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Not Just a Mother's Decision: A Multifactorial Exploration of Low Breastfeeding Rates in African American Women

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ABSTRACT

The benefits of breastfeeding for both mother and newborns are well established. Yet, black women in the U.S. consistently have the lowest rates of breastfeeding initiation and duration. Utilizing the various levels of the Social Ecological Model, this paper explores the factors that are thought to be responsible for this disparity. Poverty, a lack of resources, and societal disapproval weigh heavily upon already strained intrapersonal relationships where social support is severely lacking. Familial influence proves pivotal in a mother's decision of whether or not to breastfeed. The role of WIC clinics are also examined as a source of intervention, though literature demonstrates women receive oppositional messages from clinic workers and the free formula they provide. To conclude, Servant Leadership and Relational Leadership theories are discussed as potential methods of increasing social support, educating and empowering new mothers through the process relationship creation. I suggest these leaders remain aware of the numerous obstacles new mothers face when breastfeeding their infants, and address them through a culturally informed and sensitive approach.

Background

Among all ethnic groups in the United States, African American women have the lowest rates of breastfeeding (Bentley, Dee, & Jensen, 2003; Lewallen & Street, 2010; Sharps, El-Mohandes, El-Khorazaty, Kiely, & Walker, 2003). This is troubling, especially concerning their elevated rates of low birth weight (Forste, Weiss, & Lippincott, 2001) and infant mortality (MacDorman & Mathews, 2008), as well as numerous health conditions later in life including lung and breast cancers, heart disease, and stroke, among others (Dressler, Oths, & Gravlee, 2005).

Breastfeeding rates are consistently lower among black women in both initiation and duration; compared to Hispanics at 80.4% and whites at 74.3%, only 54.4% of blacks initiate breastfeeding (MMWR, 2010). Additionally, only 26.6% are still breastfeeding at six months, compared to 45.1% of Hispanics and 43.2% of whites. All these rates are below the *Healthy People 2010* goals for Americans to increase breastfeeding initiation among women of all ethnic groups to 75%, with 50% still continuing at six months (Khoury, Moazzem, Jarjoura, Carothers, & Hinton, 2005). Though breastfeeding has been on the rise since the 1970s, black mothers continue to lag (Mickens, Modeste, Montgomery, & Taylor, 2009).

Additionally, demographic factors consistent with lower rates of breastfeeding are consistent across the literature. Women less likely to breastfeed are unmarried, less educated, lower socioeconomic status (SES) and younger in age (Cricco-Lizza, 2005; Forste et al., 2001; Humphreys, Thompson, & Miner, 1998; Ringel-Kulka et al., 2011).

This paper will explore some of the numerous suggestions as to why black women do not breastfeed at the same rates as other ethnic groups, and offer leadership models that may build upon current public health interventions in order to ameliorate barriers to breastfeeding among African American women.

Significance of the Problem

Benefits of breastfeeding are numerous for both mother and child. The World Health Organization (WHO) recommends infants be fed solely breast milk for the first six months of life (Roudi-Fahimi & El Feki, 2011). It provides sufficient nutrition, increased immunity from infections (Roudi-Fahimi & El Feki, 2011), and decreased risk of childhood obesity, diabetes and celiac disease (Khoury et al., 2005). For mothers, breastfeeding strengthens bonding, promotes weight loss (Khoury et al., 2005), and lowers risks of osteoporosis, and breast and ovarian cancers (Khoury et al., 2005; Roudi-Fahimi & El Feki, 2011). Breast milk is also "best" for low birth weight babies, which as previously mentioned, are more common among black mothers (Roudi-Fahimi & El Feki, 2011, p. 52).

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Efforts to increase rates of breastfeeding among black women often focus on Women, Infants and Children (WIC), a federally funded public health program for low income women and their children (up to five years of age) thought to be at "nutrition risk" (USDA, 2011, p. 1).

WIC clinics now have at least a part-time peer counselor to assist in breastfeeding, offering support in clinics, over the telephone, hospital visits or leading breastfeeding groups (M. Pearlman, personal communication, Nov 3, 2011). Breast pumps are available to mothers if budgets allow (M. Pearlman, personal communication, Nov 3, 2011). Additionally, based upon whether a mother is breastfeeding fully or partially, an "enhanced food package" is available for mothers, with the most advantages going to women who are solely breastfeeding (J. Pearlman, personal communication, November 3, 2011; USDA, 2011, p. 3). Because 50% of babies born in the U.S. are part of the WIC program (Cricco-Lizza, 2005), WIC clinics are a common intervention point for public health professionals.

A mid-1990s social marketing campaign in WIC locations, *Loving Support Makes Breastfeeding Work*, appealed to the emotional rather than health benefits of breastfeeding, providing tools to clinic workers to dispel myths, offer support and information to new mothers (Bryant, 2010). In a 2011 update on *Loving Support Makes Breastfeeding Work*, Grummer-Strawn (2011) asserts that though the percentage of mothers breastfeeding at six months has doubled since 1997, attitudes and beliefs about breastfeeding have remained stagnant. Participants in a Healthstyles survey (as cited in Grummer-Strawn, 2011) recently demonstrated less public support for nursing mothers. More respondents agreed to statements such as "Infant formula is as good as breastmilk" and "Mothers who breastfeed should do so in private places only" in 2007 than in 1997 (Grummer-Strawn, 2011).

A wide gap still exists between the number of WIC versus non-WIC mothers who choose to breastfeed (Grummer-Strawn, 2011) with WIC participants having lower breastfeed rates than non-WIC mothers (Cricco-Lizza, 2005). Surprisingly, the majority (60.3%) of WIC participants are white and only 19.6% are black, suggesting alternate avenues are necessary for greater impact on the overall breastfeeding rates of black women (Connor, Bartlett, Mendelson, Condon, & Sutcliffe, 2010, p. 2). Targeting WIC clinics alone is not comprehensive enough. Though essential, focusing on leadership opportunities within WIC clinics only addresses one facet of a multidimensional problem. Peer-counselors are available for breastfeeding assistance at clinics, yet clinic hours do not always fit into client schedules and/or transportation options (Cricco-Lizza, 2005). Furthermore, as I will discuss, the support and information provided by clinic staff is not alone sufficient to sway deeply rooted social, economic and cultural practices in infant feeding.

Factors Relating to the Problem

To demonstrate the interconnectedness of the myriad factors contributing to a lack of breastfeeding, I will use the Social Ecological Model as a guiding framework.

Societal Level Factors

African Americans are disproportionately living in poverty. Whereas just over 14% of all Americans live in poverty, among blacks, the poverty rate is 25.8% (DeNavas-Walt, Proctor, & Smith, 2010, p. 15). Further, blacks often earn less than whites, even with a college degree (Williams et al., 2010, p. 78) have the lowest rates of marriage (Khoury et al., 2005), and are subject to unstable and limited housing opportunities (Greenbaum, Hathaway, Rodriguez, Spalding, & Ward, 2008), leaving many new mothers with little choice but to return to work quickly. Many black women choose bottle-feeding for its convenience over breastfeeding when working or going to school, and are more likely to face employers who are not breastfeeding friendly (Bronner et al., 1996 as cited in Khoury et al., 2005). As previously mentioned, many women are unable to arrange their schedules to fit into WIC clinic hours because of work demands; one new mother's hectic day is described:

> She worked and struggled each day to make ends meet with a small paycheck. She had just finished her night shift, picked up her infant, and rushed to the WIC clinic…she was hoping to finish her WIC appointment in time to go to the food bank to get a turkey for Thanksgiving. She said that she hoped that she could squeeze in some time for sleep after caring for her other children and before returning to work at night. She did not know how she would be able to manage to feed her children without the help of WIC and the food bank (Cricco-Lizza, 2005, p. 531).

Many women also fear the embarrassment that would come from nursing in public (Bryant, Coreil, D'Angelo, Bailey, & Lazarov, 1992; Corbett, 2000; Heinig et al., 2006). Even in recent years breastfeeding women have experienced discrimination, including women who were kicked off of a Delta flight for refusing to cover up with a blanket, and asked to move to a restroom while feeding in a Starbucks as well as in the Smithsonian's Hirschorn Museum (Schrobsdorff, 2011). It is no wonder some women feel personally

ashamed to breastfeed in public, which will be discussed as well.

Community Level Factors

Some posit the availability of free formula in WIC clinics (Ringel-Kulka et al., 2011) and provided to new mothers upon hospital discharge could be contributing to lower rates of breastfeeding (Bentley et al., 2003). Cricco-Lizza (2005) spoke to a WIC mother who said, "'When you're applying to WIC, you know the [formula] milk is free, so why wouldn't you take it?'" (p. 532).

An overwhelming amount of research on this topic points to a lack of social support as the major obstacle to black women and breastfeeding (Cricco-Lizza, 2005; Humphreys et al., 1998; Khoury et al., 2005; Mickens et al., 2009; Ringel-Kulka et al., 2011).

Health professionals are only one type of social support, yet have been discussed as both encouraging and discouraging breastfeeding. WIC clinic staff is seen as an excellent source of information and reinforcement on the benefits of breastfeeding (Heinig et al., 2006), especially lactation consultants and peer counselors who were available for troubleshooting with first time breastfeeders (Cricco-Lizza, 2005). Hospital hotlines were another source of assistance (Cricco-Lizza, 2005).

Unfortunately health practitioners served as deterrents to breastfeeding as well. Women report being told their breasts were too small to produce sufficient milk to sustain their child (Cricco-Lizza, 2005; Heinig et al., 2006). Further, some doctors gave feeding advice inconsistent with national recommendations (such as telling mothers to start giving their child cereal at one month of age) and expressing fatalistic attitudes and failing to provide suggestions to struggling mothers, instead evading the topic by telling them to just "give a bottle" (Corbett, 2000, p. 79).

Interpersonal Level Factors

Hearing about the shortfalls of their friends and family members can be enough to deter some women from starting to breastfeed. Friends who have lacked success in the past describe the pain and potentially cracked and bleeding nipples which can occur (Bentley et al., 2003), and unfortunately, clinic literature on breastfeeding may be working antagonistically by supporting what these friends tell them (Bryant et al., 1992). This is just one example of the importance of addressing this problem with a broader lens - individuals are thought to be responsible for the ultimate decision to breastfeed, but larger external forces heavily influence this decision-making process.

Within the family, grandmothers are cited as having a particularly powerful influence on new mothers (Khoury et al., 2005). Commonly, they suggest feeding additional food and liquid outside of breast milk (Bentley et al., 2003; Mickens et al., 2009), discourage breastfeeding altogether (Bryant et al., 1992), or express concern that their granddaughters' diets are not healthy enough for proper breastfeeding (Ringel-Kulka et al., 2011). Mothers, too, are found to worry about how their diets, alcohol consumption, smoking tobacco and other drugs may negatively influence their child's health through breast milk (Bryant et al., 1992; Ringel-Kulka et al., 2011).

Multiple references are made to the idea that breast milk alone cannot satiate a baby and meet all of their nutritional needs (Bentley et al., 2003; Corbett, 2000; Heinig et al., 2006). Adding formula and/or cereal, some mothers believe, will put more weight on them (which is seen as healthier) and helps to curb behavioral problems such as not sleeping through the night or being fussy (Heinig et al., 2006). Medical standards suggest switching between breastfeeding and bottle feeding may cause infants to become accustomed to suckling the bottle and refuse the breast, which in turn leads the mothers to produce less milk (Roudi-Fahimi & El Feki, 2011).

Fathers of the baby are another interpersonal influence upon new mothers. Women worry men may become jealous of the time spent with the infant (Heinig et al., 2006), but most voiced concerns with fathers and husbands are rooted in the idea that breasts are seen as sexual (Bentley et al., 2003; Bryant et al., 1992; Lewallen & Street, 2010). This concept is not exclusive to breastfeeding, in fact has been cited as a barrier to breast cancer screening among African American women (Lende & Lachiondo, 2009). Misinformation from friends, families and fathers create negative reinforcements that surround new mothers and bolster environments that are not conducive to breastfeeding initiation and continuation.

Intrapersonal Level Factors

On an interpersonal level, knowledge of breastfeeding benefits are not extensive, yet not absent either. Whereas knowledge and information is certainly beneficial, it does not appear to function as a sole motivator for mothers to breastfeed; the benefits of breastfeeding do not appear to outweigh the factors contributing to this ethnic disparity (Bryant et al., 1992). Just as in the *Loving Support Makes Breastfeeding Work* campaign, health interests for the child were not the focus, instead creators made the mother-child bonding experience the "competitive edge" over bottle feeding (Bryant, 2010, p. 294).

Implications for Leadership

A lack of social support and misinformation from family and friends are repeatedly discussed in

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the literature as one of the central reasons why black women fail to initiate and/or sustain breastfeeding. Servant Leadership and Relational Leadership Theories complement one another and address the interpersonal impediments to breastfeeding among black women.

The Servant Leadership Models calls for individuals who work side by side to those they lead, instead of above. Servant Leaders are unique because they not only take on the "role" of a servant "but also the nature of a servant, which is demonstrated by their total commitment to serve other people" (Sendjaya, Sarros, & Santora, 2008, p. 406). The core tenants of the model, 10 attributes, serve as guidelines for the individuals who will motivate others by focusing on their needs, desires and building upon their current abilities (Russell & Stone, 2002). These attributes include: listening, healing, awareness, persuasion, empathy, conceptualization, foresight, stewardship, commitment to the growth of people and building community (Russell & Stone, 2002, p. 146). A few of these attributes and the nine additional "functional attributes" will be highlighted to demonstrate how leaders who adopt a servant mentality can empower women while increasing social support (Russell & Stone, 2002, p. 146).

Servant leaders are said to have a vision, commitment, credibility and integrity (Russell & Stone, 2002). These serve as the foundation to any attempt to increase breastfeeding among African American women. Evidence shows that interpersonal relationships and social support are a formidable influence concerning breastfeeding, thus, this is where interventions and changes must focus. Further, because these relationships are deeply embedded within African American culture, changes may require extra time and patience to penetrate cultural norms and understandings. Significant increases are unlikely to come if leadership does not emerge from within this community. With a strategic vision and commitment, black leaders looking to increase breastfeeding will hold credibility and easily gain trust because of their ties to the community.

To build upon the WIC clinic efforts, local organizations and churches are an excellent starting point for increasing knowledge, adapting beliefs and attitudes among black mothers. A servant leader need not be formal, instead should be an excellent listener and provide encouragement through a broad appreciation of others' needs (Russell & Stone, 2002). Ideally, these leaders would know the benefits of breastfeeding and have had successful experiences themselves. If these leaders are already embedded within the community and make themselves accessible to those needing assistance, behavior adoption may occur slowly, but along trustworthy,

informal networks to create lasting change (Coreil, 2010). Support groups and/or mentoring programs outside of WIC clinic hours are essential, especially during transitional times such as after hospital stays and while going back to work. Encouragement, too, is critical when and if breastfeeding proves challenging.

Just as in the social marketing campaign *Loving Support Makes Breastfeeding Work*, boasting the typical benefits of breastfeeding may not provide the same motivation in black women as it does among other ethnicities. WIC promotional materials that lay claim to the fact that breast milk is "free" for mothers may be accurate, but so is the formula for WIC participants. Additionally, breastfeeding has non-financial costs in the form of time constraints, work inconveniences and a lack of support during times of need, which negate the fact that breastfeeding is no cost to mothers. Leaders must be aware of the larger, structural deterrents, as well as push culturally appropriate incentives to encourage breastfeeding.

As evidenced by the need for additional interpersonal support, mothers alone cannot remain the sole focus in breastfeeding promotion. Fathers, mothers and grandmothers of breastfeeding women need information emphasizing the necessity of their support in making breastfeeding successful. WIC Peer Counselors offering workshops may want to provide an event targeting other family members and fathers to help educate them on how to be supportive. Fathers, also, could be made aware of other ways to bond with a child in the case that they feel left out. Peer Counselors utilizing the Servant Leadership Model have an opportunity to educate, influence, empower, encourage and persuade others throughout all stages of motherhood (Russell & Stone, 2002).

The attributes of a Servant Leader coupled with a "relational orientation" will allow for breastfeeding leaders to exist at all levels of experience (Uhl-Bien, 2006, p. 655). Instead of focusing on individuals, relational leaders "start with processes and not persons, and views persons, leadership and other relational realities as *made* in processes" (Uhl-Bien, 2006, p. 655). This focus on "meaning making" is what will create currents of change about breastfeeding with Servant Leaders' attributes creating momentum (Uhl-Bien, 2006, p. 655). This leadership model serves as a basis for the Servant Leaders possessing the attributes that make them especially capable of addressing crucial interpersonal limitations to breastfeeding.

Though leadership is essential, focusing on rigid roles and authority status is not what will transform the predisposing, enabling and reinforcing factors that are holding black women back from nursing their infants. Utilizing the Theory of Planned

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Behavior, attitudes and subjective norms concerning breastfeeding, mothers' perceived control over nursing and their intentions to breastfeed must be addressed before they will act (Rimer & Glanz, 2005, p. 17). Working to confront the constructs of this model, leaders can influence these factors positively, and ultimately lead women to choose breast milk over formula.

None of the factors preventing African American from breastfeeding act in solitude. Leaders must remain cognizant of the multitude of factors responsible for low rates of breastfeeding among black women and how they all interact in order to intervene in a purposeful and effective manner. The benefits of breastfeeding actually *do* outweigh the barriers, and the health of future generations are worth investing in with time, efforts and resources.

Conclusion

Observing public health problems such as breastfeeding disparities with the Social Ecological Model allows for multifaceted interventions that focus on more than just the individual. Black women's' decision to breastfeed is influenced by their own knowledge, attitudes, beliefs and values, as well as those of their family, community and American society at large. Targeting only one aspect of a problem can exacerbate victim blaming and fail to account for multiple barriers. African American Leaders with a servant attitude and a relationship focus are an excellent starting point for approaching this public health disparity.

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