Transcript Details
This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/advances-in-womens-health/optimizing-breastfeeding-within-the-golden-hour/12742/

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Optimizing Breastfeeding Within the Golden Hour

DR. CHAPA:
Both UNICEF and the World Health Organization recommend exclusive breastfeeding for the first six months of life. And this starts within the very first hour of birth. After all, breastfeeding in the first hour of life is associated with reduction of infant mortality as well as infant temperature stabilization from direct skin-to-skin contact during this golden hour. So how can we help ensure that our patients and their newborn babies reap these benefits?

Welcome to *Advances in Women's Health* on ReachMD. I'm Dr. Hector Chapa, and here to provide strategies for optimizing breastfeeding success within that first critical hour of delivery is Dr. Susan Crowe. Dr. Crowe is a Clinical Professor of Obstetrics and Gynecology at the School of Medicine and Director of Outpatient Breastfeeding Medicine Consultative Services at Stanford Children's Health. She recently spoke about this topic at the 2021 American College of Obstetrics and Gynecology annual clinical meeting and its scientific meeting. Dr. Crowe, thank you for being here today.

DR. CROWE:
Thank you for having me.

DR. CHAPA:
This is such an important topic. I mean, I'm glad we actually give this a name. It's the golden hour. So to start us off, Dr. Crowe, what are the main benefits for mom and baby when it comes to breastfeeding within that critical golden hour?

DR. CROWE:
So colostrum is the special early milk that is produced during the first days of delivery. It's available even before delivery, but primarily during those first few days. This milk is concentrated and tailored to meet the unique newborn’s needs immediately after birth. During that first hour, the birthing person's oxytocin levels are at its highest, which allows for optimal feeding circumstances.

Another primary benefit of breastfeeding, specific to that first hour is that it sets the stage for a healthy milk supply and sends signals to the brain and the breast to initiate copious milk production even sooner. From the newborn’s perspective, babies go through stages where they're very alert and energetic during that first hour and they're optimally ready to feed. The routine procedures that we perform should be delayed during this golden hour in order to facilitate initiation during this time. A few hours after this first hour, sometimes babies will be tired; they've gone through this stressful transition from birth to breathing air, and we want to capture them before they need that rest.

DR. CHAPA:
Yeah so true, and again, bringing that point of that colostrum at that early stage is such an important point. Now we know that major organizations recommend it, but Dr. Crowe, what can you tell us about how we're doing as a country? How's the U.S. doing in terms of adherence to breastfeeding within that first hour?

DR. CROWE:
So the United States does not collect specific data on adherence to breastfeeding within the first hour. The CDC does a survey of hospitals and birthing centers called the mPINC survey. It stands for Maternity Practices in Infant and Nutrition Care. And according to the most recent survey results from 2018, 67% of hospitals are routinely offering uninterrupted skin-to-skin contact with newborns and their mothers for at least one hour after birth or until they have breastfed after a vaginal birth and for about 50% of hospitals routinely after a C-section delivery.

So we know that many babies are offered this opportunity to be together during that first hour. But we also see that many are not. So when hospital skin-to-skin contact after C-section deliveries was historically actually unusual, and the care of the baby after the C-section births would usually take place in a nursery, where the C-section was being performed far away from this nursery. We now see more and more hospitals are developing processes to facilitate skin-to-skin contact and breastfeeding within the first hour after birth, even in C-section deliveries.

Now on a global level, we do have more specific data. And according to a recent report from UNICEF, only two in five newborns were put to the breast within the first hour in 2017. And that correlates with 78 million newborns having to wait for more than one hour to initiate breastfeeding on a global level. These delays in infant breastfeeding led to a 33% increase in infant mortality risk compared to babies who are breastfed during the first hours of life. So there are many opportunities, both in the United States and globally, to improve these practices.

DR. CHAPA:
What other medical or social barriers, Dr. Crowe, do you think exist for us to prevent us from getting those numbers higher? What's your opinion on that?

DR. CROWE:
So historically, our labor and delivery units were designed to care for birthing people. And our nurseries were designed for the care of newborns. This type of design made it difficult to keep dyads together for breastfeeding initiation. So we would often send babies to a different unit on our hospitals for care after delivery.

In addition, immediately after delivery, birthing people may experience bleeding or other complications, and newborns may need special care from our pediatric care teams to provide assistance with breathing. And although skin-to-skin stabilizes infants and helps them transition to breathing and keeps their temperature normal, sometimes intensive care is required, where oxygen and other resuscitative measures can be provided. This may often require that the newborn be moved away from the mother's chest to a place where the pediatricians have access to equipment where they can resuscitate baby. We are learning more and more that much of that resuscitation can take place while the baby and the mom are together skin to skin. This is a culture change. But people are adopting it and finding that it's actually very comfortable to do resuscitative measures while a baby is skin-to-skin with its mother. However, like I mentioned, sometimes the care is more intensive and does require special equipment that is not adjacent to the mom and the baby.

DR. CHAPA:
Of course in the media, we see a lot about racial or social factors and how it impacts health care. So Dr. Crowe, what do you think about racial or social factors in terms of a health disparity in terms of breastfeeding in that first hour? And what can we do about that to make it modifiable and not a permanent barrier?

DR. CROWE:
Health disparities do exist in our breastfeeding practices within the first hour after birth in the United States. According to the CDC, most recent data representing babies born in 2017 only 74% of Black infants are ever breastfed as compared to 87% of white infants. In some parts of the country, this disparity is even greater. Maternity care practices such as skin-to-skin contact, early initiation of breastfeeding, rooming in, avoidance of marketing of breast milk substitutes are some of a number of practices that are associated with improved breastfeeding outcomes. And according to a study published by the CDC in 2014, hospitals located in areas where the percentage of Black residents was higher than the average, had fewer supportive breastfeeding practices, such as those, than hospitals serving communities with lower than average percentage of Black residents. By initiating baby-friendly hospital initiative 10 steps to successful

breastfeeding, these disparities are decreasing in some areas, but much work is still to be done.

This disparity in practices after delivery to support breastfeeding is concerning because the many health benefits derived from breastfeeding can have a lifetime impact on health outcomes.

For the lactating person, breastfeeding is associated with a reduced risk of diabetes, breast cancer, ovarian cancer, and cardiovascular disease. For the infant, it's associated with decreased infections such as ear infections, gastrointestinal illnesses, and it's also associated with reduced risk of sudden infant death syndrome, allergic diseases, diabetes, and some childhood cancers to name a few. It provides perfect nutrition for optimal brain growth and healthy childhood weight, and it may set the stage for healthy blood pressure long-term. Because breastfeeding is associated with the short and long-term health outcomes for both babies and lactating people, we can modify existing health disparities by improving our maternity care practices that result in high breastfeeding rates.

DR. CHAPA:
For those just tuning in, you're listening to *Advances in Women's Health* on ReachMD. I'm Dr. Hector Chapa, and I'm speaking really with an expert in this area, Dr. Susan Crowe, and we're talking about the benefits of breastfeeding within the first hour of childbirth and the obstacles that we often encounter that can keep patients from reaping these just wonderful benefits.

Now, Dr. Crowe, I'd like to switch gears a little bit more and come back to something that you had mentioned just a little while ago, and specifically that's optimizing breastfeeding in that first hour for specific populations. And the first one I want to get to is one that you've mentioned already: Cesarean section patients. I know you've touched on a little bit, but let's zero in on that and tell us how can we do better to initiate breastfeeding in the C-section patients?

DR. CROWE:
You can design processes in our hospitals that allow safe skin-to-skin contact between newborns and their mothers immediately after delivery and throughout the remainder of the C-section.

For example, at Stanford Children's Health, a neonatal nurse is present during C-section deliveries, and they remain in the operating room to care for the baby and assist with immediate and continuous skin-to-skin contact. This nurse assists with early breastfeeding initiation and watches to ensure that it's done safely.

As the obstetrician, I've also noticed the secondary benefit where the uterus actually contracts down in response to the oxytocin that is released during skin-to-skin and breastfeeding. This results in decreased uterine bleeding and has that secondary benefit.

DR. CHAPA:
Absolutely. And as an obstetrician myself, I can attest to that, absolutely true. The second population, I can't let escape either, and we've touched on it, but they deserve special attention as well. Tell us how we can optimize this practice in NICU patients or babies that need a little bit more initial evaluation.

DR. CROWE:
When a baby goes to the NICU for specialized care, early-hand expression of colostrum can set the stage for a healthy milk supply. In one study by Parker and colleagues, the volume of milk expressed at six weeks was 130% higher if hand expression of milk took place within an hour of delivery as compared to two to six hours after delivery. Colostrum can be collected and sent to the NICU as well. Even if the newborn is not able to feed, the NICU providers will often place a little bit of the colostrum in the baby's mouth, potentially setting the stage for optimal intestinal health.

In my experiences, this practice has also been extremely important for birthing people psychologically. It allows them to know that they are able to do something for their newborns, even if they cannot physically be present with their baby in the NICU.

DR. CHAPA:
Dr. Crowe, considering the important health benefits that breastfeeding can have for both mothers and their newborns, especially within that first hour, I think this was a fantastic topic to do. So I want to thank you, Dr. Crowe, for joining me today to share how we can optimize breastfeeding success. It was great speaking with you.

DR. CROWE:
Thank you for having me.

DR. CHAPA:
For ReachMD, I'm Dr. Hector Chapa. To access this episode and others from our series, visit ReachMD.com/AdvancesInWomensHealth, where you can Be Part of the Knowledge. Thanks for listening.