Racism and Resistance:  
A Qualitative Study of Bias As a Barrier to Breastfeeding

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Abstract

Background: Nearly 75% of Black non-Hispanic babies born in 2016 ever breastfed. However, Black mothers still experience barriers to breastfeeding, perpetuating disparities in exclusivity and duration.

Subjects and Methods: Using data collected from five focus groups with Black mothers (N = 30) in Washington, District of Columbia during summer 2019, we critically examine the influence of institutionalized and personally mediated racism on breastfeeding. We also explore the counter-narratives Black women use to resist oppression and deal with these barriers.

Results: Themes surrounding institutionalized racism included historic exploitation, institutions pushing formula, and lack of economic and employment supports. Themes regarding how personally mediated racism manifested included health care interactions and shaming/stigma while feeding in public. At each level examined, themes of resistance were also identified. Themes of resistance to institutionalized racism were economic empowerment and institutions protecting breastfeeding. Themes of resistance to personally mediated biases were rejecting health provider bias and building community.

Conclusions: There are opportunities for health providers and systems to break down barriers to breastfeeding for Black women. These include changes in clinical training and practice as well as clinicians leveraging their position and lending their voices in advocacy efforts.

Keywords: breastfeeding, racism, Black mothers, critical race theory

Introduction

Nearly 75% of Black1 non-Hispanic babies born in 2017 in the United States were ever breastfed. Although breastfeeding rates have increased among Black women since the 1970s, they still experience many barriers to breastfeeding, perpetuating disparities in duration and exclusivity.1–3 These barriers are a consequence of the intersection of racialized identity, gender, and class.4,5

Critical race theory (CRT) is a framework explaining connections between race, power, and law.6 CRT strategically considers how people who experience adverse outcomes as a result of racism work to resist oppression. CRT is useful for analyzing the barriers resulting from racism, sexism, and classism, as well as calling attention to the steps Black mothers take to advocate for themselves and counter various forms of racism along their breastfeeding journeys.
Jones\textsuperscript{7} identifies racism as the “root cause of race\textsuperscript{4} associated differences in health outcomes.” Dr. Jones defined three levels of racism: institutionalized, personally mediated, and internalized.\textsuperscript{8} The research here focuses on two levels: institutionalized racism, “differential access to the goods, services, and opportunities of society by race” (p. 1212), and personally mediated racism, “prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race” (pp. 1212–1213).

Drawing on Jones’s levels of racism and her challenge to ask “how is racism operating here?” we sought to answer the following research question: how does racism create barriers to breastfeeding for Black mothers? Drawing on CRT, we also examined the ways Black women resist racism during their quest to breastfeed.

Methods

Study design

This study was a secondary analysis of deidentified data. The original research was approved by the George Washington University Institutional Review Board on June 13, 2019 (NCR #191050). Methods for participant recruitment and data collection are described in detail elsewhere and summarized briefly hereunder.\textsuperscript{9,iii}

Participant recruitment

Purposive convenience sampling was used to recruit 30 mothers who self-identified as Black (non-Hispanic), lived in Washington, District of Columbia (DC), and had at least one child between 2016 and 2019. A socioeconomically diverse sample was achieved by promoting the study through a broad range of partner organizations in different parts of the city.

Data source

Five 90-minute focus groups were conducted in 2019. The first author, a Black female expert in focus group facilitation, led groups with a semistructured guide developed for the original study. The focus group guide included broad questions about breastfeeding, how women made the decision to breastfeed or formula feed, and their understanding of the connection between breastfeeding and health. Sample questions from the guide are shown in Figure 1. The second author served as notetaker. Focus groups were audio recorded and transcribed verbatim. It should be noted that this research is a secondary analysis. Therefore, the questions in the focus group guide were not intended to examine racism specifically; however, after initial analysis, the two cofirst authors observed that racism and resistance were dominant in the participants’ talk, and thus formed the present research question.

Data analysis

The cofirst authors conducted iterative pragmatic thematic analysis using MAXQDA Plus 2018 software, applying a priori codes for the two levels of racism (institutionalized and personally mediated) to each transcript. Coders also assigned those two codes to examples of resistance against racism. Multiple discussions of interpretations showed strong agreement on emergent patterns, which were used to identify the themes presented. For each theme reported, coders ensured that there were representative responses. In general, the authors noted a theme if there were four or more similar statements. Sample quotations were selected for inclusion in the figures as evidence for the breadth of each theme. For example, participant 8 was not the only participant to acknowledge historic exploitation of Black women’s labor, but the single quotation captures the full scope of that theme, whereas the three comments under the next theme were necessary to show the types of institutions pushing formula that were evidenced in the data.

Results

Participant characteristics

Thirty women participated in the focus groups, 90% of whom reported that they had breastfed or attempted to breastfeed. See Table 1 for detailed participant characteristics.

Institutionalized racism and resistance

Three forms of institutionalized racism as significant barriers to breastfeeding were culled out as themes, including (1) the historic exploitation of Black women’s labor, (2) institutions pushing formula on Black mothers, and (3) lack of economic and employer-based support. Participants suggested policy and systems changes that would serve to counter forms of institutionalized racism. Themes included (1) economic empowerment and compensation for mothering and (2) institutions protecting breastfeeding (Fig. 2).
In reflecting on their breastfeeding journeys, participants discussed their ancestors’ historic exploitation as wet nurses for white children at the expense of their own children. They noted this history not only to counter perceptions of breastfeeding as uncommon or unpopular among Black women but also to remark on the ways Black babies had been deprived of breastfeeding. In Figure 2, one participant discusses the meaning of Black women’s exploited labor.

Several participants noted that artificial infant formula remains common in Black communities. They suggested that formula’s popularity is, in part, due to the subsidizing of formula through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Some participants reported feeling like WIC historically and continuously pushes formula use. In contrast, several participants recognized the power of WIC’s change in messaging to promote breastfeeding, provision of peer counselors, and the enhancement of the food package for breastfeeding mothers. These comments reflect an institution both pushing formula and protecting breastfeeding.

Several mothers compared postpartum experiences at different local hospitals to illustrate the importance of institutions protecting breastfeeding. They discussed whether their babies were separated from them, and pointed out that facilities with rooming-in policies facilitated breastfeeding. Participants also described differing access to lactation support staff and receipt of unsolicited formula samples and bottle feeding supplies at discharge.

Participants across focus groups often commented on economic and employment factors as barriers or facilitators to breastfeeding. Discussion around the significance of paid maternity leave and workplace protections for nursing mothers was substantial. Participants with access to paid leave shared how essential it was in their breastfeeding success and those who did not have access to paid leave, or knew friends or family who did not, described the negative impact on breastfeeding intentions and success. Participants described the devaluing of the work of mothering and suggested it should be seen as a job, and compensated as such. Participants reported advocacy around policies to enable new mothers to spend a year at home. One participant, a pediatrician, described advocacy with local employers on behalf of her patients, and another, an executive director at an organization, described feeling empowered partly due to her socioeconomic status (Fig. 2). Several participants reported employers unsupportive or openly hostile to pumping accommodations.

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**Table 1. Demographic Characteristics of Focus Group Participants (N=30)**

| Geographic residence                          | 18 |
| Educational achievement                      |    |
| Some high school                             | 1  |
| High school diploma or equivalent            | 6  |
| Vocational training, some college or associate’s degree | 11 |
| Bachelor’s degree                            | 4  |
| Master’s degree                              | 6  |
| Doctoral degree                              | 2  |
| Financial status                             |    |
| Do not meet basic expenses                   | 4  |
| Just meet basic expenses                     | 14 |
| Meet needs with little left over             | 3  |
| Live comfortably                             | 9  |
| Ever received government assistance (food, housing, etc.), yes | 17 |
| Mother’s age at most recent birth            |    |
| Range: 18–48                                 |    |
| Mean: 32 years                               |    |
| Ever breastfed, yes                          | 27 |
| Number of children                           |    |
| Range: 1–8                                   |    |
| Median: 2 children                           |    |
| Youngest child’s age                         |    |
| Relationship status                          |    |
| Romantic relationship, yes                   | 26 |
| Living with romantic partner, yes            | 19 |
| Married, yes                                 | 9  |
| Sexual orientation                           |    |
| Heterosexual                                 | 26 |
| Religion                                     |    |
| Christian                                    | 15 |
| No religion                                  | 11 |
| Other religious identity                     | 4  |
| One or both parents foreign born, yes        | 4  |
| Parent received government support, yes      | 20 |
| Mother was nursed as an infant, yes          | 10 |

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FIG. 2. Representative sample quotations for themes related to institutionalized racism and resistance.

**Historic exploitation of Black women's labor**

**Participant 8:** Black women have always had to go out of the home and work. Black women during slavery were being milkmaids to white families, and they couldn’t breastfeed their own babies. So, there’s a whole hundred like several decades, several centuries of history in that that we all are having to deal with, right? Of suffering, right. So, look at there’s several books that talk about this; people would turn their nose down on Black people feeding their baby because it was like domestic work, right? It wasn’t seen as a wonderful natural thing because the white people who could afford it would either get formula or they pay a Black mom to feed their baby, so Black moms weren’t supported at feeding their babies. All of this is not just us and our generation, this is a dark history of Black people being forced to work and being forced to take care of white people’s babies.

**Institutions pushing formula**

**Participant 9:** That was one of the things that we learned about in my parenting class, how to access WIC and how to [Moderator: Access to formula.] yeah, and how our minority groups are targeted for the formula…

**Participant 5:** And I was getting ready to say working in the community too also and seeing the mothers that I work with a lot of that has to do with your resources, the assistance that you’re getting, and things of that nature. Forgive me, but the government pushes what they want on you. You understand what I’m saying? You have to have a certain level of knowledge too and be able to think outside the box and think outside from what the resources the government is giving you because when they start doing that - - - And the government is now starting to promote breastfeeding but before they wasn’t they was promoting you getting that formula and things of that nature that was not healthy for your kids.

**Participant 14:** Being young in D.C. and African American when you have a child, I do feel like you get pushed. And your economic status like you were saying, if you’re low income I think you get pushed into a particular hospital usually and it’s kind of become like, well at least my experience I felt very like thrown into a method that they had been doing forever. And it felt like being a young mom was a job. And automatically my doctor’s just like “yeah use formula.” And interesting enough formula is very popular with my friends actually and everyone that I know that has kids. I don’t know a lot of them that breastfed. I know most of them tried and couldn’t do two different things and they do get formula, but they can’t afford it. I hear that all the time and I think it’s really interesting that it’s so popular but it’s so expensive.

**Lack of employer supports**

**Participant 8:** So I’m a doctor and I know so many doctors who struggle to breastfeed because their jobs aren’t supportive and doctors who are not supported. I have friend who lost her job because after maternity leave because she was really pushing to get time to breastfeed and they’re like no. And I got my pay docked several hundred dollars for excess breastfeeding. So they don’t really support, yeah, so I feel the same. Like people say they support it but they don’t really support it when it comes down to it.

**Participant 38:** Most of my network and when I think specifically family, friends who had kids at the time and like the work environments that they were in dictated, and the demands of their job, dictated more when they would stop rather than themselves like I’m done. It was more like I have to do if I want to keep working. I have to be done if I want to get back on the road for consulting or whatever my job requires. I feel fortunate that I was at a family-friendly non-profit and I was executive director so it was like oh we’re going to pump in my office, oh I’m going to put the milk right in the refrigerator where everybody else’s, I wish somebody would. So I think it’s one of those things where I felt empowered because of where I was in my career too versus feeling like oh this environment isn’t friendly. I think it was a bonus that I already worked at a place that was pretty family friendly.

**Economic empowerment and compensation for mothering**

**Participant 10:** I think that’s okay to feel like I’m okay at home. My sister said to me the other day ‘what are you doing?’ And I’m like ‘I’m feeding my son.’ This is regardless of what it might look like, I was sitting on the couch chillin …that’s a job. I think it’s when people don’t recognize that this is an activity; this is something and it’s nurturing someone else’s life, like that’s a big deal.

**Participant 8:** I get on the phone and call employers all the time like ‘hey you guys have a breastfeeding room? One of your patients is coming back to work.’ I don’t say who it is but I’m like ‘she’s coming back to work; I want to make sure she’s supported. What do we do?’ So, I think it’s huge, I think it’s huge, we have to support moms more. I hear this too many times that moms don’t even want to do it at all because they’re scared about when they have to go back to work and so I’m all about paid maternity leave. I’m just going to put it out there; we’re the only country in the world that doesn’t have it, like an industrialized country. So, I think paid maternity leave, paid paternity leave equally so moms can have the support that they need. We have to get there. ‘Cause we’re never going to get 100% breastfeeding unless we have that. Like moms should be at home with their babies for a year and you should get paid.

*Figure continued (→)*
Institutions protecting breastfeeding

Participant 36: So yeah, the first two were at [Hospital A] and the first one they took him out of the room to do whatever testing they needed to do by the time he came back they had given him a bottle.

Participant 30: The reason I asked about the hospital is because I had my baby at [Hospital B] and they have a specific policy there, I forget what they call it something like family centric [means Baby-Friendly®] hospitals or something where basically your baby never leaves your room unless they need to do a different procedure like if he needed a surgery or some minor operation that would be different. But for anything, for any check-ups, exams, they don’t take him away unless they really have to.

Participant 33: Unless they really have to.

Participant 36: It actually is, it actually is from when I was pregnant with her, after I had her, after I had my eleven-year-old till now they will give you lactation specialist every appointment that you go to.

Participant 38: I feel fortunate that I was at a family-friendly non-profit and I was executive director so it was like, ‘oh we’re going to pump in my office,’ ‘oh I’m going to put the milk right in the refrigerator where everybody else’s is’...So I think it’s one of those things where I felt empowered because of where I was in my career too versus feeling like oh this environment isn’t friendly...I would say definitely privilege played a role that I was in a position to take four months off because I know without those four months I wouldn’t have been able to just solely focus on overcoming the challenges that I have with breastfeeding.

Participant 26: I think it links back to the last question too right, about the ability to keep breastfeeding sort of on the up going. That’s the face of economic privilege, right, you have to go back to work and grind after a weekend or after two months or what’s the scenario. Because I’m thinking of a handful of super-duper pro on top of their game breastfeeding Black women two parent households who are stay at home moms and don’t have anything to do with the pump but can breastfeed until these kids are twelve if they need to be. They don’t have that pressure to, not to say they’re not engaged in a whole range of things in the community but that’s huge to have that protected time and have it indefinitely protected.

Personalized mediated racism and resistance

Participants remarked on two forms of personally mediated racism, including (1) negative interactions with health care providers and (2) shaming/stigma while breastfeeding in public. Participants likewise described ways they resisted personally mediated racism and bias including themes of (1) rejecting health provider bias and (2) building community.

Across focus group sessions, Black mothers talked about health care providers pushing formula regardless of mothers previously communicating their intentions to exclusively breastfeed, resulting in Black mothers feeling unheard or ignored. One participant described the constant questioning by medical staff when she expressed her desire to breastfeed (Fig. 3). Participants offered numerous examples of hospital staff giving their babies formula without their consent. Providers disregarded Black mothers’ intentions to exclusively breastfeed their babies by offering them formula samples at hospital discharge. Participants also described feeling threatened by pediatricians with formula if their baby did not gain weight quickly; several were concerned they might be relying on outdated notions and growth charts based on formula-fed babies. Multiple participants reported not being fully informed about the potential downsides of hormonal contraception—health care providers pushed hormonal contraception either without regard to the mother’s breastfeeding status or despite being told by the mother she was breastfeeding. Participants who shared contraception stories all reported suffering milk supply issues, and without referral to lactation support, ultimately stopped nursing.

Black mothers rejected health provider bias when they were empowered to make decisions about where and from whom to seek care. One mother described avoiding potential formula promotion at the hospital by opting for a nonhospital birth (Fig. 3). Multiple mothers discussed changing pediatricians after feeling unsupported in their breastfeeding and pressured to supplement with formula.

An additional barrier was public shaming. Participants discussed the complexities of breastfeeding in public where people “watched” as they breastfed. Participants reported that breastfeeding was met with disapproving looks or stares (Fig. 3). Disapproval could come from many different
FIG. 3. Representative sample quotations for themes related to Personally mediated racism and resistance.

Healthcare providers pushing formula

Participant 11: I remember when I was in the doctor’s office, the first question that the doctor asked you before you had the baby is, “so what’s your plan, you’re going to breastfeed or bottle-feed?” And they keep asking you that. And you keep saying “breastfeed.” And they keep asking like they either want you to change your mind or you changed your mind. And so, then after you have the baby, they ask you again. “So, what do you want to do, do you want to bottle feed or breastfeed?” And you say, “breastfeed.” And so, then you find out that the baby has some sickness or has to stay in the hospital, and they say, “Well, why don’t you just feed the baby formula?” And you say, “Well, I told you the first five times I would like to exclusively breastfeed.” And so, you go home, and you pump, and you come back, and you bring the milk, and you feed the baby. And they say, “oh she’s down to just one bottle, would you like for me to just give her some Similac or some bottle?” “No, I’m exclusively breastfeeding.” And it’s like they’re trying to make you bottle feed the baby.

Shaming and stigma while breastfeeding in public

Participant 15: I knew I wanted to breastfeed my son, but like when I told people I breastfed or when people saw me breastfeeding it was like...And some people were like yes, and some people were like you’re breastfeeding or you got your boob out or something like that. Like I really had people that were rooting for me, and then there were some people just like “oh, she just wants to show her titty or whatever.” I literally had people like...I went to a restaurant one time, and I was breastfeed my son, and he was like six months. And it was a table of all women like that came and sat and then went to the hostess and was like, “can we move somewhere because she’s breastfeeding her child.”

Participant 14: I am thinking generally in the U.S., I feel shamed when I breastfeed. I think it’s generally disapproved. I think that no matter where I’ve gone, cover-up, no cover-up people look at me like something’s wrong when I’m breastfeeding.

Participant 16: I know with my first son, now that I think about it I breastfeed him until he was eight months and I was busing it [riding the bus] with him. And the stress, stress makes your supply decrease. And I remember a few times when I was actually in public I know he didn’t get full off of my breast. When I was at home I know for a fact he was getting full off of my breast; it was because I was so stressed out about how many different people was looking at me. And it wasn’t really about what people thought because I really didn’t care what people thought about it, it was just like, why are you staring at me? You know what I’m doing. You clearly can see that I’m feeding my baby but, why are you staring at me? So it’s the stress for me at least because I know a lot of the times when I was breastfeeding in public my son was not getting full.

Rejecting health provider bias

Participant 7: Education was always like a big thing, like knowing that [the newborn is] going to drop weight. Like if I wouldn’t have known that beforehand and I went to the pediatrician and they told me that she dropped weight I would have been like ‘oh it’s time to take formula.’ But someone told me they do drop weight and so I was like ‘okay we’re prepared for this.’ And then a friend had her baby exactly four weeks before my daughter was born, and she told me when I was still pregnant, she was like ‘get a lactation specialist now. Get someone to come day one.’ And the lactation specialist came to our house the same day. And so, I was like if she wouldn’t have come that same day, I probably wouldn’t have been able to do it...The network and having access. And I had my daughter not in a hospital specifically because I was afraid of people pushing the formula on me and also, I’m older. And I was like, I really wanted to do things if I could do them without having someone say hey, you’re this age you can’t do this. And so, I was like I’m going to try to—if something happened then I was going to be like okay then I’ll go to a hospital. But I was really worried about that and so I was like specifically I don’t want to have the baby in a hospital because I didn’t want them to push the formula and the whole thing.

Participant 25: My daughter, when I had A— she was nine pounds and twelve ounces. Her one-week checkup she went down to like eight pounds four ounces.¹ So, the first pediatrician was like ‘oh she lost a lot of weight you need to put her on formula she’s not feeding.’ ‘Absolutely not, it’s only been a week. It’s normal for them to drop weight, did you not know that?’ ‘Well a formula baby wouldn’t drop weight.’ ‘A formula baby drop weight as well.’ New pediatrician please.

Building community

Participant 38: I would say on the flip side of that the Facebook groups that I was a part of there’s a Black Breastfeeding Facebook group and there’s one other I don’t remember the name of it, I’m still on them now. And once I got up through my journey felt more in a position to give advice, so much room for people to share strategies, this is what worked for me, but also say and it might not work for you. Like it was iterative and the groups that I was a part of were never derogatory. There are some groups out there that are crazy but definitely for breastfeeding specifically, Black breastfeeding moms the two groups that I was on were great.
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FIG. 3. (Continued)

Participant 14: Certainly, for me after having my first child I definitely decided to get into the community of Black women period; Black women’s health, Black moms. And definitely the second time around with my son. And even this new one I have spun into a whole thing that I’m trying to do to set up just a place [on social media] where Black moms can basically like this have discussion and see me and what I’m doing and like all of you said you just don’t know about certain things or you didn’t know about water birth and breastfeeding and all that.

Participant 8: And whenever I see women in public that are breastfeeding, I always give them props because I remember how hard it is to feel confident in that and so I’m always like “go sis, yes. You need help sis? You need anything?” I always ask anybody.

souces including family, friends, and strangers. Participants worried about nursing in front of men or boys and talked about women commenting on their choice to breastfeed, where they chose to breastfeed, and whether they used a covering.

Black mothers resisted personally mediated racism by building and relying on community. Many participants described examples of emotional, informational, and instrumental supports from their community networks, namely family and close friends. Social media provided one channel for building community. One older mother described how she remains actively engaged in a Facebook group to pass on lessons learned to other breastfeeding Black mothers (Fig. 3). Another younger mom described how she was initiating a project to create virtual space to share and educate her peers on birthing and parenting topics. Other ways participants described building community were through intentionally offering words of support and encouragement to other Black mothers whom they did not know when they encountered them in public spaces, and by intentionally nursing in public, often uncovered, to actively change norms.

Discussion

By highlighting examples of institutionalized racism, participants immediately countered perceptions that infant feeding is reflective only of personal choice. Instead, and in line with Jones’ Gardner’s Tale and prior research in breastfeeding, they shined a light on broader structural and environmental factors that impede breastfeeding for many Black mothers.

The historic exploitation of Black women’s labor draws attention to a phenomenon Andrea Freeman calls “an incident of slavery,” or an event that is a continuation of oppression originating during the antebellum period. Some of the barriers Black women experience date back to social practices and policies from the period of enslavement, as noted in Dorothy Roberts’ seminal text Killing the Black Body. For example, Black women’s employment circumstances today are the legacy of historic institutionalized racism. Access to paid parental leave differs by race/ethnicity with Black mothers being less likely to have access than White mothers. Yet, paid leave policies help Black mothers the most, leading to improved maternal and infant health and reduced negative financial impacts of unpaid leave. The Washington, DC’s paid family leave program took effect in July 2020 and has the potential to address some needs unfulfilled by employers; however, it falls short of the year-long paid leave advocated by participants. DC must ensure residents are aware of the program as research in California found that workers least likely to be aware were those who stood the most to gain: young, non-White, lower socioeconomic status, and those with no employer-provided benefit.

Institutional support for breastfeeding from employers and hospitals is an essential ingredient for countering institutionalized racism. Participants’ negative workplace pumping stories implied the importance of employers protecting breastfeeding rights. Despite the existence of laws protecting nursing mothers in DC, participants reported noncompliant employer practices, so enforcement should be a priority. To this end, the U.S. Breastfeeding Committee supports a workgroup dedicated to education on employee rights and employer responsibilities, sharing resources, and advocacy around identified gaps in laws to expand protections for employees.

Greater access to hospitals designated as Baby-Friendly® was implied as another solution to counteract institutionalized and personally mediated racism. Policies advanced through the Baby-Friendly Hospital Initiative would have helped counter some of the biases women reported related to separation during postpartum hospitalization, challenges accessing in-hospital lactation support, and receiving formula samples or the baby being given formula unnecessarily in the hospital. However nationally, access to Baby-Friendly hospitals differs by geography, and due to racial segregation, Black communities have limited access to Baby-Friendly hospitals or birthing facilities implementing effective policies. Recent research supports the importance of improved maternity care practices to increase breastfeeding, especially in areas of geographical segregation with limited access to lactation supports. Their intervention research suggests that hospital and community-based initiatives can be effective in increasing rates of breastfeeding initiation and exclusivity among Black infants.

Study participants illustrated the power of changing policies to increase institutional support when they recognized WIC’s role in promoting breastfeeding. Evidence has consistently shown that mothers participating in WIC are less likely to breastfeed. However, mothers in this study

1The authors recognize this amount of weight loss, if the participant was recalling accurately, could be a valid cause for concern. However, this quotation still demonstrates her mistrust, expectation that lactation support or referral be the first course of action instead of mandating formula use, and willingness to seek another provider due to perceived bias or lack of support.
highlighted the positive impact of actively promoting breastfeeding, beginning in 2004 with the new Loving Support marketing and peer counseling program and reinforced by 2009 policy changes to nutrition benefits.24,25

Personally mediated and institutionalized racism are connected. Although not all participants recognized or verbalized the intersection between their experiences and race, prior evidence supports this link. Women of color, and particularly Black women, are more likely to experience mistreatment during pregnancy and childbirth including loss of autonomy, being scolded, and being ignored, among others forms.26 Mistreatment is worse for mothers of lower socioeconomic status. In addition, one study found that Black babies were more than nine times as likely to receive formula in the hospital than White babies.27 Furthermore, the commonness of participants’ experiences shared during focus groups on Black breastfeeding suggests their experiences are undeniably connected to race, and are the result of intersecting patriarchy, classism, and racism. Negative interactions with health care providers as reported here are not inconsequential. Being dismissed may impact Black women’s willingness to continue to engage with the health care system, thereby impacting their long-term health outcomes. Killing the Black Body demonstrates the close link between the interpersonal interactions Black women have with providers and the history of racist policies and practices intended to regulate Black women’s sexuality and reproduction.

Some study participants felt empowered to make health care choices and resist provider-mediated racism. This power came from a place of education and privilege, especially having the consumer’s power of the purse, choosing to seek care elsewhere if necessary. Unfortunately, mothers with fewer resources to navigate systems were not as able to push back. One mother even described feeling like being young, Black, and lower income left her with no choice regarding where to seek health care (Fig. 2). Participants spoke highly of peers, midwives, and doulas, often who looked like themselves or had similar lived experiences. Others consulted fellow moms in lieu of traditional health care providers. The negative interactions reported and this dependence on other types of support reinforce that medical education and training does not adequately prepare clinicians to support Black breastfeeding mothers.28 Indeed, some participants remarked on the lack of Black health care providers, which may contribute to personally mediated racism. Recently, the American Academy of Pediatrics released a statement calling for the dismantling of racism on every level and a recommitment to ending inequities that threaten the health and well-being of children, representing a sense of hope that the medical field may be changing.29

Building and relying on community, especially other Black mothers, were acts of resistance, and consistent with prior research.30 Evoking Audre Lorde’s concept of radical self and collective care,31 participants resisted oppression by seeking and accepting sources of social support and by seeking communities of Black mothers or building them when necessary. Their act of resistance was, in Lorde’s word, “self-preservation,” and they cared for others by passing on knowledge, encouragement, and tools to succeed in a “common battle.” The building of community with other Black mothers underscores the value and lack of access to culturally congruent, or at least competent,32 lactation support and the value of seeing mothers who look like themselves succeeding at breastfeeding.

Many mothers report feeling uncomfortable or stigmatized when breastfeeding in public.33,34 Although participants did not expound on this connection, public shaming and stigmatizing of Black mothers while breastfeeding may be linked to long held norms about the role and position of women. Through chattel slavery, Black women could not comply with antebellum America’s Cult of True Womanhood principals of piety, purity, submissiveness, and domesticity. In the 20th century, popular media promoted “controlling images” of Black women as hypersexual jezebels. In response to negative representations, some African Americans endorsed “respectability politics,” in which Black people attempted to show their worth (to the wider culture) by policing the behaviors of those within their racial group. For Black women, modesty is part of respectability politics; therefore, the visibility of the breast, even for feeding one’s baby, may be deemed inappropriate by some. Thus, these negative public interpersonal interactions are inextricably connected with race and racism. The authors believe this is why several of the more empowered mothers were determined to breastfeed, often uncovered in public to help destigmatize it for other Black mothers.

Taken together, institutionalized and personally mediated racism served as toxic forms of stress for Black mothers. Participants reported being overwhelmed by the stress of dealing with bias at the institutional level, by their interactions with health care providers, and being stigmatized by members of the public. Across focus groups, participants said, “Black women are stressed.” The idea that Black mothers are stressed or have a lot on their shoulders goes to writer Zora Neale Hurston’s idea that Black women are “mules of the world.”35 In other words, Black women are defined by their strength, but that strength has its limits and being strong takes a toll. Allostatic load, a measure of cumulative stress, has been associated with preterm birth, low birth weight, and higher rates of Black infant mortality.36,37

Strengths and limitations

This research has strengths and limitations that should be acknowledged. A strength of this study is that there were an equal number of women from socially and economically diverse backgrounds and representative of different parts of the DC. A limitation of the research is that 90% of women in the sample indicated that they breastfed, which may lead to bias in responses. However, we believe that our sample was appropriate to answer the stated research question.

Conclusion and Implications for Practice

This research documented that racism is a present barrier to breastfeeding at multiple levels, yet most participants were breastfeeding mothers. Echoing Dr. Stuebe’s recent call to action,38 breastfeeding medicine and other maternal and infant health providers can join Black mothers in resisting racism on several fronts. Dismantling racism in clinical care

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starts with examining and countering our own biases, diversifying recruitment, and improving training for future providers. Clinicians must leverage their positions to advocate alongside and on behalf of Black women and mothers, for equitable access to economic empowerment including living wages, affordable housing, paid family leave, workplace protections, and for access to breastfeeding friendly birthing facilities, WIC for eligible mothers, and culturally sensitive lactation support for all.

Authors’ Contributions

Dr. C.D. contributed to conceptualization of the research presented, participated in data collection and analysis, and led in article writing. Dr. A.V.K.V. led conceptualization of the research presented, participated in data collection and analysis, and contributed to article writing. Dr. M.M.T., Dr. S.L., and M.K.L.: contributed to study design and critically reviewed the initial article.

Acknowledgments

The authors thank the participants who generously shared their time and entrusted their stories to us. We also thank our community partners who facilitated recruitment, and Mamatoto Village and the East of the River Lactation Support Center for serving as focus group sites. The authors also acknowledge the advice of coinvestigator, Anayah Sangodele-Ayoka, CNM, MSN, MSEd. Clinical Instructor, George Washington University School of Medicine and Health Sciences.

Disclaimer

The article contents are solely the responsibility of the authors and do not necessarily represent the official views of the National Center for Advancing Translational Sciences or the National Institutes of Health.

Disclosure Statement

No competing financial interests exist.

Funding Information

This research was generously supported by the Clara Schiffer Fellowship for Women’s Health and a fellowship from the Sumner M. Redstone Global Center for Prevention and Wellness. REDCap™ infrastructure that made this project possible was partially supported by the National Institutes of Health National Center for Advancing Translational Sciences (award number UL1TR001876).

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