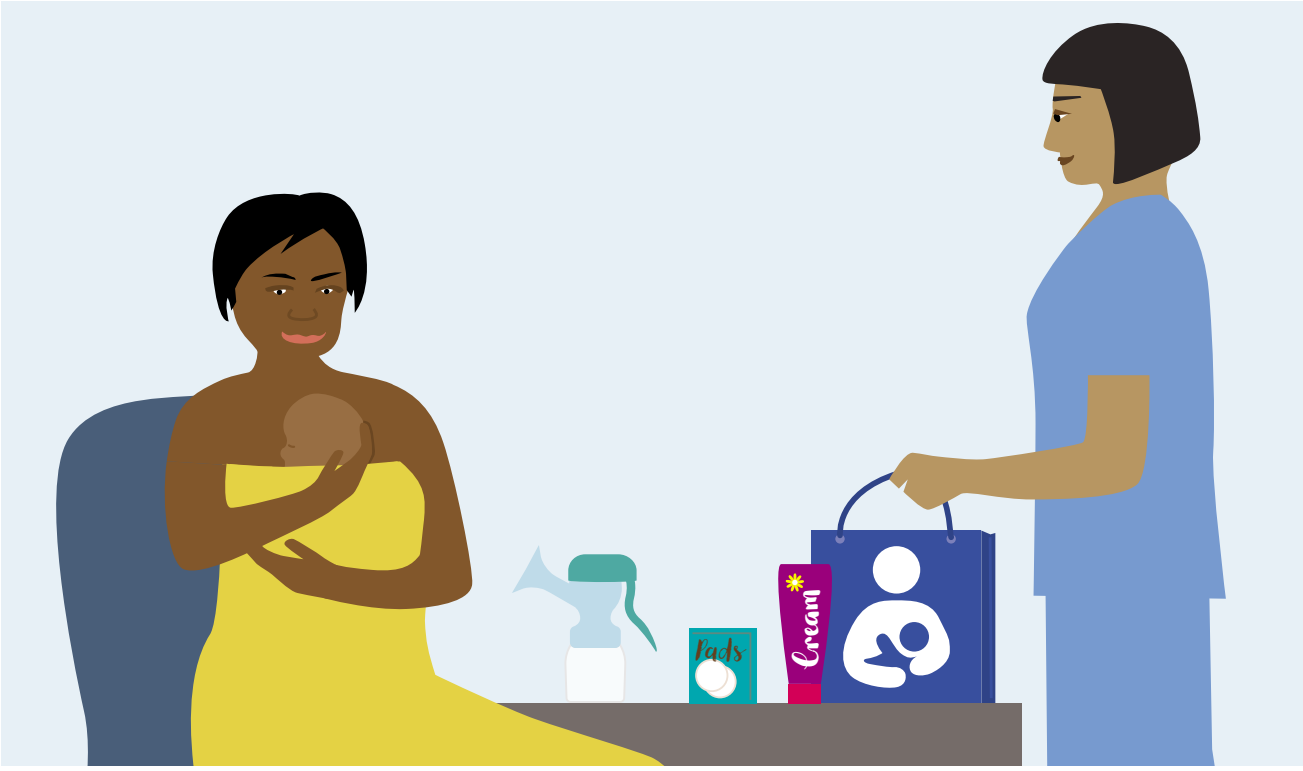
FACT SHEET

Changing the System to Address Racial Inequities in Breastfeeding

ChangeLab Solutions

Introduction

Breastfeeding has important health benefits for children and families,[1-8] and many parents want and intend to breastfeed their children. However, many parents fall short of their breastfeeding goals. Breastfeeding can be physically taxing as well as time and resource-intensive. Successful breastfeeding requires more than the mother's desire to do so; time, money, and professional and social support are each key predictors of breastfeeding success. Racial inequities in access to these factors may contribute to racial inequities in breastfeeding outcomes. Interventions to alleviate racial inequities in breastfeeding must take into account inequities in access to these predictors of breastfeeding and seek to address them through policy, system, and environmental changes.



Racial Inequities in Breastfeeding

Racial inequities in breastfeeding rates persist, despite slight improvements since 2000.[9] Black mothers have significantly lower breastfeeding initiation and duration rates than white or Hispanic women. In a 2017 study, only 64% of black mothers said they initiated breastfeeding — a significantly lower proportion than white mothers (82%) or Hispanic mothers (82%).[10] This racial gap in breastfeeding rates has not narrowed over the past decade.[10]

Another survey found inequities in other important measures of breastfeeding: Black women in the survey who breastfed did so for only 6 weeks on average, compared with 16 weeks among white women, 10 weeks among English-speaking Hispanic women, and 17 weeks among Spanish-speaking Hispanic women. Black women were also less likely to intend to breastfeed than white or Hispanic women: 57% of black women intended to breastfeed, compared with 77% of white women, 88% of English-speaking Hispanic women, and 92% of Spanish-speaking Hispanic women.[11]

Research suggests intersecting inequities in breastfeeding. Not only are breastfeeding initiation rates lower among low-income mothers, but rates are even lower among low-income black mothers (37%) and black mothers younger than 20 years of age (30%).[12]

These inequities in rates and duration of breastfeeding lead to racially disparate access to the benefits of breastfeeding. The racial gap in breastfeeding is part of what drives racial inequities in infant mortality.[13] The American Academy of Pediatrics recommends breastfeeding in its guidelines on SIDS and other sleep-related infant deaths.[14]

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INITIATED BREASTFEEDING

Predictors of Breastfeeding Success

Breastfeeding can be a difficult behavior to maintain, despite parents' desire to do so. In 2014, over 80% of US infants were breastfed at birth, indicating a strong parental desire to breastfeed.[15] However, less than half of mothers were still exclusively breastfeeding by the time their baby was 3 months old, and less than 25% of mothers were exclusively breastfeeding at 6 months.[15] In a study of women who planned to breastfeed before their baby was born, more than 85% of them planned to exclusively breastfeed for 3 months or more, but only 32% achieved their goal.[16]

The data in the preceding paragraph suggest the influence of factors beyond the mother's control. Researchers have theorized about a socio-ecological model of barriers to and facilitators of breastfeeding. Forces at interpersonal, community, institutional, and societal levels all might shape a mother's ability to breastfeed; therefore, interventions to address breastfeeding should target factors at multiple levels.

Research on predictors of breastfeeding tends to focus on individual and interpersonal factors, perhaps because breastfeeding feels so personal. As a result, many proposed solutions are also centered in personal and interpersonal spaces (eg, culturally competent education campaigns targeting women, their partners, or their mothers). Nevertheless, factors outside the control of mothers and their social networks can also influence breastfeeding success. Systemic solutions like improved workplace policies, hospital practices, and professional support networks can promote breastfeeding more broadly than an education campaign — but only if they are designed to reach everyone and to prioritize those who currently have the least access to these supports.

Removing Barriers to Breastfeeding

Known predictors of breastfeeding at community and institutional levels include workplace policies, hospital practices, professional support, and WIC practices. Each of these factors can be addressed in ways that both improve breastfeeding outcomes and decrease racial inequities.

PREDICTOR	BARRIERS	SOLUTIONS
Workplace policies	Paid leave from work after childbirth is a key factor in establishing breastfeeding. Among California mothers, using paid family leave (PFL) roughly doubled the median duration of breastfeeding. Among new mothers in low-quality jobs in California (defined by the researchers as jobs that lack employer-sponsored health insurance or pay less than $20 per hour — or both), 92.5% of those who used PFL initiated breastfeeding, compared with 83.3% of those who did not use PFL.[17] Women of color in the United States are disproportionately less likely to have access to paid maternity leave through their employer.[18] Other researchers have noted significant racial inequities in access to paid leave nationwide, with Latinas being the least likely to have paid leave or workplace flexibility.[19]	**GOVERNMENT** ▸ Create a government-funded paid family leave program that applies to all workplaces, including those most likely to employ groups with disproportionately low rates of breastfeeding (eg, low-wage and hourly workers). ▸ Mandate paid breaks for workers who are breastfeeding. **WORKPLACES** ▸ Provide on-site child care. ▸ Meet or exceed current federal, state, and local lactation accommodation requirements. ▸ Ensure that lactation rooms are clean, comfortable, private, and easy to locate. ▸ Create opportunities for breastfeeding parents to meet and support each other. ▸ Allow paid breaks for workers who are breastfeeding.
Hospital practices	Adopting practices that promote breastfeeding in hospitals, such as the 10 Steps to Successful Breastfeeding used by the Baby-Friendly Hospital Initiative, leads to greater rates of breastfeeding,[16,20–24] and several studies have indicated greater gains in breastfeeding among groups that typically experience breastfeeding inequities.[22,25,26] Yet there are racial inequities in access to maternity care practices known to support breastfeeding, such as rooming in, initiating breastfeeding within 1 hour of birth, and limiting the use of supplemental (formula) feeding.[27] Black women are significantly more likely than white women to have formula introduced to their babies in the hospital.[11,16]	**GOVERNMENT** ▸ Create requirements or incentives for hospitals to become Baby-Friendly or institute Baby-Friendly practices, including funding for the Baby-Friendly designation process. ▸ Create a model breastfeeding policy for hospitals to adopt. ▸ Set quality standards for maternity care and help hospitals achieve Baby-Friendly designation. **HOSPITALS** ▸ Obtain Baby-Friendly Hospital designation or adopt Baby-Friendly practices. ▸ Replace gift bags from the formula industry with gifts that support breastfeeding (eg, manual breast pump, nipple cream, or breastfeeding pads). ▸ Control formula industry representatives' access to patient care areas and clinical staff. ▸ Hire African American and Latina International Board-Certified Lactation Consultants, peer counselors, or community health workers to provide culturally competent care to expectant and new parents on breastfeeding.

PREDICTOR	BARRIERS	SOLUTIONS
Professional support	Professional support is a key predictor of successful breastfeeding.[28,29] Breastfeeding mothers of all races frequently cite their doctors as a point of encouragement to breastfeed. Black women are less likely to receive this encouragement from their providers and are more likely to receive information about formula.[11,27,30] Black women are less likely to see a certified lactation consultant. While no data on race or ethnicity of certified lactation consultants are publicly available, it is well known that there are very few lactation consultants who are women of color, suggesting a lack of culturally competent care in this field.[31] Cost is another issue in obtaining lactation support. Under the Affordable Care Act, private plans must cover breastfeeding supplies and counseling with no co-payment;[32] however, only 26 states cover lactation support for families on Medicaid, and that coverage varies widely by state.[33] This creates an additional barrier for families on Medicaid, who are disproportionately African American and Latino.[34]	**GOVERNMENT** ▸ Require Medicaid coverage of lactation support services, including outpatient consultations with lactation consultants. ▸ Expand the types of practitioners who can provide Medicaid-reimbursable lactation counseling. **PRIVATE INSURANCE** ▸ Expand the network of practitioners who are covered to provide lactation support. **HOSPITALS** ▸ Create consistent, supportive messages on breastfeeding and disseminate them across the continuum of care, from prenatal care through labor and delivery, maternity care, and pediatric care. ▸ Identify and designate breastfeeding "champions" among hospital staff. ▸ Provide practical training in lactation support for hospital staff. **PROFESSIONAL ORGANIZATIONS** ▸ Diversify the pipeline of certified lactation counselors by offering scholarships or recruiting doulas or community health workers of color. ▸ Collect and publish data on racial and ethnic diversity among certified lactation counselors. ▸ Create or build upon a home-visiting program to assist parents with establishing and maintaining breastfeeding. ▸ Address common misconceptions about breastfeeding, such as racial stereotypes.
WIC practices	For low-income mothers, The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is an important source of information about breastfeeding. WIC has dedicated funding and educational materials to promote breastfeeding.[35] Because of this concerted effort, WIC has been the site of several effective environmental and policy interventions to promote breastfeeding, including culturally relevant messaging, breast pumps available on demand, and revisions to the food package to provide for the nutritional needs of breastfeeding mothers.[36] Supportive WIC counselors can also improve breastfeeding self-efficacy.[37] However, WIC sites that serve a higher proportion of African American mothers are less likely to offer clinic-based breastfeeding support services.[38]	**GOVERNMENT** ▸ Scale up WIC's successful state and local breastfeeding interventions to the national level through incentives or requirements. ▸ Train or recruit more breastfeeding peer educators in African American areas. ▸ Provide training to dispel implicit and explicit racial stereotypes about African American women and breastfeeding.

Conclusion

Breastfeeding is not a panacea, nor is it the right choice for all families. But race should not determine a family's ability to meet their breastfeeding goals. The reality is that race often determines access to the tools that families need to breastfeed effectively. Interventions that increase access to these tools may be effective in decreasing racial inequities in breastfeeding, which, in turn, could lead to decreased inequities in other key indicators of population health, such as infant mortality. The policy, system, and environmental interventions suggested here could improve the health of the most vulnerable and eventually lead to better health for all.

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