Feeding the Future: Addressing Low Rates of Exclusive Breastfeeding and Racial Disparities in San Francisco County

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Author Note

This scholarly research paper was written earlier in my undergraduate program as a culminating assignment for a public health-specific Writing Workshop course. I had strong writing skills prior to this course and I was familiar with APA standards, but the exercises and lessons from this course helped me identify weaknesses and improve my writing. This assignment presented me with the opportunity to examine the existing literature related to a health issue of my choice and present evidence-based recommendations for addressing it.

Abstract

In San Francisco County, low breastfeeding rates, with further disparities found across racial and ethnic groups, threaten general public health outcomes as well as widen pre-existing health disparities. Breastfeeding is a well-researched topic, with global efforts to increase low rates being an international public health focus for decades. Nationally, breastfeeding rates are falling short of the U.S. Department of Health and Human Services' Healthy People 2020 Initiative goals, and are not on track to reach the Healthy People 2030 goals. In San Francisco County, overall rates are improving and, in 2020, were marginally higher than the Healthy People goal. However, racial disparities are revealed when those statistics are more closely examined. This is disproportionately true for Black/African Americans. Upon review of existing literature on this issue, it is evident that there is a great deal of consensus among topic experts that measures need to be taken to improve breastfeeding, especially exclusive breastfeeding, outcomes through systemic, policy, and cultural changes that usher in equitable health practices.

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It is widely accepted that exclusive breastfeeding is a critical element of optimal maternal and infant health. Research has repeatedly shown that any amount of breastfeeding has many health benefits for mothers and their infants in the postpartum stage and throughout their lifetimes (Younger Meek & Noble, 2022). These benefits are amplified by the duration and exclusivity of breastfeeding, with the American Academy of Pediatrics (AAP) recommending no less than 6 months of exclusive breastfeeding after birth (Younger Meek & Noble, 2022). Despite progress towards increasing rates of exclusive breastfeeding in San Francisco County, disparities and inequities across racial and ethnic groups persist. Public health professionals in San Francisco County can have a lasting impact on community health by taking action to increase rates of exclusive breastfeeding with an added emphasis on birth justice and health equity. It is paramount that we address this issue with adequate provider education and training, culturally congruent messaging and discussions around breastfeeding, and advocacy for policy and social supports that encourage parents to make family-centered decisions.

Background

Across the United States, the 2020 exclusive breastfeeding rate through 6 months after birth of 24.9% fell marginally short of the U.S. Department of Health and Human Services' Healthy People 2020 initiative goal of 25.5% - a significant improvement on the 2009 national rate of 15.6% (National Center for Health Statistics, 2021). The state of California as a whole, at a rate of 27.3% of infants exclusively breastfeeding through 6 months, exceeded the national target (National Center for Health Statistics, 2021). In San Francisco County, the exclusive breastfeeding rate through 3 months after birth for 2019-2021 was 40.1% (California Department

of Public Health, 2024), falling short of the Healthy People 2020 target of 46.2%. On the surface, these numbers do not seem to be a cause for alarm when it comes to progressing towards maternal, child, and infant health goals. However, when examined more closely, disparities and inequities across racial and ethnic groups become apparent. In a 2021 survey, the California Department of Public Health reported that only 35.8% of Black birthing parents had breastfed exclusively through three months postpartum, compared to 49.2% of White birthing parents.

Breastfeeding is a practice that is located at a complex intersection of cultural, social, institutional, economic, and political factors and personal decision-making. Initiation, intention, and duration of exclusive breastfeeding through 6 months are affected by multiple social determinants of health (SDOH) and impact the short- and long-term health of all populations (Younger Meek & Noble, 2022). Federal- and state-level programs such as BabyFriendly Hospital Initiative (BFHI) and Women, Infants, and Children (WIC) are important sources of education and support for birthing parents, but local and county-level groups hold the potential to tailor lactation support initiatives to the populations who are being left behind.

Past and current initiatives to improve breastfeeding outcomes have shown to be impactful among White populations, but the care gap for birthing people of color, especially Black communities, has continued to widen. Nationally, the rate of exclusive breastfeeding through 3 months among White birthing parents is 49.0% and 36.3% among Black birthing parents, rates that drop down to 26.9% and 19.1% respectively by 6 months after birth (Centers for Disease Control, 2022). In San Francisco County, the rate of exclusive breastfeeding through 3 months among White birthing parents is 49.2% compared to 35.8% for Black birthing parents (no data available for 6 months after birth) (California Department of Public Health, 2024). Closing this gap and eliminating disparities across racial and ethnic lines by investing resources

and efforts into reaching all communities needs to be prioritized by policymakers, medical institutions, and public health professionals.

The Importance of Breastfeeding

Maternal and infant health practices lay a foundation for optimal lifelong health outcomes for both the birthing parent and the infant. The AAP recommends 6 months of exclusive breastfeeding due in part to the significant contributions of human milk to an infant's developing immune system (2022). For infants, studies have shown exclusive breastfeeding for the recommended duration to be associated with increased intelligence and decreased rates of sudden infant death syndrome (SIDS), diabetes mellitus, asthma, lower respiratory tract infections, severe diarrhea, otitis media, and obesity in infancy and throughout their lifespan (Younger Meek & Noble, 2022). The health benefits of breastfeeding are not limited to the infant, as breastfeeding has been shown to decrease the risk of type 2 diabetes mellitus; breast, ovarian, and endometrial cancers; and hypertension in birthing parents (Younger Meek & Noble, 2022). These are health benefits that have the potential to improve the overall health of the entire population, not just postpartum birthing parents and breastfeeding infants. By improving breastfeeding rates and reducing the risk of developing these morbidities, future generations will see lower incidences of disease and lower costs associated with healthcare.

A Closer Look at Racial Disparities

Evidence of racial disparities in breastfeeding rates is indisputable, and many experts have weighed in on possible explanations for those disparities. There is a consensus across the literature about this topic that the disparities are a result of multiple factors that are deeply interconnected with one another, as well as perpetuate each other. Social, historical, and political

contexts help us understand these factors, and help us identify root causes with the aim to dismantle them.

Historical Roots

In 2021, Mieso et al. argued that one explanation for modern racial disparities seen in breastfeeding among Black/African Americans stemmed from historical experiences and the resulting generational trauma. Slavery had a profound effect on breastfeeding practices as enslaved women were forced to interrupt breastfeeding their babies to be wet nurses to slave owners' children. Historical trauma associated with the practice passed down from generation to generation has continued to affect communities to this day (Mieso et al., 2021). Communities of color, especially Black communities, were targeted by aggressive breast milk substitute marketing campaigns starting in the 1950s that made false claims about infant formula being more nutritious than breast milk and undermined Black mothers' confidence in their ability to breastfeed their babies (Mieso et al., 2021; Pérez-Escamilla, 2022). These historical experiences drove down rates of breastfeeding among Black mothers, and to this day associations are perpetuated by hospital staff and providers who make biased assumptions that Black birthing parents are uninterested in or unwilling to breastfeed their babies, leading to Black mothers receiving little or no breastfeeding initiation information and education while in hospital (Mieso et al., 2021). Seeing this issue through a historical lens is critical to understanding the disparities as they exist today, and we can apply a trauma-informed approach to low breastfeeding rates among Black/African American mothers.

Social Determinants of Health

The racial disparities seen in breastfeeding rates among Black/African American birthing parents compared to their White, Asian, and Hispanic counterparts are mirrored in other facets of

health care. Race, income, and residential segregation are social determinants of health that impact a birthing parent's ability or decision to breastfeed. Despite making up 13.4% of the U.S. population, Black/African Americans account for 20.8% of Americans who are considered low-income (Vasquez Reyes, 2020). Lower-income neighborhoods have less access to resources like breastfeeding counseling or lactation specialists that can provide prenatal, in-hospital, and postpartum breastfeeding education. These lower-income neighborhoods also tend to have larger populations of BIPOC and are less likely to have hospitals that comply with BabyFriendly guidelines (Mieso et al., 2021). These intersecting social determinants of health are also associated with higher rates of diabetes, hypertension, and obesity in Black/African American people. Obesity is a growing concern across all racial and ethnic groups with estimates saying that by 2035, 27% of adult women (842 million) globally will have obesity (Pérez-Escamilla, 2023). Considering that there are links between maternal obesity and the ability to initiate and continue breastfeeding through six months, we can further explain racial disparities in breastfeeding rates on the interconnectedness of these social factors.

Contemporary Policy

According to Pérez-Escamilla, the United States remains the only high-income country without a federal mandate for paid maternity leave (2022). The Family Medical Leave Act grants 12 weeks of unpaid leave for qualifying parents following birth or adoption, but not all parents qualify for those benefits and can utilize them (San Francisco Breastfeeding Coalition, 2023). Service industry workers who work part-time jobs are mostly made up of people of color, and those jobs typically offer no protections for family leave or accommodations for breastfeeding, pumping, or storing breast milk at work (Pérez-Escamilla, 2022). Breast milk substitutes are often marketed towards families of color with infants and young children, and no federal

regulations exist to protect families from predatory false advertising. There is also evidence that influential lobbying groups stand in direct opposition to evidence-based nutrition recommendations, and the failure of the federal government to regulate their influence has a direct negative impact on all birthing parents, especially on vulnerable populations (Pérez-Escamilla, 2022). Prioritizing profits and the free market over the wellbeing of the population is unsustainable, and will only lead to further racial and socioeconomic disparities and inequities in the future.

Impact of the COVID-19 Pandemic

The COVID-19 pandemic has affected everyone, but it has especially impacted vulnerable populations. Less than a year into the pandemic, the mortality rate of COVID-19 for Black Americans was 97.9 per 100,000, which was significantly higher than their Hispanic (64.7 per 100,000), White (46.6 per 100,000), and Asian (40.4 per 100,000) counterparts (Vasquez Reyes, 2020). People of color are more likely to work service industry jobs that do not allow sick time and are also more likely to live in multigenerational households, both factors that increase one's risk of exposure to COVID-19 (Vasquez Reyes, 2020). Many hospital protocols changed during the pandemic to stop the spread of COVID-19. According to Spatz, 14.0% of hospitals discouraged and 6.5% prohibited skin-to-skin contact in mothers with confirmed or suspected COVID-19 (2021). Furthermore, 20.1% of hospitals discouraged direct breastfeeding but would allow it if it was the mother's choice. Over one-third (37.8%) of hospitals discouraged and 5.3% of hospitals prohibited rooming-in (Spatz, D.L., 2021). All of these practices are important components of initiating breastfeeding, resulting in delays to initiation. The COVID-19 pandemic brought on a paradigm shift to virtual services and online resources across all sectors, including health care. In many ways, this increases accessibility and reduces the costs of

breastfeeding education and training. However, these online resources need to be available in tandem with in-person assistance that is sometimes needed. Addressing disparities in healthcare will require striking a balance between these remote services and resources and in-person care in order to meet the needs of different populations.

A Global Perspective

While global health initiatives aim to improve rates of exclusive breastfeeding everywhere, rates of exclusive breastfeeding are highest in low-income countries (Ahishakiye, et al., 2020). In Rwanda, 94% of infants exclusively breastfeed up to one month of age, but that number significantly drops to 81% by five months of age. While these numbers are much higher than we see in the U.S., Ahishakiye et al. conducted a qualitative study among a cohort of 39 women in rural Rwanda aimed to compare and analyze women's prenatal breastfeeding intentions with their actual postpartum breastfeeding practices. All 39 of the study participants intended to breastfeed their infants, and 32 of the 39 (82%) intended to breastfeed exclusively for the recommended first 6 months. In the end, 12 of the participants (31%) exclusively breastfed their infants for the first 6 months. Barriers to exclusively breastfeeding for the participants varied in similarity to barriers seen in America. Barriers that were reported were "limited professional and social support; postnatal discomfort; perceived breast milk insufficiency; perceived need for traditional medicines; influence of family members; perceived infant hunger cues; mothers' concerns over their infant's health issues; mothers' heavy workload; household food insecurity affecting milk supply; and conflicts with partner (Ahishakiye et al., 2020, pp. 7-9)." While exclusive breastfeeding rates are higher because breast milk is often the most economical and readily available infant food source, different factors affect a birthing parent's ability or choice to breastfeed.

When is Breast not Best?

Despite the health benefits of exclusive breastfeeding and the global focus on increasing those rates, more harm than good could be coming to mothers who choose not to breastfeed, discontinue breastfeeding before the recommended time, or are unable to breastfeed, but still receive social, cultural, or medical pressure to do so. The phrase *breast is best* is repeated to women in prenatal preparation classes, by family members and friends, and by their OB/GYNs. However, this social pressure can take its toll on a birthing parent during a vulnerable time. Sometimes, it can lead to postpartum depression, postpartum anxiety, or feelings of shame and guilt if the breastfeeding experience is not meeting their expectations (Diez-Sampedro et al., 2019). The mother's well-being needs to be considered, even if that means switching to formula temporarily or discontinuing breastfeeding early to take care of herself. Ultimately, exclusive breastfeeding is an important global health goal to work towards improving, but nonjudgmental support for parents who cannot or choose not to needs to be readily available.

Recommendations

Many factors across multiple sectors affect a birthing parent's ability and choice to breastfeed, calling for a multi-pronged approach to improving breastfeeding outcomes. The key components of a solution to impact these rates and reduce inequities are foundational in-hospital practices to initiate breastfeeding; advocacy and policy that supports parents by mandating parental leave and workplace accommodations for pumping and breast milk storage; standardizing care across hospitals to require all facilities to meet BFHI standards; standardize breastfeeding education and training for medical students who are training to be general practitioners, family practitioners, and pediatricians, not just those going into

obstetrics/gynecology; and implementing local patient breastfeeding education and training that is culturally-congruent and tailored to meet the needs of the population it is serving.

Conclusion

Disparities in breastfeeding rates across racial and ethnic groups directly lead to poorer maternal health outcomes, nutritional deficits, and susceptibility to life-long morbidities for BIPOC. We must ensure a foundation of health and equity for future generations by focusing our efforts and investing resources into initiatives and programs that will effectively improve exclusive breastfeeding outcomes. If breastfeeding rates remain low, the effects will be evident throughout the health system and racial disparities will continue to widen. Public health professionals must prioritize the practice by advocating for policy that protects people and champions families because breastfeeding is preventive medicine.

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