Breastfeeding and Racial Disparities in Infant Mortality

Celebrating Successes and Overcoming Barriers

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Editorial

Many exciting changes occurred in 2013 in the breastfeeding world. One of the best changes was the increase in breastfeeding rates in the African American community. In 2013, the Centers for Disease Control and Prevention (CDC) indicated that increased breastfeeding in African American women narrowed the gap in infant mortality rates (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a1.htm#tab>). As the CDC noted:

From 2000 to 2008, breastfeeding initiation increased . . . from 47.4% to 58.9% among Blacks. Breastfeeding duration at 6 months increased from . . . 16.9% to 30.1% among Blacks. Breastfeeding duration at 12 months increased from . . . 6.3% to 12.5% among Blacks.

Much of this wonderful increase in breastfeeding rates among African Americans is the result of efforts within that community. In 2013, we saw the first Black Breastfeeding Week become part of World Breastfeeding Week in the U.S. Programs, such as A More Excellent Way (<http://www.newpeers.org/media/MEWbrochure1.pdf>), Reaching Our Sisters Everywhere (ROSE; <http://www.breastfeedingrose.org/main-page/>), and Free to Breastfeed (<http://freetobreastfeed.com/>), offer peer counselor programs for African American women.

We can celebrate these successes. But there is still more to do. Although the rates of infant mortality have dropped, African American babies are still twice as likely to die compared to White babies. In addition, although rates of breastfeeding have increased among African Americans, they are still lower than they are for other ethnic groups (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a1.htm#tab>).

For each of the 2000–2008 birth years, breastfeeding initiation and duration prevalences were significantly lower among Black infants compared with White and Hispanic infants. However, the gap between Black and White breastfeeding initiation narrowed from 24.4 percentage points in 2000 to 16.3 percentage points in 2008.

Barriers to Overcome

To continue this wonderful upward trend in breastfeeding rates, we need to acknowledge possible barriers to breastfeeding among African American women. Here are a couple of barriers I've observed. They are not the only ones. But they are ones I've consistently encountered. Addressing

these will not be a quick fix, but these barriers can be overcome if we recognize them and take appropriate action.

1. **Pathways for IBCLCs of Color.** In their book, *Birth Ambassadors*, Christine Morton and Elayne Clift highlight a problem in the doula world that also has relevance for the lactation world: most doulas (and International Board Certified Lactation Consultants [IBCLCs]) are White, middle-class women. And there is a very practical reason for this. This is generally the only demographic of women that can afford to become doulas (or IBCLCs). The low pay, or lack of job opportunities for IBCLCs who are not also nurses, means that there are limited opportunities for women without other sources of income to be in this profession. Also, as we limit tracks for peer counselors to become IBCLCs, we limit the opportunities for women of color to join our field. I recently met a young African American woman who told me that she would love to become an IBCLC but couldn't get the contact hours needed to sit for the exam. That's a shame. (I did refer her to someone I knew could help.)

We need to have some dialogue about how we can bring along the next generation of IBCLCs. We need to recognize the structural barriers that make it difficult for young women of color to enter our field. And these discussions can start with you. Sherry Payne, in her recent webinar, *Welcoming African American Women into Your Practice*, recommends that professionals who work in communities of color find their replacement from the communities they serve (<http://praeclaruspress.givezooks.com/events/welcoming-african-american-women-into-your-practice>). Even if you only mentor one woman of color to become an IBCLC, you can have a tremendous impact in your community. If we all do the same, we can change the face of our field.

2. **Bedsharing and Breastfeeding.** This is an issue that I expect will become more heated over the next couple of years. But it is a reality. As we encourage more women to breastfeed, a higher percentage of them will bedshare. As recent studies have repeatedly found, bedsharing increases breastfeeding duration. This is particularly true for exclusive breastfeeding (Ball, 2007; Lahr, Rosenberg, & Lapidus, 2007; Middlemiss & Kendall-Tackett, 2013).

Bedsharing is a particular concern when we are talking about breastfeeding in the African American community (Lahr et al., 2007; Middlemiss & Kendall-Tackett, 2013). Of all ethnic groups studied, bedsharing is most common in African Americans. It is unrealistic to think that we are going to simultaneously increase breastfeeding rates while decreasing bedsharing rates in this community. The likely scenario is that breastfeeding would falter. It's interesting that another recent CDC report, *Public Health Approaches to Reducing U.S. Infant Mortality*, talks quite a bit about safe-sleep messaging, with barely a mention of breastfeeding in decreasing infant mortality (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6231a3.htm>). A more constructive approach might be to talk about being safe while bedsharing. But as long as the message is simply "never bedshare," there is likely to be little progress, and it could potentially become a barrier to breastfeeding.

Reason to Hope

Even with these barriers, and others I haven't listed, Baby-Friendly Hospitals are having a positive effect. When hospitals have Baby-Friendly policies in place, racial disparities in breastfeeding rates seem to disappear. For example, a study of 32 U.S. Baby-Friendly Hospitals revealed breastfeeding initiation rates of 83.8%, compared to the (then) national average of 69.5%. In-hospital exclusive breastfeeding rates were 78.4%, compared with a national rate of 46.3%. *Rates were similar even for hospitals with high proportions of Black or low-income patients* (Merewood, Mehta, Chamberlain, Phillipp, & Bauchner, 2005). This is a very hopeful sign, especially because more hospitals in the U.S. go baby-friendly. But we need to make sure that we follow Step 10, and that mothers have great support in their communities once they leave the hospital.

In summary, we have made significant strides in reducing the high rates of infant mortality in the U.S., particularly among African Americans. I am encouraged by the large interest in this topic, and the number of different groups working toward this goal. Keep up the good work. I think we are reaching critical mass.

And to all of you, thanks for impacting your community—one mother at a time. Wishing you a happy and healthy 2014!

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Helpful Links

- Black Mothers' Breastfeeding Summit, <http://youtube/b8MXkKkO1a4>
- Teach Me to Breastfeed Rap, http://www.youtube.com/watch?v=ax85hE3_2uE
- Interview With Sherry Payne on Fighting Breastfeeding Disparities With Support, <http://kcur.org/post/kc-group-fights-breast-feeding-disparities-education-support>

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