

**West Virginia Pregnancy
Risk Assessment
Monitoring System
(PRAMS)**

**Racial/Ethnic Maternal and
Infant Disparities Report
2016-2020**

Pregnancy Risk Assessment Monitoring System

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Table of Contents

Introduction	4
Purpose of the Pregnancy Risk Assessment Monitoring System	4
Technical Notes	5
Demographics	6
Pregnancy Intention	7
Pre-pregnancy Contraception Use	7
Postpartum Contraception Use	9
Prenatal Care Initiation	10
Flu Vaccination	10
Pre-Pregnancy Body Mass Index (BMI)	13
Maternal Smoking Habits	14
Maternal Alcohol Consumption	17
Diabetes --- Pre-pregnancy and Gestational	19
Maternal Oral Health	21
Postpartum Health and Care	23
Infant Safe Sleep: Position and Environment	25
Breastfeeding	28

Introduction

Purpose of the Pregnancy Risk Assessment Monitoring System (PRAMS)

West Virginia PRAMS is a joint research project between the West Virginia Department of Health and Human Resources Office of Maternal, Child and Family Health and the Centers for Disease Control and Prevention (CDC). The project is an on-going, population-based surveillance system designed to identify maternal attitudes and experiences before, during and after pregnancy.

PRAMS was developed in 1987 by the CDC because infant mortality rates were not declining as rapidly as they had in previous years, and the number of low birthweight babies had changed little in the previous 20 years. Research indicates that maternal behaviors during pregnancy influence infant birthweight and death rates. The goal of PRAMS is to identify maternal risk behaviors that may affect both maternal and infant health.

Each month, approximately 200 mothers are randomly selected from the West Virginia Birth Certificate Registry and asked to participate in the PRAMS survey. All West Virginia mothers who have had a live birth have about a one in fourteen chance of being chosen two to four months after their baby's birth. Selected mothers are contacted first by mail and asked to complete a questionnaire; then, after several attempts by mail, the non-respondents are called and asked if they would like to participate by phone. After completion of the survey, each participant receives a special gift.

PRAMS provides data not available from other sources about pregnancy and the first few months after birth. This information can be used to identify groups of mothers and babies at high risk for health problems, to monitor changes in health status and to measure progress toward goals in improving the health status of mothers and infants. PRAMS information is also used by state and local agencies to plan and review programs and policies intended to decrease poor health outcomes among mothers and babies.

Technical Notes

This multiyear Surveillance Report covers a variety of maternal and infant health topics. West Virginia data were collected by the PRAMS questionnaire and West Virginia Vital Statistics from 2016-2020. Due to West Virginia's population distribution, data were combined for the 5 year period from 2016-2020 to account for the small racial/ethnic populations that responded to the survey yearly. Due to small number estimates, Non-Hispanic American Indian, Asian/Pacific Islander and other racial groups are combined in the racial/ethnic group Other/Non-Hispanic (NH). A new phase of the survey, Phase 8, was implemented in 2016 where new content was added, and some questions were removed. Selection of the questions were determined by input from the West Virginia PRAMS Steering Committee, including the PRAMS Director and Coordinator. Topics are broken down into several categories: family planning, prenatal care, pregnancy risk factors, infant health and care, maternal health and care and state-interest perinatal topics and services. Statewide trend data are reported in graphs and charts throughout the report along with additional descriptive narrative.

It is important to note that PRAMS data collected from the questionnaire are self-reported by participants. After data collection ends each year, survey data are linked with appropriate birth certificate data. The combined birth certificate/survey database is then weighted by the CDC to adjust for sample design, non-response and omissions in the sampling frame.¹ This weighted dataset is an estimation, reflective of West Virginia's PRAMS eligible population (i.e., residents who delivered a live infant during the survey year of interest). The data methods used by West Virginia PRAMS are standardized CDC protocols used by all participating PRAMS states.

Each participating states' survey is unique, as states have the ability to add or eliminate topics based on interest when developing their surveys. Previously each state had to reach a minimum 60% survey completion rate before data was considered substantial, currently that threshold decreased to 50% for valid data reporting purposes. PRAMS states not achieving the threshold minimum for a particular year are *not* included in the collective data. As of 2019, 47 US states and New York City, Puerto Rico, the District of Columbia and the Great Plains Tribal Chairmen's Health Board (GPTCHB) were participating in PRAMS. For more details concerning state participation and PRAMS data availability, visit <http://www.cdc.gov/prams/index.htm>.

Note: To have valid and reliable data, CDC recommends there be at least 30 respondents per variable. Because PRAMS uses random sampling, not all variables will meet that recommendation for every year so combining years of data are necessary and even then, some variables may still not meet that threshold..

¹ CDC PRAMS Methodology: <http://www.cdc.gov/PRAMS/methodology.htm>

Demographics

WV Racial Breakdown 2019

Characteristic	Population Size*	Percent*
Total	1,792,147	
Race		
White	1,668,004	93.1
Black	65,925	3.7
American Indian or Alaska Native	3,601	0.2
Asian	14,311	0.8
Native Hawaiian/Pac. Islander	399	0.0
Other	7,657	0.4
Two or more races	32,250	1.8

WV PRAMS Maternal Race Breakdown 2016-2020

Characteristic	PRAMS Eligible Population		PRAMS Survey Participants	
	Population Size	Percent	Respondents [†]	Estimated Percent
Total	78,920	--	3,813	--
Race				
White/NH [‡]	71,679	90.8	3,483	91.36
Black/NH	2,671	3.4	148	3.88
Hispanic	1,598	2.0	64	1.67
American Indian	196	0.2	3	0.0
Asian/Pac. Islander	767	1.0	28	0.73
Other/Mixed	1,885	2.4	76	1.99

‡NH-Non-Hispanic

†Respondents = the actual number of respondents who fall into the referenced demographical group who participated in the survey.

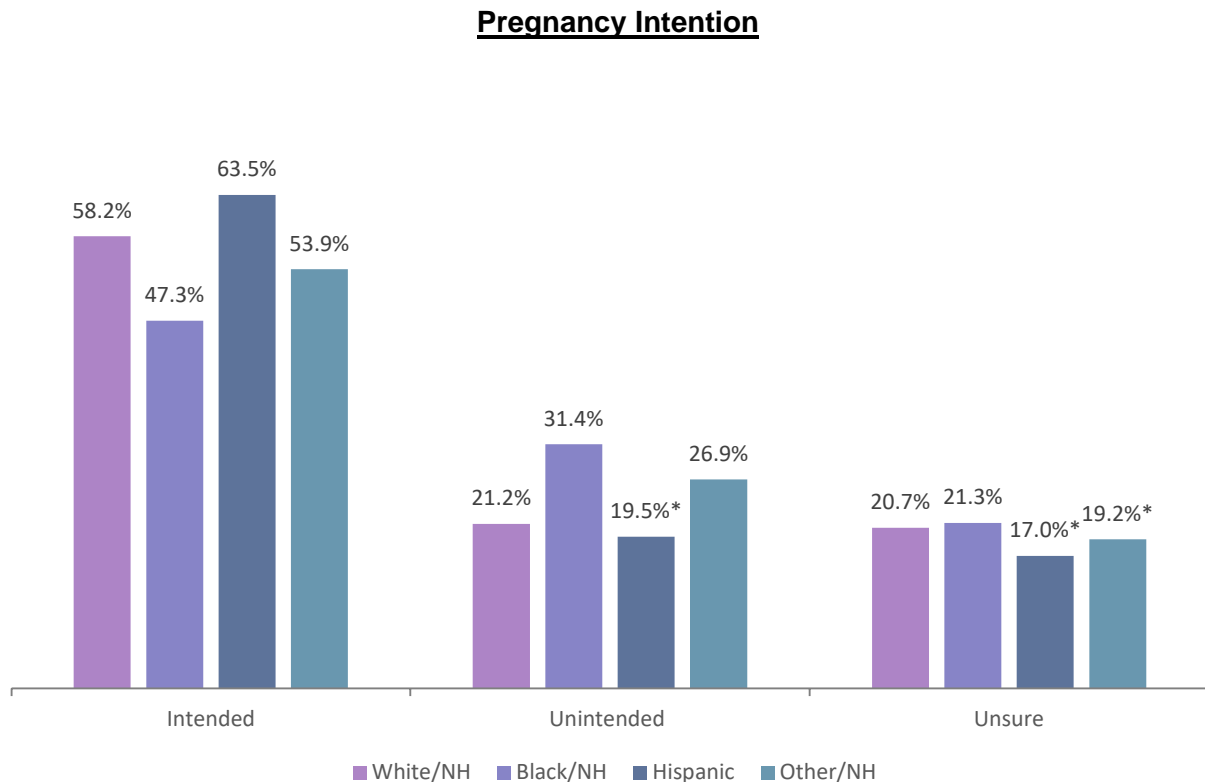
* Data source: 2019 American Community Survey 1-Year Estimates due to the 2020 American Community Survey 1-Year Estimates being experimental because of the COVID-19 Pandemic

Pregnancy Intention

An unintended pregnancy is a pregnancy that is mistimed, unplanned or unwanted at the time of conception. Unintended pregnancies are associated with an increased risk of problems for mother and baby. Although women of all races and ethnicities are at risk of an unintended pregnancy, minorities, specifically Hispanic and Black/African American women are at increased risk. Research has determined that multiple factors have led to the increased risk of unintended pregnancies among these racial groups including, but not limited to income, insurance status, relationship status and education level. (Troutman , Rafique, & Plowden, 2020)

Black/NH women reported the highest rate of unintended pregnancy at 31.4% compared to Other/NH (26.9%), White/NH (21.2%) and Hispanic (19.5%) counterparts. Hispanic women were least likely to report they were unsure about their pregnancies at 17% and more likely to report an intended pregnancy, 63.5% (**Figure 1**).

Figure 1.

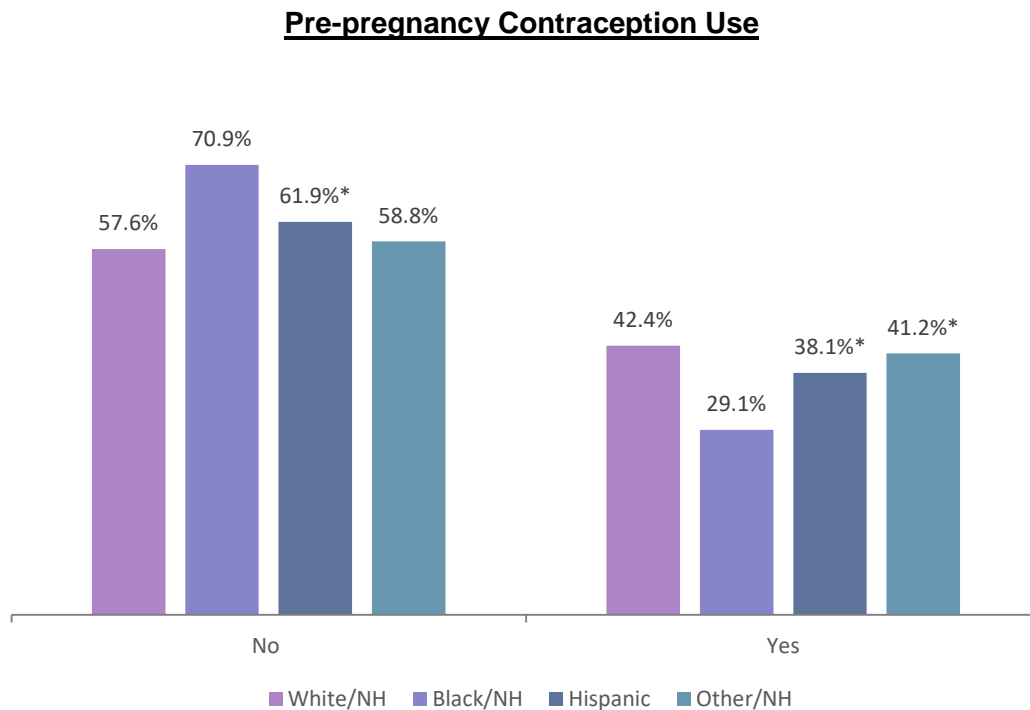


(*) Respondents is <30, interpret with caution.

Pre-pregnancy Contraception Use

The most effective way to prevent an unintended pregnancy is by using reliable and effective contraception during one's reproductive years. However, attitudes toward contraception in minority groups differ from that of white women. Black/African American and Latina women frequently choose less effective contraception methods such as condoms or the withdrawal method when compared to their white counterparts (Payne, 2014). Highly effective contraception methods such as the use of Long Acting Reversible Contraception (LARCs) have low failure rates but are typically associated with up front out of pocket cost that may not be feasible for women with lower incomes. (Troutman, Are higher unintended pregnancy rates among minorities a result of disparate access to contraception? - Contraception and Reproductive Medicine, 2020). Black/NH women (70.9%) had the lowest prevalence of using contraception prior to getting pregnant when they were not trying to conceive as compared to White/NH women (57.6%). Other/NH women (41.2%) were more likely to report contraceptive use prior to pregnancy when not trying to conceive compared to Hispanic and Black/NH women (38.1% and 29.1%) (Figure 2).

Figure 2.



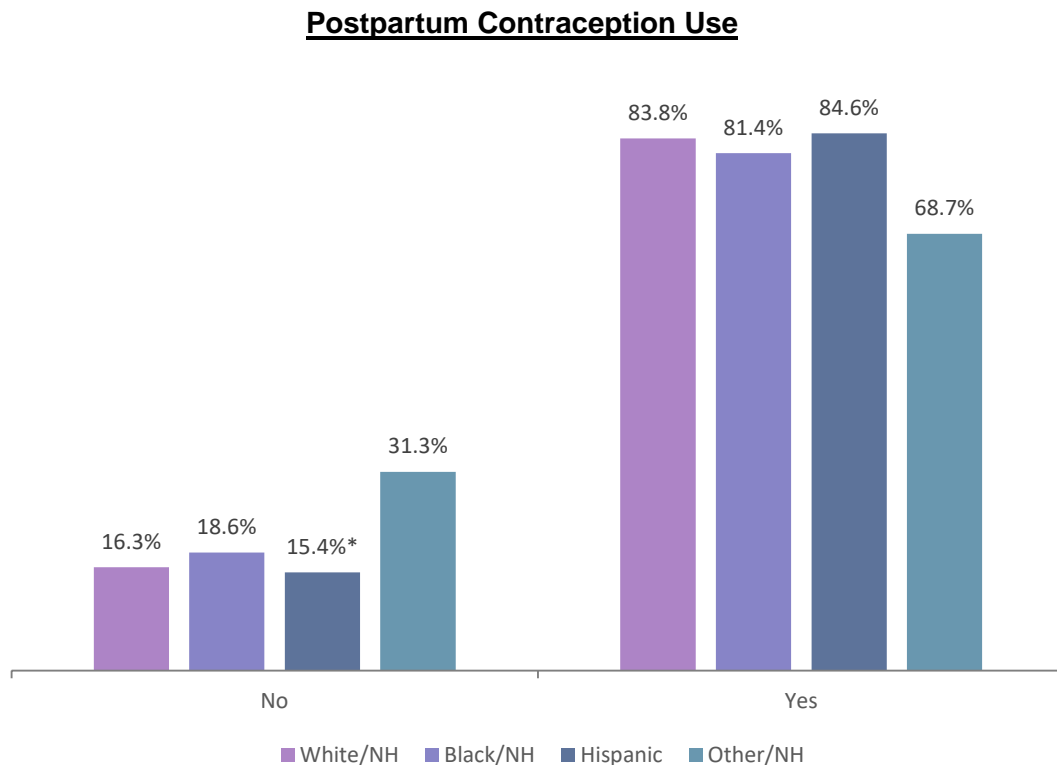
(*) Respondents is <30, interpret with caution.

Postpartum Contraception Use

Postpartum contraception use is an important part of postpartum care for women as it helps women, and their families achieve the best chance in interpregnancy intervals and avoid unintended pregnancies and preterm births. According to a study examining postpartum contraceptive usage among women of different ethnicities, it was shown that Black/NH and Hispanic women have higher rates of non-contraceptive usage overall, differences in contraceptive method choice, lower rates of method fulfillment, contraceptive failure and unintended pregnancies when compared to White/NH women. Women of other races were less likely to experience a delay in receiving their desired highly-effective method compared to White/NH women. Black/NH women were more likely to experience with a repeat pregnancy compared to White/NH women (Ngendahimana, 2021).

Despite some literature stating otherwise, Other/NH (31.3%) women in West Virginia were more likely to report not using contraception postpartum compared to Black/NH (18.6%), White/NH (16.3%) and Other/NH (15.4%) women. Hispanic women (84.6%) were slightly more prevalent to report using contraception postpartum compared to other racial/ethnic groups (**Figure 3**).

Figure 3.



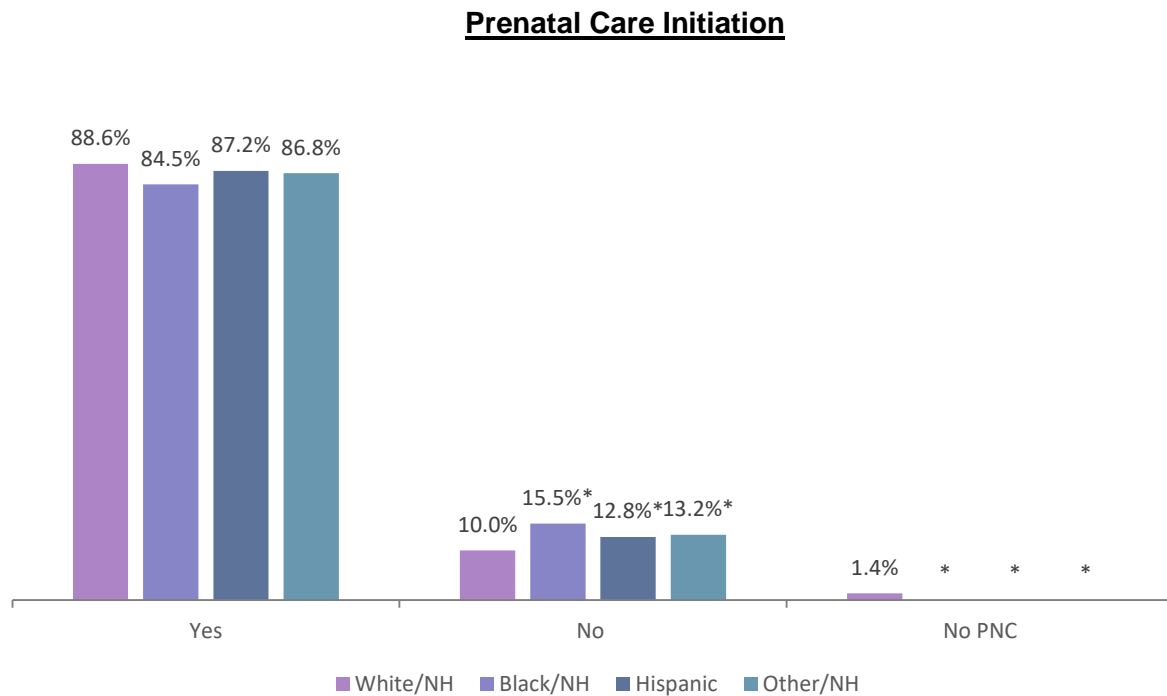
(*) Respondents is <30, interpret with caution.

Prenatal Care Initiation

Prenatal care (PNC) visits are vital for the health of both mother and baby. It is important for pregnant mothers to begin prenatal care in the 1st trimester of pregnancy (within the first 12 weeks). Early initiation of prenatal care allows health care providers to identify and manage a woman's risk factors and health conditions. Findings have suggested that maternal socioeconomic status primarily drives racial/ethnic gaps in both PNC initiation and PNC adequacy (Green, 2018). Black/NH and American/Indian/Alaska Native have a number of factors that contribute to maternal mortality, one of those being delayed prenatal care initiation due to personal experiences of bias and racism (Barfield, 2021).

One of the goals of the Healthy People 2020 initiative was to increase the proportion of pregnant women who receive prenatal care in the first trimester from 77.1% in 2016 to 84.8% in 2020 (Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2022). Combining 2016-2020 data, most WV women initiated their prenatal care in the 1st trimester of pregnancy. During that time, racial/ethnic women were higher than the baseline for HP2020 and White/NH (88.6%), Hispanic (87.2%), and Other/NH (86.8%) women reached the HP2020 goal respectively, Black/NH women (84.5%) fell slightly short. (**Figure 4**).

Figure 4.



(*) Respondents is <30, interpret with caution.

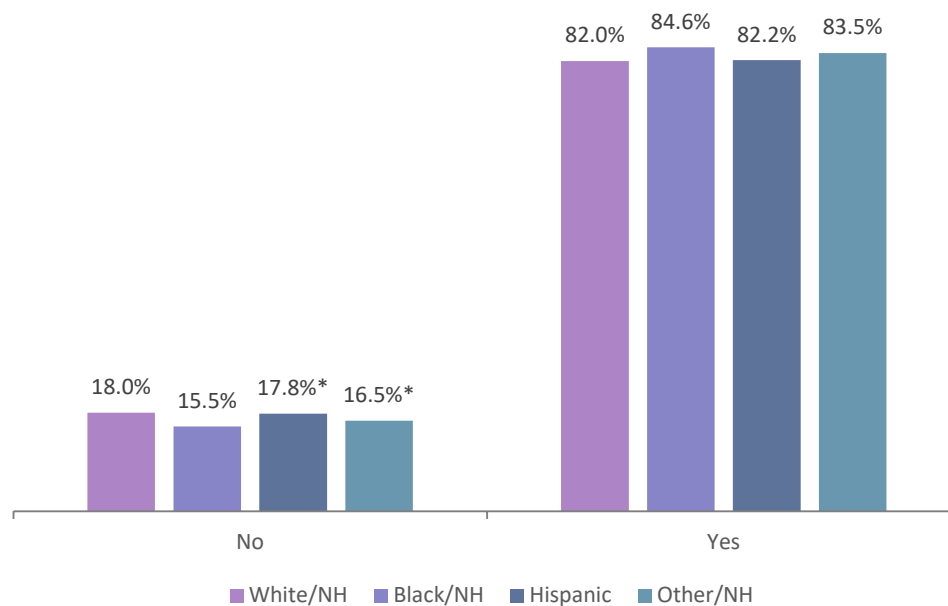
Flu Vaccination

The CDC recommends pregnant women receive a flu shot during their pregnancy. Changes in the immune system, lungs and heart during pregnancy make mothers more susceptible to the flu. Research has shown that getting a flu shot during pregnancy helps protect the mother and baby and does not harm the fetus. Historically racial/ethnic minority groups have had lower rates of flu vaccination, but also experience higher rates of severe influenza illness (Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, 2021). Specifically, Black/NH women have repeatedly had the lowest rate of flu vaccine during pregnancy (Callahan, Coleman-Cowger, Schulkin, & Power, 2021). A 2012-2015 study involving national PRAMS data found that Black/NH women were less likely than White/NH women to have the flu vaccine recommended and to get the flu vaccine in the 12 months prior to delivery. Health care providers were also less likely to recommend the flu vaccine to pregnant women who are Black/NH or Asian than pregnant White/NH women (Arnold, Luong, & Chang, 2019).

Overall, over 82% of women from all racial/ethnic groups reported being offered or told to get a flu vaccine in the 12 months prior to delivery (**Figure 5**). Despite many women being offered or informed about the flu vaccine, less than 60% of White/NH (55.9%), Black/NH (57.4%) and Hispanic (46.8%) women received the vaccine either before or during their pregnancies. Hispanic women (53.2%) were more likely to not receive a flu vaccine (**Figure 6**).

Figure 5.

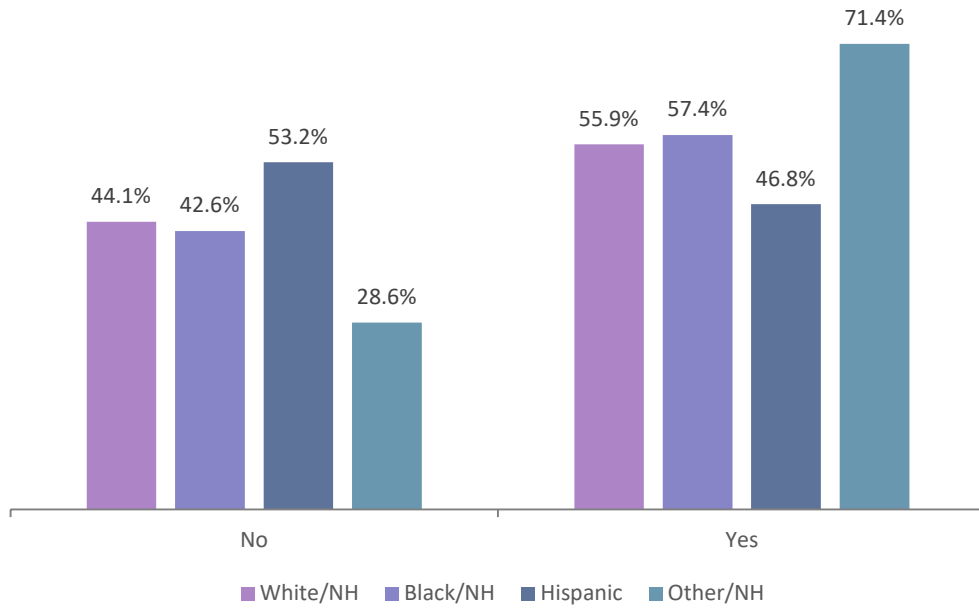
Healthcare Worker Offered Flu Shot or Told Mother to Get One



(*) Respondents is <30, interpret with caution.

Figure 6.

Flu Vaccine Before or During Pregnancy

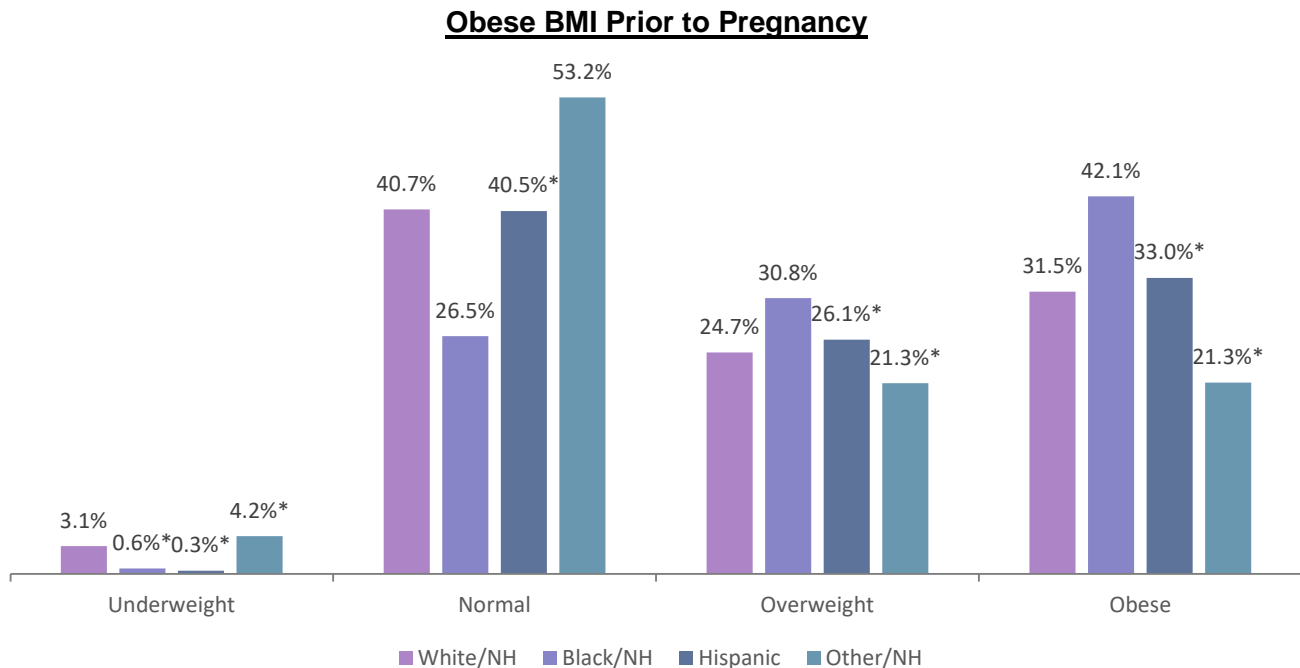


Pre-Pregnancy Body Mass Index (BMI)

West Virginia had the 8th highest prevalence of obesity for women in the United States at 37.6% in 2020 (Centers for Disease Control and Prevention, 2015). Obesity contributes to other chronic health conditions including, but not limited to high blood pressure, type 2 diabetes, coronary heart disease, stroke, and an overall lower quality of life. Obesity prevalence for women of childbearing age has increased in West Virginia in the last 10 years, increasing over all racial/ethnic groups. The prevalence of obesity among women of childbearing age increased from 32.1% in 2010 to 37.6% in 2020 in West Virginia. Compared to non-Hispanic whites, women in all Asian subgroups had markedly lower risks of pre-pregnancy obesity, severe obesity, and overweight/obesity, whereas Samoans, Hawaiians, AIANs, blacks, Mexicans, Puerto Ricans, and Central/South Americans had significantly higher risks (Singh & DiBari, 2019) (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention, 2021) Pre-pregnancy obesity is a key risk factor for the development of Adverse Pregnancy Outcomes (APOs), including preterm birth, low birth weight, gestational hypertension, and preeclampsia (Wang, et al., 2021).

Black/NH women (42.1%) had the highest prevalence of obesity prior to pregnancy from 2016-2020, followed by Hispanic (33%), White/NH (31.5%) and Other/NH (21.3%) women. Other/NH women (53.2%) were more likely to report a normal weight prior to pregnancy compared to other racial/ethnic groups, White/NH (40.5%), Hispanic (40.7%) and Black/NH (26.5%) women (**Figure 7**).

Figure 7.



(*) Respondents is <30, interpret with caution.

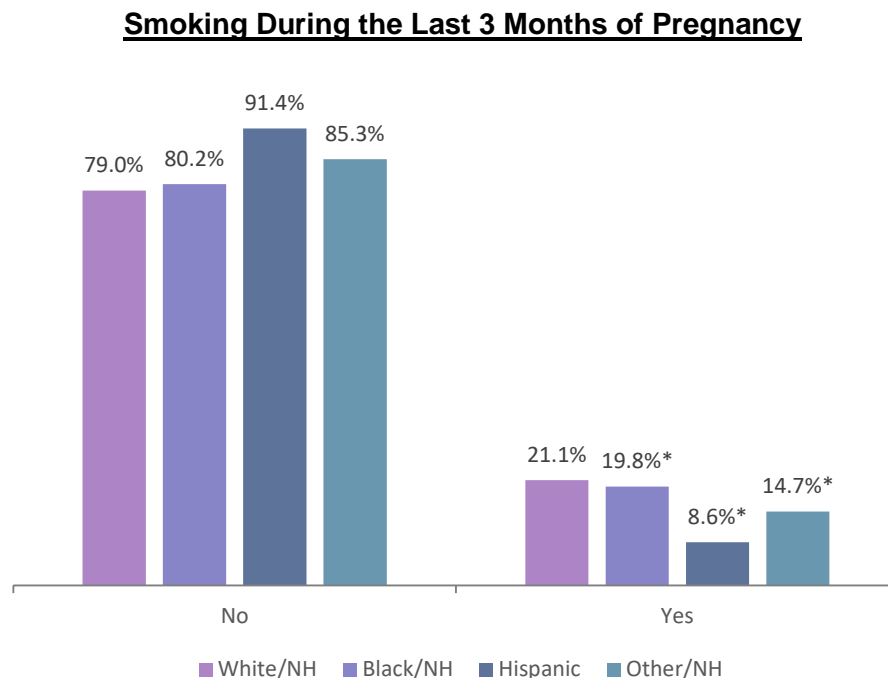
Maternal Smoking Habits

Pregnant women face additional risks associated with smoking. They are more likely to have miscarriages, stillbirths, preterm labor and premature babies than mothers who do not smoke. Additionally, babies born to smoking mothers may be low birthweight and have slow physical growth and mental development. Smoking makes children more prone to allergies, colds, asthma, lung problems and can contribute to sudden unexplained infant death (SUID) if their mother smokes.

West Virginia has the highest prevalence of pregnant smokers in the nation. According to America's Health Rankings, in 2019 23% of West Virginia mothers smoked during their pregnancy (CDC WONDER, Natality Public Use Files, 2019). This rate is nearly four times higher than the national average (6%). A National CDC study in 2016 showed that non-Hispanic American Indian and Alaska Native women (16.7%) had the highest prevalence of smoking during pregnancy, followed by White/NH (10.5%), Black/NH (6.0%) and Hispanic women (1.8%) (Drake, Driscoll, & Mathews, 2019)

From 2016-2020, Hispanic women (8.6%) were least likely to report smoking during the last 3 months compared to White/NH (21.1%), Black/NH (19.8%) and Other/NH (14.7%) women (**Figure 8**).

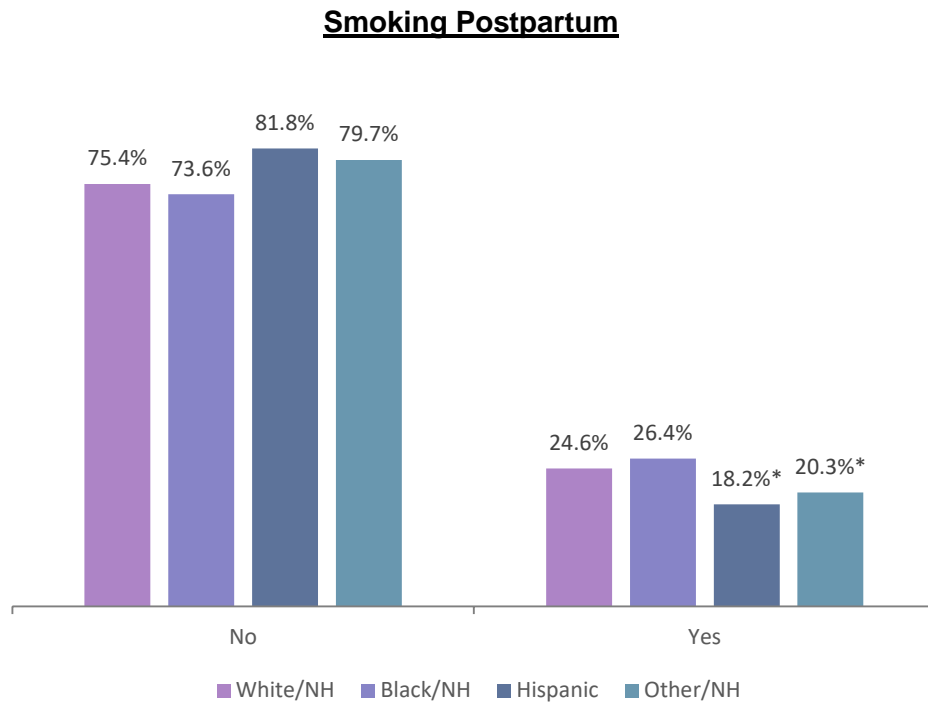
Figure 8.



(* Respondents is <30, interpret with caution.

Postpartum smoking increases a women’s health risks, but it also increases the chances of exposure for their infant. Infants exposed to tobacco smoke have the potential for increased risks linked to sudden infant death syndrome, ear infections, respiratory tract illness, and asthma (Levine, Cheng, & Marcus, 2016). Gains have been made towards smoking cessation during pregnancy but maintaining cessation after delivery is still an issue (Nichter, et al., 2008). From 2016-2020, Black/NH women (26.4%) were slightly more likely to smoke postpartum compared to White/NH women (24.6%). Other/NH women (20.3%) reported smoking postpartum more than Hispanic women (18.2%) (**Figure 9**).

Figure 9.



When compared to their White/NH (18%) counterparts, Black/NH women (31.5%) were more likely to not be advised to quit smoking during pregnancy from 2016-2020. Other/NH (87.8%) and White/NH (80.1%) women were more likely among all racial groups to report being recommended to quit smoking during their prenatal care visits (**Figure 10**).

All racial/ethnic groups reported almost or over 88% of smoking not being allowed in the home at any time. Although above 80%, Black/NH women (87.9%) were least likely to report not allowing smoking in their home compared to Hispanic (95.6%) and White/NH (93.4%) and Other/NH (91.5%) women (**Figure 11**).

(*) Respondents is <30, interpret with caution.

Figure 10.

Prenatal Care Provider Advise to Quit Smoking During Pregnancy

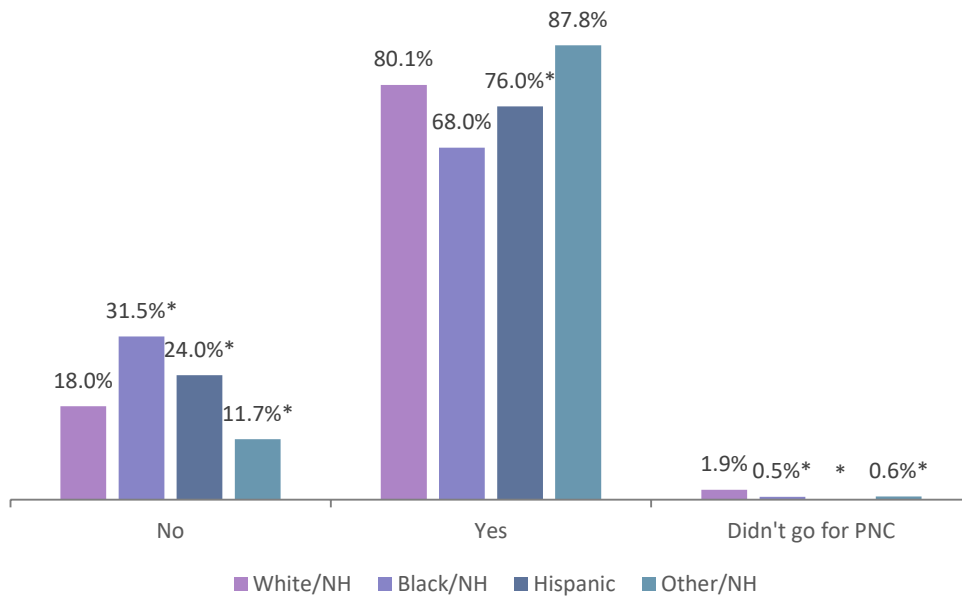
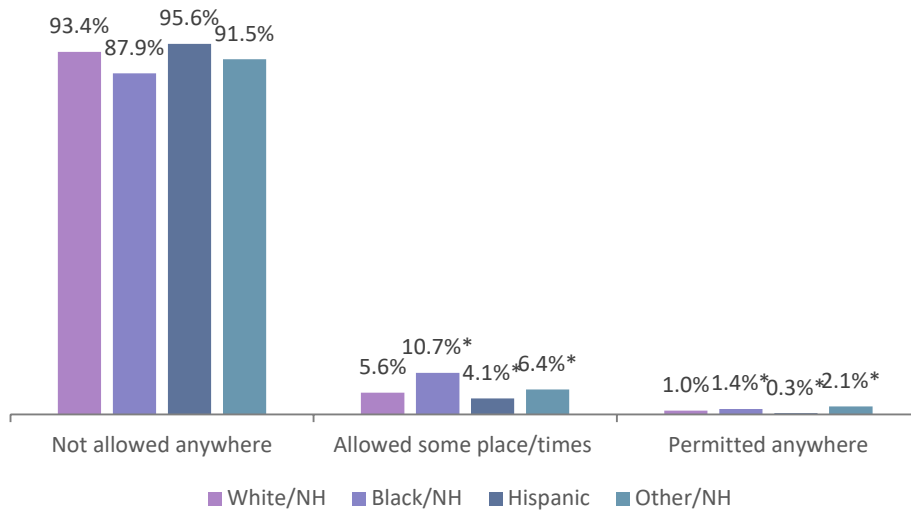


Figure 11.

Smoking Rules: No Smoking Allowed in Home



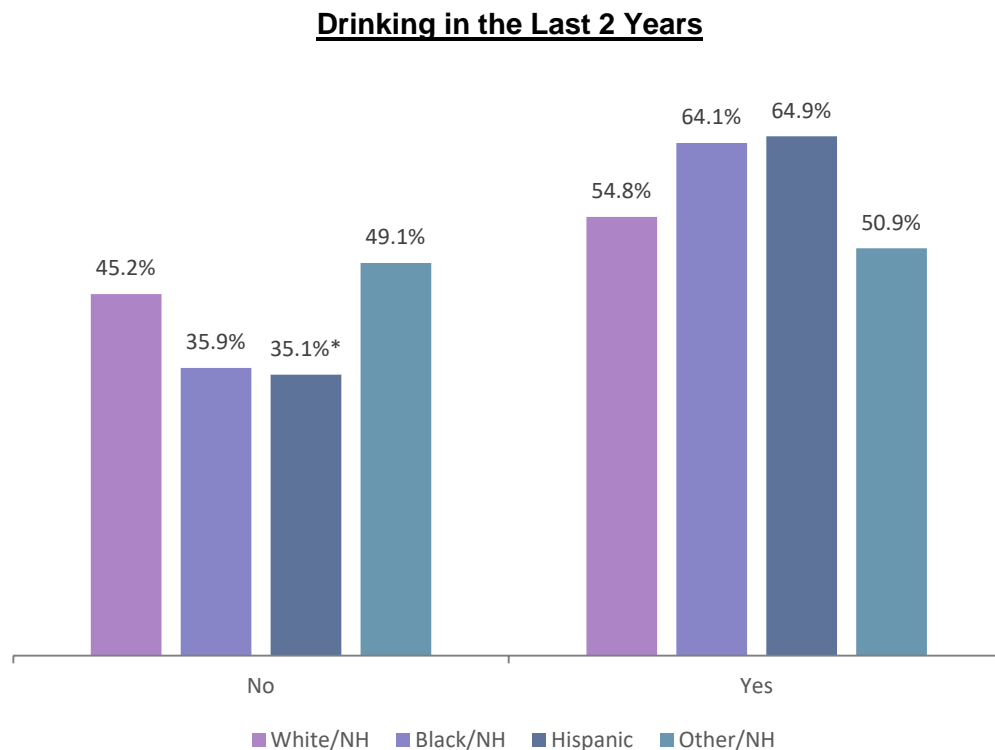
(*) Respondents is <30, interpret with caution.

Maternal Alcohol Consumption

Alcohol consumption is not recommended for women who are pregnant or may be pregnant. About 18% of women of child-bearing age binge drink (National Center for Chronic Disease Prevention and Health Promotion, 2022). The weighted prevalence in 2019 for West Virginia of “Any Alcohol Use” among women was 41.4% and “Binge Drinking” was 12.1% (Centers for Disease Control and Prevention, 2021). Studies in mice have shown that drinking alcohol prior to and during pregnancy can cause serious health risks to a developing fetus (Lee, et al., 2020). If a woman is unaware she is pregnant and consumes alcohol, her baby may be at risk for many adverse health outcomes including: abnormal facial features, smaller than normal head size, poor memory, low body weight, learning disabilities, vision or hearing problems, and problems with the heart, kidney or bones.

Hispanic women (64.9%) were slightly more likely than Black/NH (64.1%) women to report drinking in the last 2 years compared to other racial/ethnic counterparts. Other/NH women had the lowest prevalence of drinking in the last 2 years leading up to delivery (**Figure 12**).

Figure 12.



From 2016-2020, Black/NH women (53.2%) were more likely to report drinking in the 3 months prior to pregnancy compared to other racial/ethnic groups (White/NH – 40.9%, Hispanic – 38.6% and Other/NH – 33.8%) (**Figure 13**). Black/NH women (6.9%) reported slightly more excessive drinking in the 3 months prior to pregnancy than Hispanic women (5.2%) and White/NH women (1.9%) (**Figure 14**).

Figure 13.

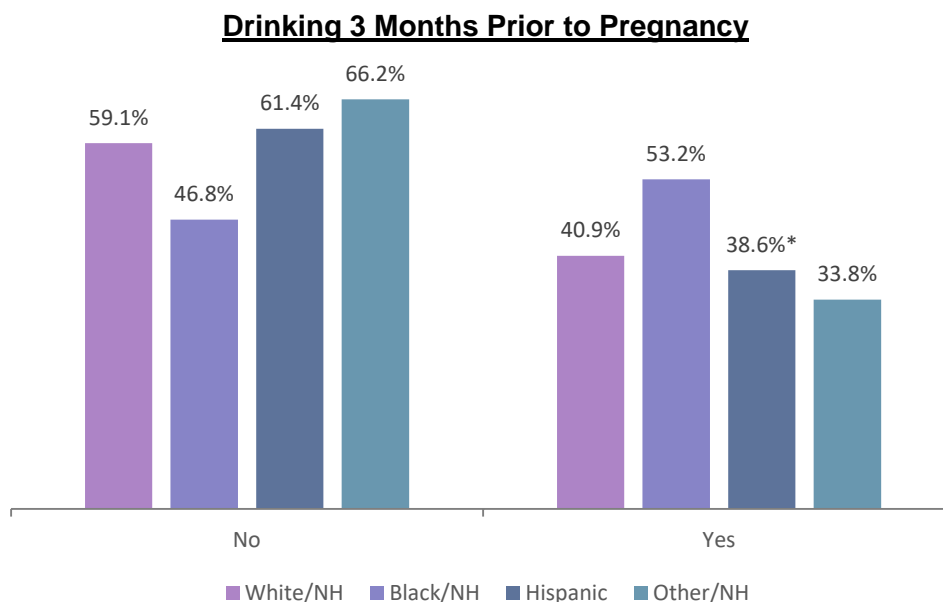
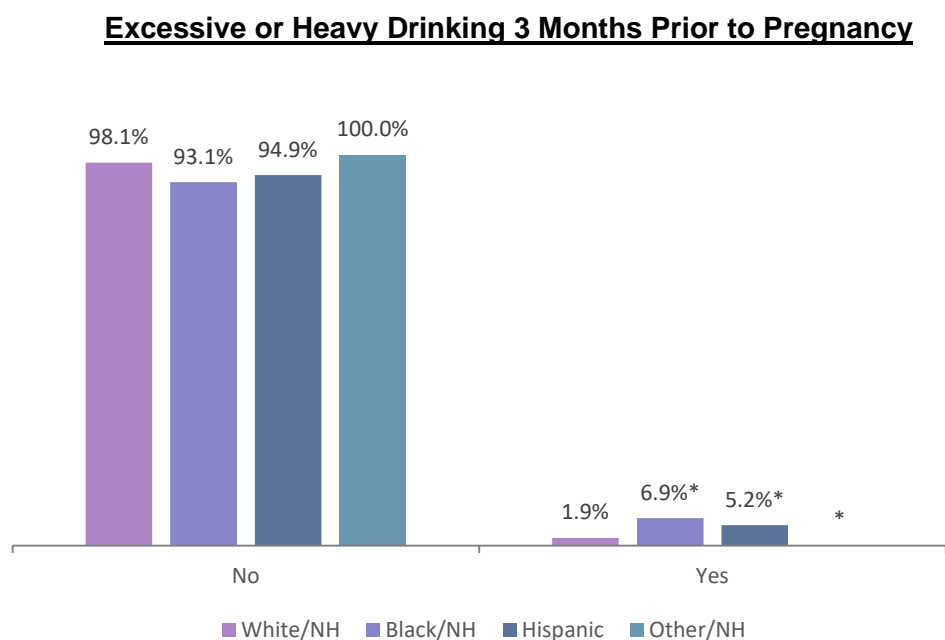


Figure 14.



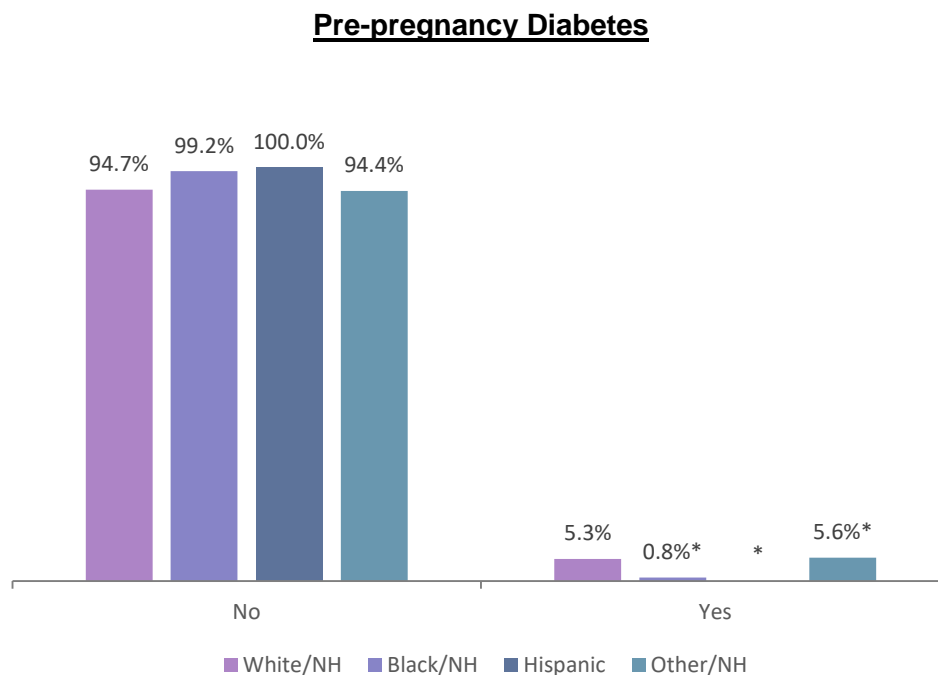
(*) Respondents is <30, interpret with caution.

Diabetes --- Pre-pregnancy and Gestational

In 2020, West Virginia had the highest prevalence of diabetes among adults in the United States at 15.7%, higher than the national average of 10.6% (National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, 2015) Factors that can contribute to diabetes are obesity, lack of exercise and a genetic predisposition for diabetes. Racial and ethnic minorities have a higher burden of diabetes, trouble controlling their diabetes and are more likely to experience complications related to their diabetes (FDA, 2020) Diabetes that occurs during pregnancy is called gestational diabetes, and usually sets in between 24 and 28 weeks of pregnancy. Gestational diabetes generally goes away after the baby is born, but the mother is more likely to develop type 2 diabetes later in life. Black/NH women are at the lowest risk for gestational diabetes mellitus (GDM), but the highest risk for conversion of GDM to type 2 diabetes afterwards. But Black/NH, Hispanic and Other/NH have the highest risk for diabetes (Bower, Butler, Bose-Brill, Kue, & Wassel, 2019)

Close to or over 95% of women from all racial/ethnic groups reported not having diabetes prior to their pregnancies, Hispanic women reporting 100% (**Figure 15**).

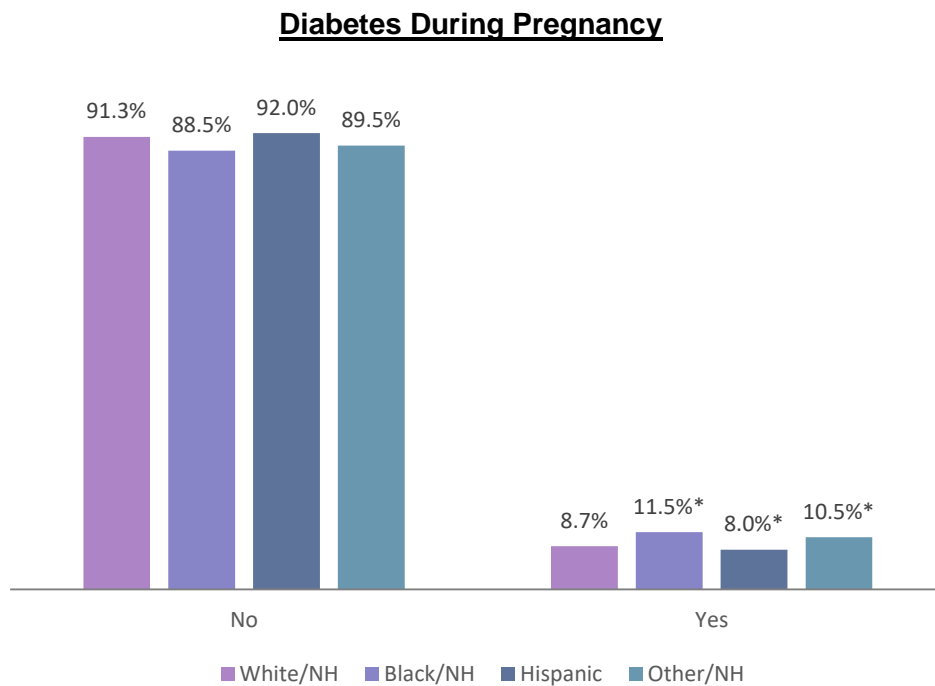
Figure 15.



(*) Respondents is <30, interpret with caution.

Gestational diabetes affects between 2% to 10% of pregnancies in the United States (Herndon, 20). A study found that the highest prevalence of gestational diabetes was among individuals who identified as Asian/Pacific Islander which are included in the Other/NH group, followed by others of Hispanic descent (Bower, Butler, Bose-Brill, Kue, & Wassel, 2019). However, during pregnancy, 11.5% of Black/NH women reported having gestational diabetes, followed by 10.5% of Other/NH women. White/NH and Hispanic women reported similar proportions (**Figure 16**).

Figure 16.



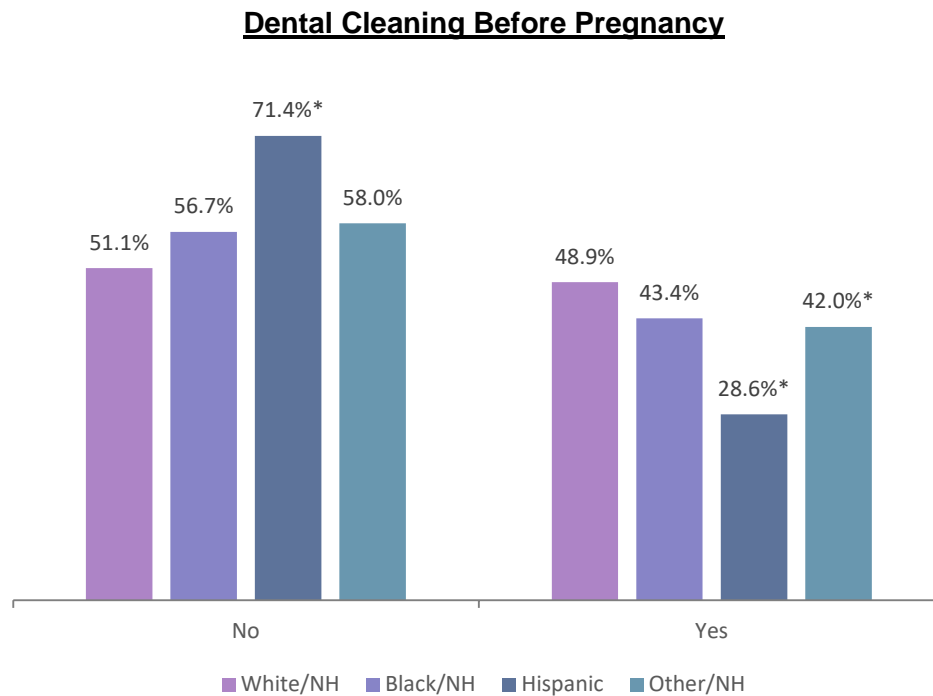
(*) Respondents is <30, interpret with caution.

Maternal Oral Health

Oral health is a key indicator of overall health and well-being for mothers and is particularly important prior to conception and during pregnancy. Maintaining good oral health during pregnancy is beneficial to the mother and the baby. Access to routine dental care during the perinatal period can reduce the risk of negative birth outcomes and promote good health for mother and baby after delivery. However, there is increased risk of poor oral health at every age for individuals who are low-income, uninsured, and/or members of racial/ethnic minority, immigrant, or rural populations than for others who have access to quality oral health care (Northridge, Kumar, & Kaur, 2020)

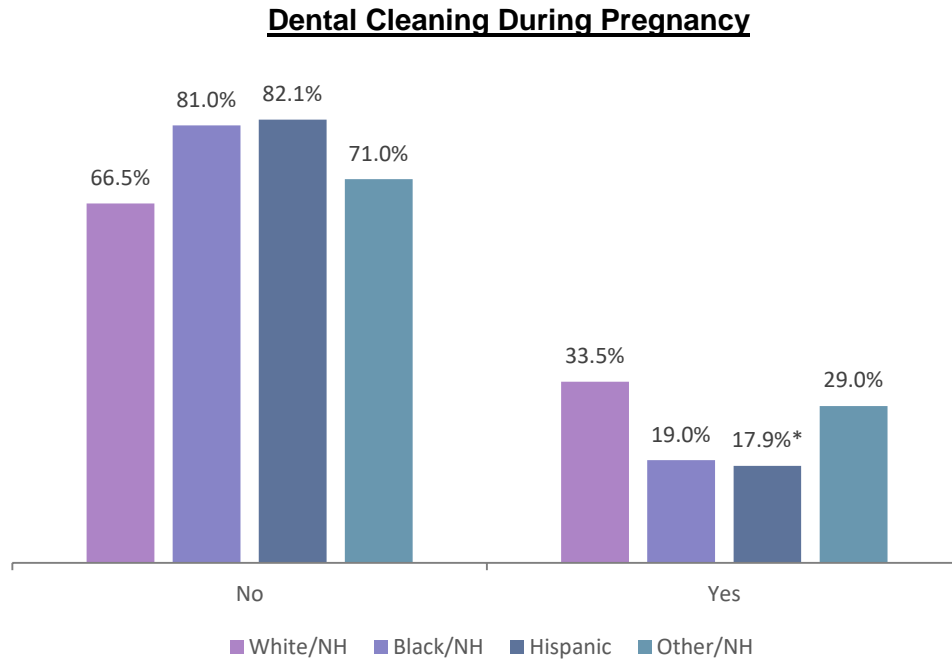
In West Virginia, Hispanic women (28.6%) were least likely to report to have a dental cleaning prior to their pregnancies compared to their White/NH (48.9%), Black/NH (43.4%) and Other/NH (42.0%) counterparts (**Figure 17**). Similar to dental cleanings prior to pregnancy, Hispanic women reported the lowest prevalence of dental cleaning during their pregnancies at 17.9%. In addition to Hispanic women, Black/NH women reported the next lowest prevalence at 19%. White/NH women reported the highest dental cleanings during pregnancies, 33.5%, followed by Other/NH, 29%. (**Figure 18**).

Figure 17.



(*) Respondents is <30, interpret with caution.

Figure 18.



(*) Respondents is <30, interpret with caution.

Postpartum Health and Care

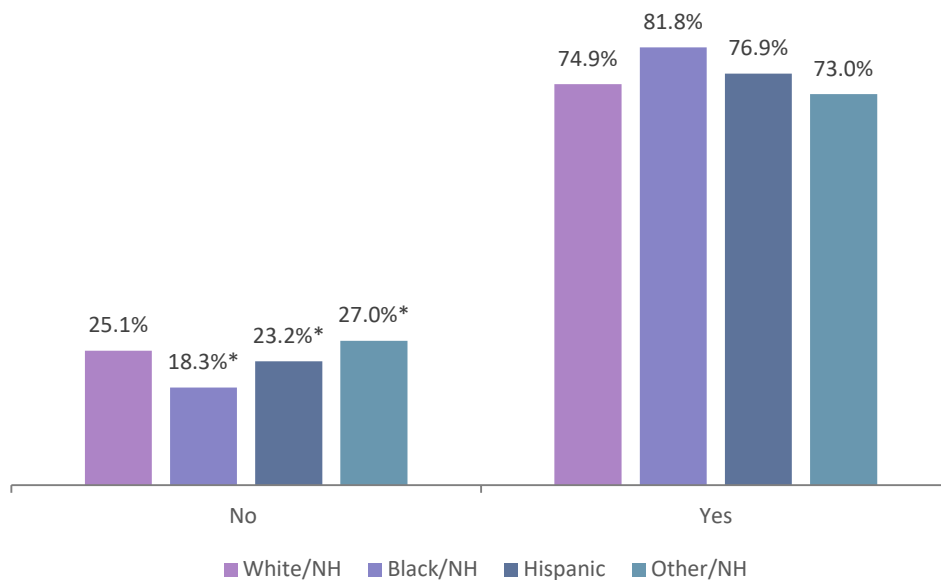
Postpartum health is just as important to mothers as prenatal health. Mothers should receive a postpartum checkup six weeks after delivery to identify and address any health concerns. During the checkup, providers perform a physical and gynecological exam. Additionally, providers can use the opportunity to discuss postpartum birth control, update vaccinations and screen for postpartum depression. Physical, emotional and lifestyle changes can trigger mood changes. However, mothers may develop a more severe form of depression called postpartum depression. It is essential that mothers be screened for signs and symptoms of postpartum depression during the six-week checkup.

In 2008, the Centers for Disease Control and Prevention estimated that Black and Hispanic mothers have the highest rates of postpartum depression among all racial and ethnically diverse groups, but research on these mothers is lacking. Mothers of color may be less likely to receive needed services because of personal reasons including insufficient time, inconvenient appointment times and locations (Keefe, Brownstein-Evans, & Rouland Polmanteer, 2016).

Over 70% of all racial/ethnic groups reported talking with a healthcare worker about depression during their prenatal care visits, with Black/NH having the highest prevalence at 81.8% (**Figure 19**). Almost or over 90% of women reported attending a postpartum visit (**Figure 20**).

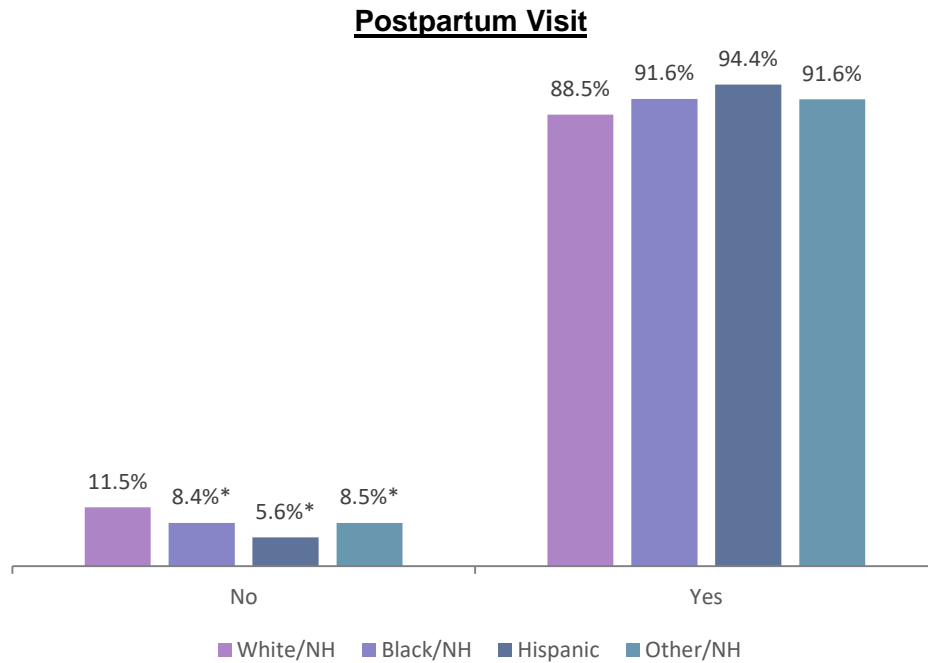
Figure 19.

Healthcare Worker Talked About Depression During Prenatal Care Visits



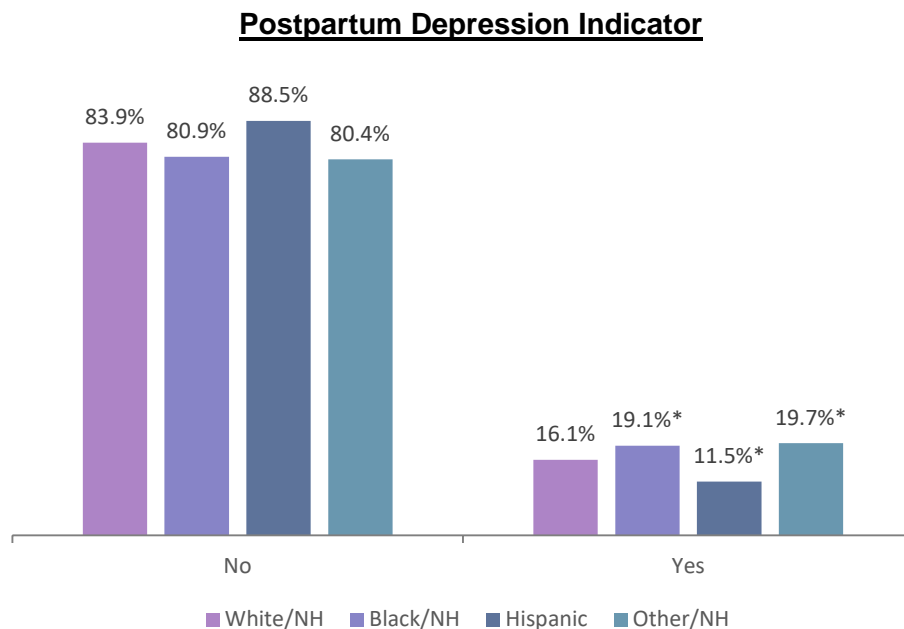
(* Respondents is <30, interpret with caution.

Figure 20.



To identify potential postpartum depression symptoms, mothers were asked to rate their feelings of being down or depressed, hopelessness and slowed down on a scale of 1-5 (1 = never and 5 = always). Mothers who reported a 4 or higher in all three categories were identified as having possible postpartum depression symptoms. Hispanics reported the lowest prevalence of the postpartum indicator, 11.5%. Other/NH and Black/NH women were more likely to meet the requirements for the postpartum indicator, 19.7% and 19.1% respectively (**Figure 21**).

Figure 21.



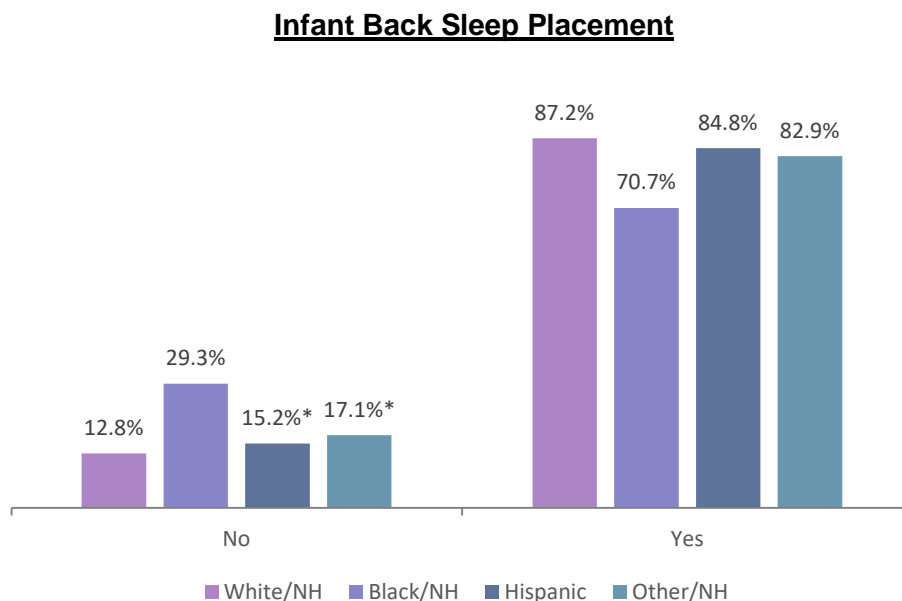
(*) Respondents is <30, interpret with caution.

Infant Safe Sleep: Position and Environment

Providing a safe sleep environment for infants is extremely important. According to the CDC, about 3,500 US infants die of sudden unexpected infant death (SUID) (Safe Sleep for Babies, 2018). Although the exact cause of death of many of these babies is never determined, most occur while the infants are in an unsafe sleep environment. The American Academy of Pediatrics recommends the following for a safe sleep environment: infants should sleep on their backs and should never sleep with anyone else; the infant's bed should be an approved crib with a firm mattress and free of soft bedding or other soft items. Despite efforts in infant safe sleep, Black infants are still twice as likely to die from SIDS and other sleep-related infant deaths such as accidental suffocation and strangulation in bed, ill-defined causes of death, all associated with bed sharing (Mathews, Joyner, Oden, Alamo, & Moon, 2015). SUID rates for American Indians, Alaskan Natives and Non-Hispanic Black infants are more than twice those of white babies (NICHQ, 2022)

Black/NH women (70.7%) reported the lowest prevalence of supine (back) sleep placement compared to their racial/ethnic counterparts. Over 80% of White/NH, Hispanic and Other/NH women reported placing their infants on their back to sleep. White/NH women reported the highest prevalence of supine placement among all racial/ethnic groups, 87.2% respectively (**Figure 22**). Despite Black/NH women reporting the lowest prevalence of supine sleep placement, advice from doctors or healthcare workers regarding back placement and the items that can/cannot go in their infant's bed were the highest among racial/ethnic groups (**Figure 23**).

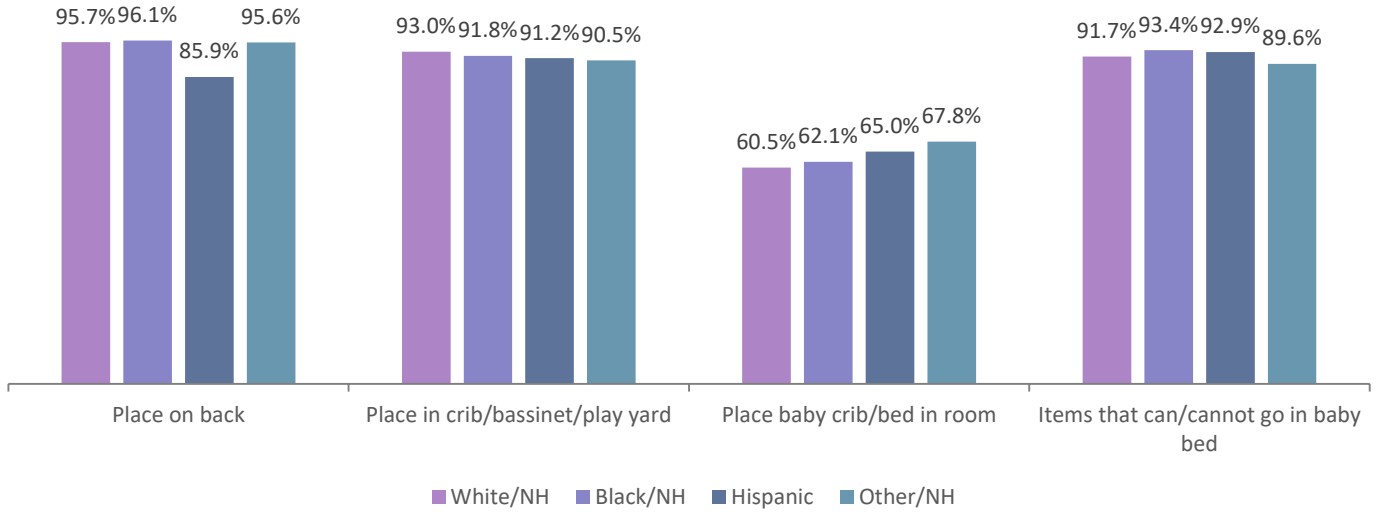
Figure 22.



(*) Respondents is <30, interpret with caution.

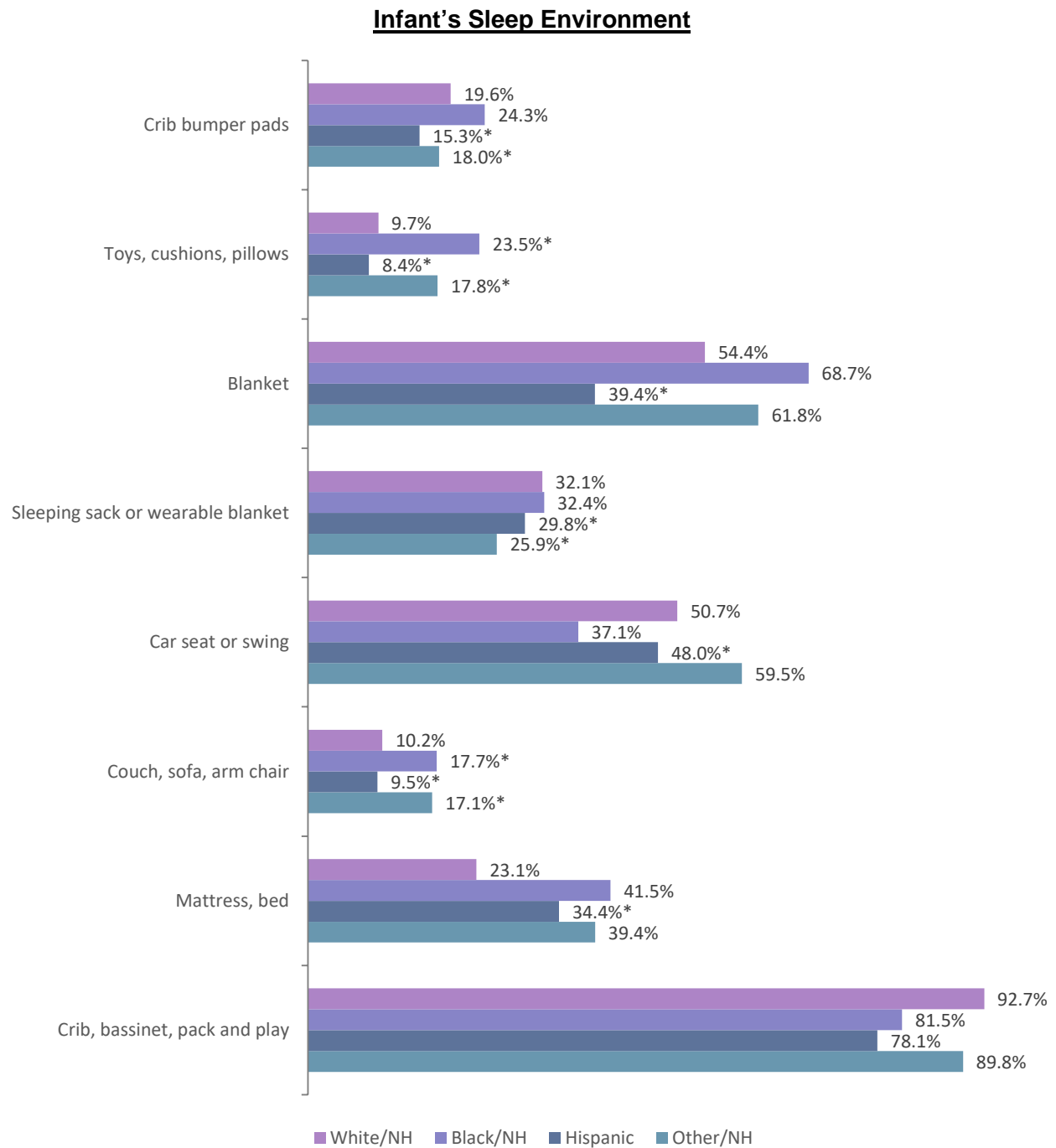
Figure 23

Doctor or Healthcare Worker Recommended Sleeping Suggestions



Black/NH women reported the highest prevalence of crib bumper pads, toys, cushions and pillows, blankets in their infant's sleep environment and a slightly higher prevalence of placing their infants on a mattress or bed. Hispanic women reported the lowest proportion of placing their infants in a crib, bassinet or pack and play compared to other racial/ethnic groups (**Figure 24**).

Figure 24



(*) Respondents is <30, interpret with caution.

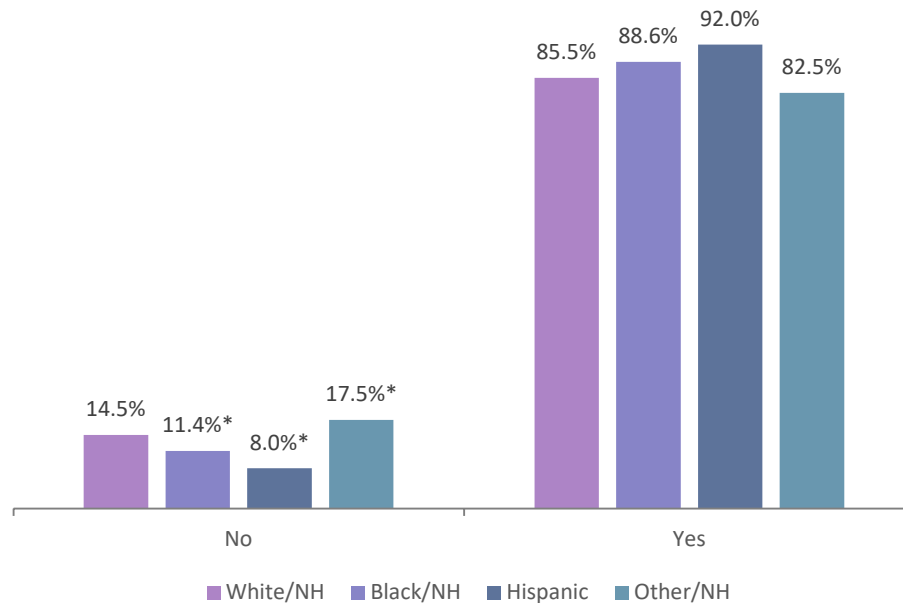
Breastfeeding

The benefits of breastfeeding are numerous for both mother and baby, but the benefits may be greater for minority women. Minority women are disproportionately affected by adverse health outcomes, which may improve with breastfeeding (Jones , Power, Queenan, & Schulkin, 2015). Human breast milk provides the ideal nutrition for infants and is more easily digested than formula. It also contains antibodies and other substances that are needed for healthy immune system and can reduce an infant's risk of developing other illness later during childhood. Black and Hispanic women have increased rates of obesity, diabetes, and cardiovascular disease, but women who breastfeed may reduce the mother's risk of hypertension and cardiovascular disease. However, racial and ethnic minority women continue to have lower breastfeeding rates than white women (Jones , Power, Queenan, & Schulkin, 2015).

Over 80% of women reported being talked to about breastfeeding during their prenatal care visits, Hispanic women reporting the highest number, 92% (**Figure 25**). Over 72% of all racial/ethnic group women reported breastfeeding initiation, with Hispanic women reporting the highest, 88% and White/NH women reporting the lowest, 72.1% (**Figure 26**). Black/NH women (36%) reported the lowest prevalence of breastfeeding continuation, while Hispanic women reported 68.3% (**Figure 27**).

Figure 25

Health Care Worker Talked About Breastfeeding



(*) Respondents is <30, interpret with caution.

Figure 26

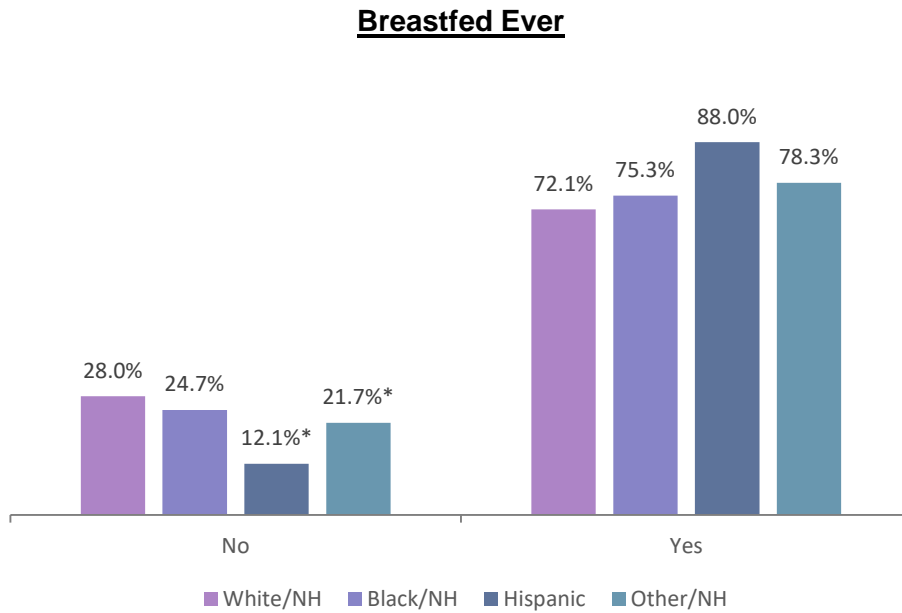
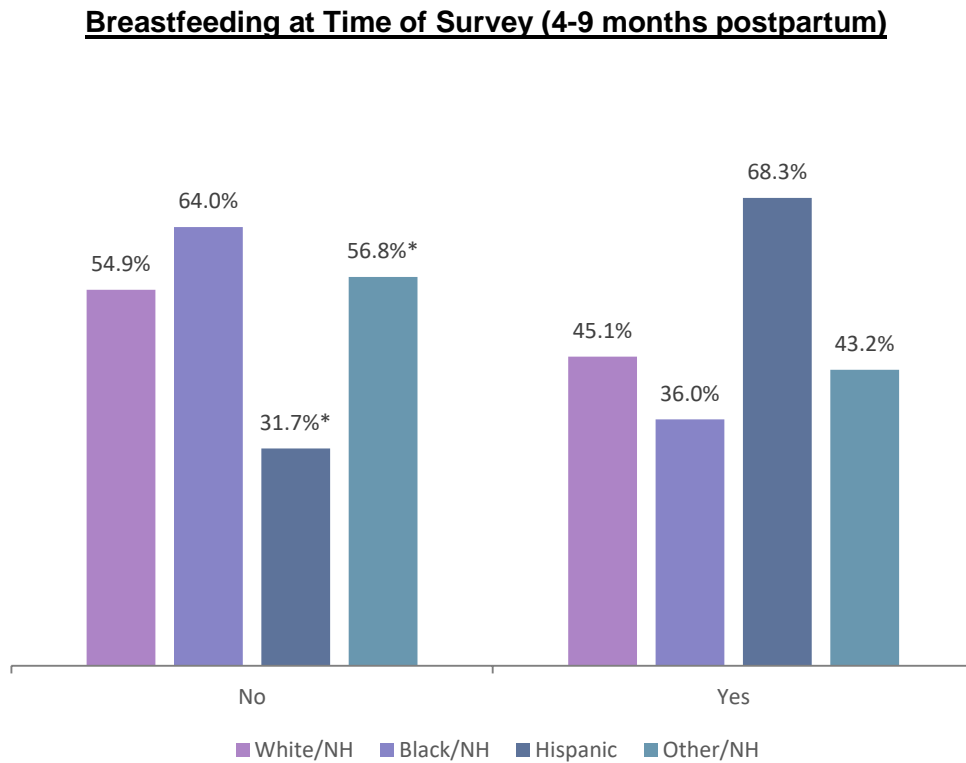


Figure 27

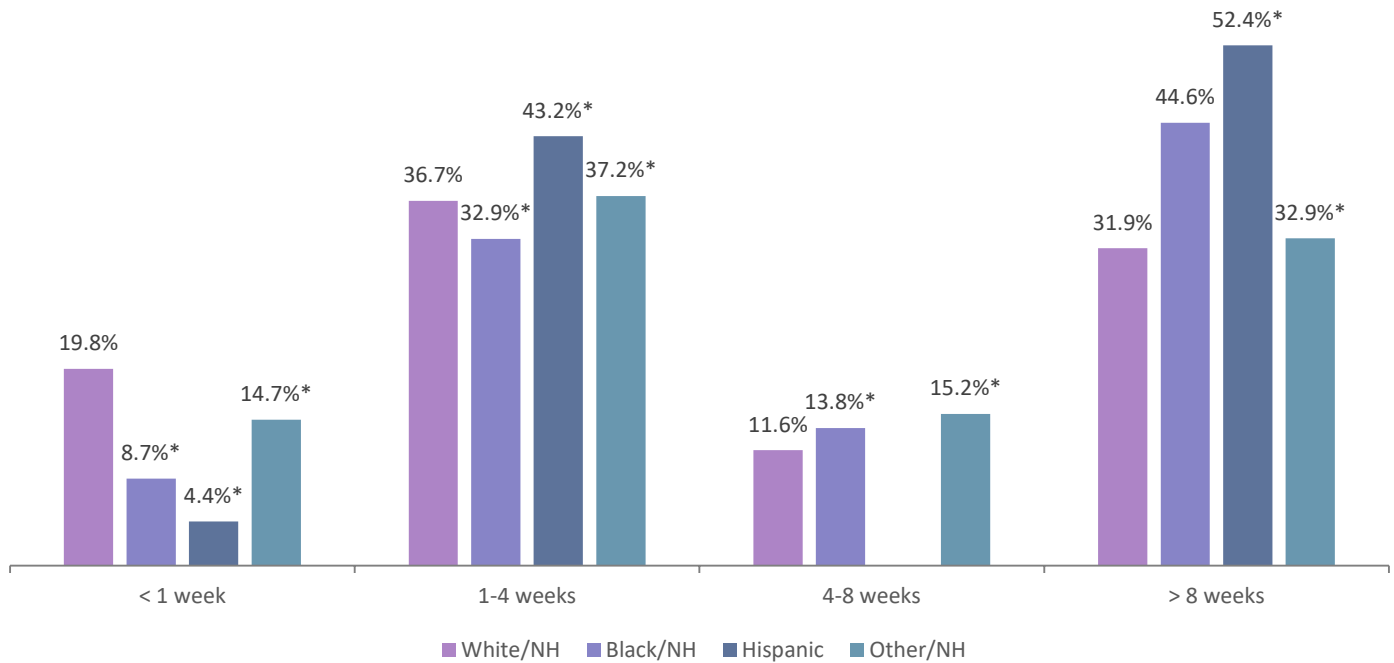


(*) Respondents is <30, interpret with caution.

Among women who reported they had stopped breastfeeding by the time of the survey (4 to 9 months postpartum), White/NH women (19.8%) reported the highest prevalence of 1 week or less of breastfeeding. Hispanic women reported the highest proportion of breastfeeding 1-4 weeks but dropped to 0% for breastfeeding for 4-8 weeks. Other/NH women (15.2%) reported the highest prevalence of breastfeeding in the same time frame of 4-8 weeks compared to other racial/ethnic groups. Hispanic women reported the highest rates of breastfeeding >8 weeks (52.4%) (Figure 28).

Figure 28

Breastfeeding Length



(*) Respondents is <30, interpret with caution.

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