officers in study limits generalization to this subgroup

TABLE 2 (Continued): Research on Breastfeeding and Active Duty Women

Author	Date	N=	Type of Study	Population	Results	Strengths / Weaknesses
Stevens [44]	2003	9	Qualitative, unstructured interviews	Active duty, Air Force, Midwest	Identified military specific issues as deployment, rank, and weight standards; Pumping issues, commitment, and work place support were similar to civilian women.	First published study exploring breastfeeding experiences of military women; may lack generalization to military stationed elsewhere
Vanderlaan [49]	1990	44	Descriptive, mailed questionnaires	Active duty, Tri-service, Madigan Army Medical Center	43% decided feeding method before pregnancy; most breastfeed shorter durations than anticipated and stopped breastfeeding due to work schedules, physical training requirements, and inadequate milk supply	Provided information about maternal attitudes and impact of military employment on breastfeeding; return rate 49%; small sample; sample under-representative of African American soldiers

permission [10].

Military Breastfeeding Resources

Bell [10] surveyed DoD hospitals to evaluate the resources available to military women. Prenatal and inpatient breastfeeding support were typically good. Hospitals with the best breastfeeding support obtained grants to support their programs. Ninety-five percent of hospitals had trained lactation consultants, although most were part-time positions. The majority of facilities offered prenatal breastfeeding classes and practiced post partum rooming-in. However, only one military hospital has been awarded "Baby-Friendly" status.

On the other hand, outpatient support for breastfeeding military mothers was generally lacking due to limited resources. Only 47 percent had program to support working mothers. Furthermore, only 16 percent had breast pump loan programs and even less (11%) had workplace lactation rooms available outside of the hospital [11].

Benefits of Breastfeeding

Breastfeeding is recognized as the optimal infant nutrition by numerous health care authorities. Most authorities recommend exclusive breastfeeding for the first six months of life to promote optimal growth and development with the addition of age-

appropriate foods and continued breastfeeding until at least 12 months of age. These recommendations are based on a wealth of evidence attributing breastfeeding with decreases acute and chronic health conditions. [1, 2, 3, 5, 7, 26, 29, & 32].

Extensive research has shown multiple benefits for mothers, infants, and society. Mothers who breastfeed have decreased rates of breast and ovarian cancer, decreased rates of osteoporosis, decreased postpartum blood loss, delayed fertility, and possibly more rapid return to normal weight. In addition, many mothers describe physiological benefits of breastfeeding such as increased self-esteem and improved maternal-infant bonding [2, 12, 26, & 32].

The benefits of breastfeeding for infants are immense. Studies have shown that breastfed infants have decreased rates of ear infections, diarrhea illnesses, allergies, and respiratory illnesses. Some benefits appear to continue into later life with breastfed infants having lower rates of diabetes, obesity, inflammatory bowel disease, and some forms of cancer. Other benefits include less chance of Sudden Infant Death Syndrome and higher intelligence scores [2, 12, 26, & 32].

The societal benefits of breastfeeding are far-reaching and include less expense for formula, decreased health care cost, and less absenteeism [25]. The cost of formula for the first year of life is estimated to be more than $900. Health care savings resulting from less acute care visits and lower health insurance premiums are helpful for both individual families and employers. Employers that support breastfeeding have found that women who are supported in their breastfeeding efforts have increased job satisfaction and less absenteeism [16].

Factors that Influence Decision to Breastfeed

More than half of women decide how they will feed their newborn early in pregnancy or before pregnancy [12, 22, &42]. Their decision is often influenced by personal, interpersonal, and system factors. Partners, mothers, and grandmothers have more influence on breastfeeding decisions than health care professionals, but information from health care providers can play an important role in a woman's feeding choices [30]. Military women are frequently separate from their family and friends, thus making health care providers more influential in their feeding decisions. In order to help women chose to breastfeed health care providers must

understand what influences a woman's feeding decisions.

By the end of the first trimester, 50% to 70% percent of women have decided how they plan to feed their newborn

Personal Factors

Personal factors that may influence a woman's breastfeeding decisions are the woman's demographics, attitudes, and beliefs. Knowing demographic data may help predict those women more or less likely to breastfeed. For example, older Caucasian women with higher education levels are more likely to breastfeed [33]. However, demographics such as age, economic status, and ethnicity are not changeable and are of limited usefulness in influencing feeding choice.

A woman's personal attitudes about breastfeeding are the best predictor of whether she will chose to breastfeed [41]. Women with positive attitudes about breastfeeding are more likely to choose breastfeeding. Women who choose breastfeeding do so because it is best for their newborn; whereas, women who chose bottle feeding do so because it is best for them [12 & 33]. The most common reasons for not breastfeeding are pain, embarrassment, returning to work, inconvenience, time-consuming, previous bad experience, medical reasons, and father's preference [8, 30, & 33].

Interpersonal Factors

Interpersonal factors that influence a woman's feeding choices are the attitudes, opinions, and recommendations of others. The father of the baby, mother's mother, and other family members and friends are the most likely individuals to influence a woman's decision [6, 8, & 30]. About 71 percent of women discuss their infant feeding choice with their partners [30]. Several studies concluded that fathers have an important role in infant feeding decisions and that the woman's views of her partner's attitude or approval of breastfeeding is a "powerful predictor" of breastfeeding intention [6, 8, & 30]. Father's who express negative breastfeeding views such as breastfeeding interfering with sex or causing "ugly" breast are likely to negatively impact the mother's feeding choices [30]. However, there is good news since one study fond that 81 percent of father's would prefer that their wives breastfeed [36].

About 29 percent of women report discussing their feeding choices with their mothers [30]. Women who were breastfed by their mothers are more likely to breastfed [42]. If a woman's mother has positive views about breastfeeding the women is likely

to choose breastfeeding; whereas, if a woman's mother has negative views about breastfeeding the woman is likely to bottle feed, especially among primiparas.

Family members and friends can also have a strong influence on a woman's feeding decision, often more so than health care providers. The views of family and friends are often based on their own breastfeeding knowledge and experiences which can have both positive and negative effects on a woman's decision.

System-level Factors

The impact of system-level factors often influences a woman's feeding decision in more subtle ways. For example, views of health care providers can be either facilitators or barriers to breastfeeding. Research has shown that expectant mothers are more likely to chose breastfeeding if it was recommended by their health care providers [22, 46, & 47]. However, lack of knowledge and education among health care providers continues to be a barrier to breastfeeding.

Other common system-level factors are the media, societal norms, community resources, and work status. The media often portrays bottle feeding as the norm and formula samples from hospitals and health care providers have been associated with early cessation of breastfeeding [13]. Women who see other women breastfeeding are more likely to breastfeed. In addition, positive work and community resources encourage women to breastfeed by showing that the benefits of breastfeeding are valued by employers and the community.

Women who plan to work full-time or who return to work before six weeks post partum initiate breastfeeding less often and breastfeed for shorter durations [13, 16, & 24]. However, working part-time has not shown to have any effect of the initiation or continuation of breastfeeding [13]. Thus, employment in itself is probably not a barrier to breastfeeding, but rather the problems women face while at their work place lead to breastfeeding difficulties. Commonly cited workplace problems include lack of support, lack of time, no place to pump, embarrassment, and prolonged separation from infant [25, 37, 44].

Helping Women Chose to Breastfeed

In order to best help women choose to breastfeed, health care providers must address the needs and concerns of women and their families. This includes assessing a woman's strengths, weaknesses, support systems, and perceived

barriers. Such barriers can be reduced be examining the woman's attitudes, beliefs, and past experiences.

Asking a woman what she knows about breastfeeding and about her past experiences is paramount. Women who have had positive breastfeeding experiences in the past or who know other woman who have successfully breastfeed are more likely to breastfeed. Furthermore, such questions provide an opportunity for health care providers to dispel any myths the woman may have.

Dispelling Myths

Women and their families frequently have many misperceptions concerning breastfeeding, especially expectant fathers [36]. One of the biggest misperceptions is that breastfeeding must be all or nothing. Many women do not realize that partial breastfeeding is possible or that any amount of breast milk is better than none. Table 3 provides an overview of some common breastfeeding myths.

Exploring Attitudes and Beliefs

A woman's attitudes and beliefs concerning breastfeeding are key factors in a woman's decision to breastfeed. Biacuzzo [12] describes the three Cs which are critical to choosing, initiating, and continuing breastfeeding. These three Cs are confidence, competence, and commitment.

Health care providers can support a woman's feeding decision and help build her self-confidence by giving positive messages about breastfeeding and the woman's ability to breastfeed. Competence is supported by helping a woman belief she has the necessary skills to achieve her breastfeeding goals. This is best accomplished

Table 3: Common Responses to Breastfeeding Myths [12 & 31]

Myth	Response
Breastfeeding hurts	Some tenderness during the first few days is common, but breastfeeding should not be painful. Painful nipples are a result of incorrect positioning and latch
I can't breastfeed because I don't drink milk	A woman does not have to drink milk to make milk
I don't want to breastfeed because I like to eat (whatever food)	There is seldom a need to give up certain foods.
Breastfeeding ties the mother down	Babies can be breastfeed anywhere and anytime. Breast milk requires no refrigeration, warming, or bottle. Actually, breastfeeding is more convenient.
My breast are too small (or too big)	The size of the breast does not effect the amount of milk produced

by providing brief, general answers to questions rather than overwhelming the woman with specific, and sometime technical, answers that makes breastfeeding seem unrealistic. Commitment to breastfeeding is demonstrated by woman taking ownership of the benefits of breastfeeding by the use of personal pronouns. For example, the woman who states "I think breastfeeding is best for my baby" is more committed than the woman who states "The books say breastfeeding is best."

In addition, a woman's intention to breastfeed is an excellent predictor of breastfeeding initiation and duration [12 & 41]. Women who intend to breastfeeding usually initiate breastfeeding as planned. What a mother states about her intended duration of breastfeeding is the strongest predictor of how long she actually breastfeeds.

Assessing Support Systems
Assessing a woman's support systems is vital to helping her identify positive resources and to reduce barriers to breastfeeding. Such assessment should include family support, community resources, and health care support. It is important to assess if the health care providers for the woman and her infant are supportive of breastfeeding. Community support can include support groups, lactation consultants, Le Leche League, and peers. The level of support of family support may be limited in military women since many have moved away from their families to due to military obligations.

Providing Advice and Education
Studies have shown that advice and education from health care providers increased breastfeeding rates [18, 41, & 46]. Yet, the frequency of provider advice varies greatly amongst studies. Women reported that providers advised them to breastfeeding 37 to 80 percent of the time [27 & 41] Furthermore, increased parental breastfeeding knowledge was significantly associated with increased breastfeeding rates [46].

Supporting Breastfeeding

A woman's decision to breastfeed is only the first step towards actually initiating and continuing breastfeeding. Barriers to breastfeeding may occur during the antepartum, intrapartum, and postpartum periods. Helping women anticipate and overcome these barriers will improve breastfeeding success.

Antepartum Barriers
Potential antepartum barriers include physical and psychological factors that may jeopardize a woman's decision or ability to breastfeed. A careful prenatal history and physical should help identify woman at risk for breastfeeding difficulties. There

are very few medical conditions which are contraindicated with breastfeeding. Currently in the United States, HIV-positive women and women with human T-cell leukemia virus type 1 (HTLV-1) should not breastfeed due to the risk of transmitting these viruses to their infants [25 & 31].

Furthermore, only a few physical conditions actually affect a woman's ability to breastfeeding. These conditions include a history of breast surgery, especially breast reduction, and insufficient glandular tissue [12 & 32]. In evaluating women who have had breast surgery the most important question is whether the milk ducts were served during the procedure. Regardless of the technique, women with a history of breast surgery are at risk for delayed lactogenesis and low milk supply [17 & 45].

Common psychological risk factors that identify woman at risk for choosing bottle feeding are history of sexual abuse and aversion to close contact. The feelings of these women can be explored, but ultimately health care providers need to support the woman's feeding decision.

Intrapartum Barriers

Barriers to breastfeeding can, and do, occur during the intrapartum period. Common barriers are anesthesia or analgesia use in labor, operative delivery, and birth of a comprised newborn.

For years, there has been ongoing controversy around whether or not the use of intrapartum analgesia or anesthesia interferes with breastfeeding efforts by decreasing newborn suckling ability. To date the research remains conflicting. Research does show that newborns of medicated mothers are more likely to have decreased neurological and adaptive behaviors [32, 39, & 50]. But research has not clearly linked these decreased newborn behaviors to poor suckling or breastfeeding difficulties. Riordan and colleagues [39] did find that suckling scores were lower in infants that received intravenous and epidural anesthesia when compared to unmediated groups; however, there was no difference in the breastfeeding initiation or duration rates between the groups. Thus, it seems prudent to educate women that no clear cut evidence exists, but that the possibility of decreased suckling efforts and suboptimal breastfeeding with the use of pharmacological pain relief in labor.

In addition, deliveries by cesarean section, forceps, or vacuum-assistance are thought to delay breastfeeding efforts. Evans and colleagues [23] found that mother who delivered by

cesarean had less milk transfer at 2 to 5 days when compared to mother who delivered vaginally. While it remains unclear if the operative delivery in itself is a barrier to breastfeeding. The increased post partum pain associated with these procedures can become a barrier to breastfeeding [13, 20, & 35]. Women often delay initiating breastfeeding and delay regular feedings when they are pain. Thus, it is important to offer strategies to decrease pain such as positioning and analgesics.

Furthermore, newborns born premature or with health complications may result in separation of the mother and newborn, feeding restrictions, and maternal fears. Women frequent comment "I was planning to breastfeed" after delivering a comprised newborn. This situation requires education concerning the infant's capabilities and/or limitations, the benefits of offering breast milk, and exploration of the women's feelings. Women who desire to continue with there plans of breastfeeding should start expressing milk as soon as possible until the infant can begin suckling.

Postpartum Barriers

Postpartum barriers can be divided into early and late barriers. Common barriers to initiation of breastfeeding in the early postpartum period are pain and system-level factors. Late postpartum barriers are return to work and the mother's perception of low milk supply [13, 24, 33, & 47]. In addition to operative pain previously discussed, nipple and breast pain are the most common reasons for abandoning breastfeeding in the first week of breastfeeding [13, 42, & 47]. Sore nipples are most often due to incorrect latch, thus assisting women with correct positioning and latch-on will decrease this barrier.

System-level factors such as separation of mothers and newborns, lack of support, formula samples, inadequate education of health care providers, and the use of artificial nipples can be so detrimental to breastfeeding efforts [13 & 42]. Hospital procedures and centralized nurseries lead to separation of mothers and newborns and interference with breastfeeding. Rooming-in has been shown to have positive effects on breastfeeding. Yamauchi and Yamanouchi [51] reported that rooming-in was associated with significantly higher breastfeeding frequencies and less supplementation when compared to newborns that did not room-in.

Any procedures that interferes with breastfeeding can affect milk supply, thus hospital employees should delay "routine" admission procedures until after the

newborn has successfully breastfeed, ideally within one hour of birth. The use of bottles, pacifiers, and formula supplementation are shown to lead to early weaning and may result in newborn sucking difficulties [32 & 38] Thus, the use of artificial nipples and supplementation should be avoided useless medically necessary.

Lack of support and inconsistent information from health care providers continues to be a problem. In fact, most health care providers admit to having inadequate education regarding breastfeeding [27]. While most women report that nurses frequently give hands-on support for breastfeeding, nurses were less likely to provide the much needed emotional support for the women's breastfeeding decisions despite the fact that encouragement from health care providers has been shown to decreases the incidence weaning before 12 weeks [47]. While most providers recommend breastfeeding, they also give subtle messages that formula is equal to breastfeeding by providing free formula samples and literature from formula companies. Giving formula samples and gift packs to breastfeeding mothers leads to early weaning and should be discouraged [27 & 41].

Second to sore nipples, a mother's perception of inadequate milk supply is the next most common reason for weaning [13 & 47]. It is natural for mothers to worry about whether the newborn is receiving enough milk. This fear is confounded by repeated message from the media and family members that their infant needs formula. Mother should be educated about normal newborn feeding and elimination patterns to help minimize these fears.

Women, who return to full-time work, especially before 3 months postpartum, are more likely to wean early [13 & 47]. Active duty women typically return to work at or before 6 weeks postpartum making them at increased risk. As discussed earlier, identifying perceived and actual barriers at work is important to help the women develop ways to successfully combine breastfeeding and military employment.

Return to Work / Duty Support

Successful breastfeeding after returning to work involves time, space, and support. On-site daycare is ideal since this allows women the ability to breastfeed during their breaks. Since this is not an option for most military women due to their work situations and workplace hazards, providing a designated space in the workplace for pumping breast milk is critical. The space should be a private place behind closed

doors with electrical outlets and a small sink. A small refrigerator and hospital-grade electric pumps make pumping more convenient by decreasing the amount of time needed to breast pump and by providing storage facilities for expressed breast milk.

Allowing time to breast pump is essential for working women to maintain their supply of breast milk. Regularly scheduled breaks, or flexible work schedules, can make this possible. This requires the support of commanders, supervisors and co-workers. In addition, written policies supporting the woman right to breastfeed (or express breast milk) while at the workplace are needed to minimize the perception that women are given special treatment in terms of extra breaks.

Supporting breastfeeding in the military can be extremely challenging due to deployment and training requirements that result in long periods of separation for mothers and infants. Madigan Army Medical Center's lactation program developed a program to support breastfeeding mothers during field training exercises by providing breast pumping facilities with refrigeration in addition to daily pick up and delivery of breast milk from the field to the infant's caregiver (L. Jones, personal communication, January 12, 2004). The above example shows that breastfeeding barriers can be overcome with employer support.

Military deployment, on the other hand, is a much different issue. Military women in all services are deployable after four months post partum and the duration of deployments typically varies from 1 to 12 months, making the continuation of breastfeeding impossible. Some women choose to stop breastfeeding as soon as they are deployable to avoid the need to wean rapidly in the event of a sudden deployment [31 & 49]. The only way to decrease this barrier is for military policy to delay deployment for a longer period of time for breastfeeding mothers. In fact, the Institute of Medicine [28] recommends delaying deployment for six months to allow exclusive breastfeeding as recommended by the American Academy of Pediatrics.

Workplace hazards, mainly exposure to toxic chemicals, are of concern for many breastfeeding military women. Many military jobs may expose breastfeeding women to potentially harmful chemicals such as pesticides, solvents, heavy metals, and jet fuel. Although work places are regularly monitored for safe exposure levels there no studies have measured the level of potential containments in military women who return to work with

hazardous chemicals. The risk associated with potential exposure must be weighed against the benefits of breastfeeding; which in general the benefits are thought to outweigh the risks [11]. Bell [11] recommends that potential workplace exposure be evaluated by qualified occupational health providers on a case-by-case basis.

Another postpartum concern for many military women is adherence to weight and physical training standards of the military [44 & 49]. Military women are given 6 months post partum to achieve weight standards. Some women reported concerns over decreasing their milk supply if they lost weight too rapidly to meet standards. Women can be reassured that most women will continue to produce adequate milk unless severely malnourished. In addition, women report being uncomfortable and embarrassed while practicing in physical training at their workplace due to heavy breast and leaking milk [49].

Conclusion

Breastfeeding provides substantial benefits to mother, infants, and society. To maximize these benefits and to meet the Healthy People 2010 goals, health care providers must educate women to help them identify and overcome common breastfeeding barriers. Many common barriers can be easily overcome through education, support, and avoidance of unnecessary interventions. At a system level, health care providers are responsible for implementing evidence-based practices to promote and support rather spoil breastfeeding efforts.

Breastfeeding within the military is an important issue that needs support and written guidance. Establishing programs to support breastfeeding and establishing written guidelines in support of breastfeeding at a local level could help active duty women continue their breastfeeding efforts. Such support and policies could increase the operational readiness, quality of life, and retention of active duty women in addition to improving health and decreasing health care costs.

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POST TEST

T F 1. Active duty military women breastfeed longer than their civilian counterparts.

T F 2. Women who chose to breastfeed do so for their newborns.

T F 3. Less than 50% of military women are of childbearing age.

T F 4. Full-time employment is associated with decreased incidence and duration of breastfeeding.

T F 5. Most health care providers are well educated concerning breastfeeding.

T F 6. Labor pain relief decreases the initiation and duration of breastfeeding.

T F 7. Rooming-in does not affect breastfeeding frequency.

T F 8. Sore nipples are an expected outcome of breastfeeding.

T F 9. A woman's intention to breastfeed is an excellent predictor of whether she actually does breastfeed.

T F 10. Weight management issues and deployment were barriers to breastfeeding for military women.

Answers on page 22

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Post Test Answers: 1- F, 2- T, 3- F, 4- T, 5- F, 6- F, 7- F, 8- F, 9- T, 10- T