Breastfeeding among Low Income, African-American Women: Power, Beliefs and Decision Making

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ABSTRACT Breastfeeding rates among African-American women lag behind all other ethnic groups. National data show that only 45% of African-American women reported ever breastfeeding compared to 66 and 68% of Hispanic and white women, respectively. Of African-American women who do choose to breastfeed, duration is short, with many discontinuing in the first days after birth. This report applies a social ecological framework to breastfeeding to investigate macrolevel–microlevel linkages. We posit that macrolevel factors, such as the media, aggressive marketing of breastmilk substitutes, welfare reform, hospital policy and breastfeeding legislation, interact with microlevel factors to influence a woman’s decision to breastfeed. These microlevel factors include features of the community, neighborhoods, workplaces that support or discourage breastfeeding, social and personal networks and cultural norms and individual beliefs about breastfeeding. The report discusses how power operates at each level to influence women’s choices and also emphasizes the value of ethnographic data in breastfeeding studies. Through a case study of a sample of low income, African-American women living in Baltimore, MD, where breastfeeding role models are few, beliefs that discourage breastfeeding are many, and where everyday life is full of danger and fear, it is understandable that breastfeeding is not considered practical. The narrative data provide important information that can be used to enhance intervention efforts. To reach the Surgeon General’s Healthy People 2010 breastfeeding goals requires a shift in cultural norms and structures at all levels that will support breastfeeding for all women. J. Nutr. 133:305S–309S, 2003.

KEY WORDS: breastfeeding, African-American, social ecological framework, beliefs, power

Breastfeeding rates among U.S. women fall far short of the Healthy People 2010 national goals, which are: 1) to increase to 75% the proportion of women who initiate breastfeeding; 2) to increase to 50% the proportion of women who continue breastfeeding their babies until 6 mo of age; and 3) to increase to 25% the proportion of women who breastfeed their babies until 1 y of age (1). In 2000 the Surgeon General issued A Blueprint for Action on Breastfeeding. This policy document promotes efforts to increase initiation and duration of breastfeeding in the United States, particularly among those subpopulations of women who are least likely to breastfeed (2). In 1997 the American Academy of Pediatrics (AAP) released a policy statement recommending that pediatricians advise women to exclusively breastfeed for the first 6 mo of the infant’s life, and to continue breastfeeding, along with complementary foods and liquids, for 1 y or “as long thereafter as mutually desired” (3).

Although there has been an upward trend in breastfeeding initiation rates among all ethnic groups in the last two decades, rates among African-American women lag far behind those of white and Hispanic women, as shown in Figure 1 (Mothers’ Survey, Ross Products Division, Abbott Laboratories, North Chicago, IL).

What is going on? Why do breastfeeding rates among all women fall short of the national goals? Why is there such a large gap between African-American women and other women? We present a social ecological framework to demonstrate how macrolevel factors (such as media, political, economic and legislative policy) and microlevel factors (such as

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the beliefs, social networks and the community) interact in ways to influence a woman’s choice to breastfeed. Following Pelto and Backstrand (this volume), we use the term “power” to represent a dynamic that operates throughout the model.

Data sources

In this report we provide examples from the media and the published literature, and draw on data collected among low income, African-American women living in Baltimore. Primary data derive from ethnographic and quantitative data collected during a WIC clinic–based breastfeeding intervention study in Baltimore, MD, conducted from 1992 to 1994. The study design, methods and results were described previously (4–8). The ethnographic data presented here were based on interviews with 136 WIC-enrolled mothers, conducted before and during the intervention study (4; Jensen, J., unpublished dissertation, 1998). The Institutional Review Board of the Johns Hopkins University approved the research.

Social ecological framework

We apply the Social Ecological Framework to breastfeeding (9). The model conceptualizes overlapping spheres of influence (Fig. 2).

The framework includes macrolevel factors such as the important role of media; national legislation that either directly or indirectly influences breastfeeding rates; political economic factors that lead to health disparity and poverty; marketing by infant formula companies, including free formula samples provided to women in hospital; hospital policies and health provider practices; community and environmental factors that support or discourage breastfeeding; and the role of family, kin and knowledge and beliefs. We begin with the outer (macrolevel) spheres of influence and continue through the inner (microlevel) spheres.

Media influence

Media is pervasive and powerful and has the potential to affect social norms about breastfeeding and decision making. Television shows and commercials, viewed by millions every day, are particularly important in their ability to influence perceptions and beliefs. This may include collaboration between powerful broadcasting companies and major corporations, as occurred in the creation of a series of episodes of the program Chicago Hope and subsequent news stories. The project, “Living with Hope,” involved a partnership between CBS Broadcasting, The Johns Hopkins School of Medicine and the Pharmaceutical Research & Manufacturers of America (PhRMA), an organization including major infant formula companies.

Aired on October 21, 1998, a controversial episode of Chicago Hope portrayed an exclusively breastfed, 6 week old infant who, according to an autopsy report, died from heart failure, secondary to dehydration, which the chief physician said was indicative of starvation. The mother’s lawyers blamed the hospital’s “Baby-Friendly Contract,” in which the mother signed a statement saying she would do everything she could to breastfeed her baby. In a dramatic emergency room scene, one of the physicians suggests that the mother might not have been producing enough milk. Unconvinced, another character, a harried breastfeeding physician, demands that the mother be charged with criminal negligence. When challenged about the ethics of dramatizing an extremely rare condition, PhRMA replied that it was “backing the show out of a sense of responsibility. . .viewers can expect to be educated on issues such as. . .the risks associated with breastfeeding” (PR Newswire, 9/28/1998).

The Chicago Hope story line was partly based on the case of Tabitha Walrond, a young, breastfeeding African-American mother who was charged with second-degree manslaughter after the “starvation death” of her 2-mo-old son. Ms. Walrond reported that she received no information from health providers regarding the possibility that her surgically reduced breasts might not produce sufficient milk, and she was refused medical care for her son because he had no Medicaid card (Nina Bernstein, New York Times, September 9, 1999). Nor do the media limit their focus to underserved populations. In an article in the July 22, 1994, issue of the Wall Street Journal, “Dying for Milk: Some Mothers, Trying in Vain to Breast-Feed, Starve Their Infants—‘Yuppy Syndrome’ Among Well-Meaning Parents Stems From Bad Advice—a Generation of Perfectionists,” journalist Kevin Heliker suggested that “yuppy” women, in overzealous attempts to exclusively breastfeed, were perhaps improperly advised not to give formula to their babies, some of whom later died from dehydration.

Print media also contribute to the perception that formula feeding is the norm and breastfeeding is not. Media images of formula feeding pervade American society, through ubiquitous television commercials for infant formula, bottles and related supplies. The December/January 2002 cover of Working Mother magazine featured singer/actress Vanessa Williams with her young daughter, drinking from a bottle of what appears to be baby formula.
infant formula. This image of the beautiful and happy mother and daughter was widely viewed.

The media also have the power to affect social norms about women's breasts. Yalom (10) reviews the many instances in which women's breasts have been used in advertisements to sell alcohol, magazines, lingerie, perfume, produce and many other consumer goods. Media's sexualization of breasts filters down from the macrolevel to microlevel beliefs about breastfeeding.

**The outer sphere: political economy, policy and organizations**

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [Public Law 104-103], often referred to as the Welfare Reform Act, seeks to decrease welfare rolls by requiring recipients to work, to receive benefits, and by limiting receipt of welfare to a total of 5 years. As a result of the Act, 40% of states now require mothers with children less than 6 months of age to work, which may have potentially negative consequences for breastfeeding (11). In an evaluation of the effect of welfare reform on breastfeeding, Haider et al. (11) found that if welfare reform had not been adopted, U.S. breastfeeding rates at 6 months postpartum would be 5.6% higher than they are today.

There is legislation that supports breastfeeding, such as the “Right to Breastfeed Act” [H.R. 1848]. Signed in 1999 this law protects and ensures a woman’s right to breastfeed on all federal property. Nevertheless, only 16 states have enacted similar laws to protect the right to breastfeed on public property. Other legislative efforts include bills to 1) protect working women who wish to breastfeed or pump milk during their breaks [H.R. 1478], 2) provide tax incentives for employers who offer pumping or breastfeeding facilities for their employees [H.R. 1163] and 3) to establish safety requirements for breast pumps [H.R. 3372]. Organizations such as the AAP, La Leche League International (LLLI), the African-American Breastfeeding Alliance (AABA) and infant formula manufacturers can have a strong macrolevel influence on breastfeeding. The AAP, LLLI and the AABA are all active in efforts to promote and support breastfeeding at the policy level, whereas some formula companies’ aggressive marketing efforts may thwart breastfeeding. By providing free formula to hospitals, the companies’ actions conflict with the World Health Organization International Code of Marketing of Breast Milk Substitutes (12), adherence to which is requisite for hospitals to be awarded “Baby-Friendly” status (13).

**The middle sphere: community and environment**

Women who make decisions about how to feed their infants live in communities where they are exposed to local organizations or workplace environments that can either support or discourage breastfeeding. Some hospitals have practices and policies that support breastfeeding, such as “rooming in,” and providing in-hospital lactation support to women who need it to build their skills and help them gain confidence in breastfeeding (14). In contrast, it is standard policy in many hospitals to provide free infant formula to breastfeeding mothers upon discharge, which has been shown to interfere with or discourage breastfeeding (15).

Community factors can reinforce the power of macrolevel factors, as our case study data show. In multivariate analyses of the Baltimore data, African-American women who received free formula packets from the hospital were much less likely to breastfeed than those who did not receive the packets (5). In addition, among those who initiated breastfeeding in hospital, returning to work was a significant predictor of quitting (6). This has been reported in other studies as well (16,17).

Our case study data, however, provide contextual information that is often missing in the breastfeeding literature. Nearly all the women in our Baltimore sample lived in neighborhoods with high levels of crime and danger. Nearly all relied on public transportation, and throughout the interviews, women showed a preoccupation with issues of personal safety for themselves and particularly for their children. In this neighborhood, down at that end, it’s just wild and crazy. Drugs, shootings. We had two killings around here. One, right out in my back alley. Then we had one about two weeks ago right here at this corner. (32-year-old mother of one child, Jensen 1998: 192)

It was a terrible neighborhood where we lived before. This is a little better. There’s still drugs but it’s not as bad as it was down there. Before, I lived on the eighth floor. These elevators would break and we would have to go down the steps. Sometimes we would have to go down the steps. And the police would chase drug dealers...all through the ramps when the kids were playing, with their guns out...instead of waking up with birds, we were waking up with gunshots. (35-year-old mother of two children; Jensen 1998: 193)

**The interpersonal sphere**

This part of the model includes the set of individuals that make up a woman’s social network, such as family, friends and health care providers, among others. It focuses on whether, how and when they talk to each other about breastfeeding or alternative choices. This is also where macrolevel factors, such as media images or beliefs about breastfeeding, may interact with these microlevel factors. A number of studies have shown the importance of family, friends and social networks on breastfeeding (18,19). Health providers, with their aura of knowledge, authority and power, are an important component in the model (4). The data from Baltimore confirmed the medical doctor’s influence on maternal intention to breastfeed in the antenatal period; women who reported that their doctor had talked with them about breastfeeding were much more likely to breastfeed (4). Grandmothers’ and fathers’ opinions were both strong, independent predictors of maternal intention to breastfeed, and intention was strongly related to initiation (4). Multivariate analyses revealed that the influence of the father of the baby (or significant other) was more powerful than the influence of all other kin, including that of the woman’s mother (4). The opinion of the father of the baby (or romantically involved partner) could operate either to support or to dissuade a woman’s decision.

I have been thinking about it, because his father was telling me, why don’t you try it and see how you like it? Because he was a breastfed baby, and so was I. (26-year-old mother of two children; Jensen 1998: 179)

Some guys are like, you’re not putting your breast in that baby’s mouth, because they don’t know the reasons why girls should breastfeed, and that it is healthier for the baby. (18-year-old mother of one child; Jensen 1998: 178)

In the Baltimore data, the grandmother plays a key role in a woman’s decision to breastfeed, and in when and what to introduce complementary foods and liquids (4,5,8; Jensen 1998). Younger mothers in this population are often single and living at home with their own mothers (20). This structural factor can shift the locus of decision making to the household member who wields authority and experience (4).
SUPPLEMENT

It wasn’t me that wanted to breastfeed my child; it was my mother at the time. She breastfed all of us, and she said, it’s only fair that I breastfeed my baby. (21-y-old pregnant mother of two children; Jensen 1998: 182)

Our data indicate that the extremely early introduction of complementary fluids and foods can be strongly influenced by grandmothers and is likely to influence breastfeeding and formula-feeding practices (8). By 7–10 d, 16% of infants were fed cereal in the bottle, and by 8 wk, 77% of infants received other foods/fluids (7). Cultural beliefs are important in understanding feeding patterns and the decision-making processes involved, including concerns about how “milk runs right through” the infant, and the inability of breastmilk or formula to satisfy the needs of a “greedy” baby.

Some babies, they tend to eat what they’re supposed to eat. Then some babies are greedy. So you’ve got to feed that baby. If you don’t that baby gonna holler, holler, holler. (38-y-old mother of two biological children and two foster children; Jensen 1998: 170)

I was breastfeeding, but being that he was greedy, I found that I couldn’t produce any more milk...I don’t like it, but I have no choice. He only breastfed for the first three weeks. (29-y-old mother of four children; Jensen 1998: 171)

The individual sphere: knowledge and beliefs

Individual-level factors, such as ethnicity, maternal age, education, employment, parity and marital status have been widely reported as important factors in breastfeeding (16,17). In the Baltimore data, all were associated with both initiation and duration, but many were not significant in multivariate analyses. The explanatory power of demographic factors, therefore, is secondary in our model. It is through the narrative data on beliefs that we see their power on women’s choices. Whereas some cultural beliefs supported breastfeeding, they were outweighed by beliefs about the problems and consequences of breastfeeding. Among these, two factors emerged as key barriers: concerns about pain and breastfeeding in public.

Although most women interviewed did not actually know anyone who had breastfed, beliefs or anticipation about the pain involved in breastfeeding was common, including stories about cracked and bleeding nipples or pain related to breast engorgement. Most women who talked about the pain of breastfeeding believed it was inevitable, and many thought that it would last until they weaned their infant.

Pain is involved here. I know, so it’s a state of mind a person is just going to have to adjust to. What I’ve heard, it takes about three months to get over it, but you do get used to it. (18-y-old pregnant woman; Jensen 1998: 160)

Women’s concerns about breastfeeding in public were common throughout our ethnographic interviews, and provide an example of how media images that sexualize the breast overlap with women’s concerns about breastfeeding.

People are like, what is she doing? And looking and staring. And they say, oh she is feeding the baby. And people were really staring. If I was her, I would have felt like I was a freak in a sideshow because they were just staring, they were actually gaping at her. (26-y-old mother of two children; Jensen 1998: 155)

One father and a pregnant woman voiced more extreme views.

Your breasts is one of your personal spots, you can’t just pull that out or show that anywhere. That’s for you and you only, you and your companion. If a guy sees a breast, his hormones will react to what he sees. I think that breastfeeding out in the public will cause you to get raped or something. (21-y-old father of two children; Jensen 1998: 157)

The breasts (are) more or less like a sexual component. It’s there to turn on the male sex. And for the baby to be attracted to that part of the body, is in my mind, it’s like a turn off, do you need this loving? Like, in your mind, you want this baby to love you, and it’s not that I think people are sick that do it [breastfeed], but what are they searching for, really, within themselves? (27-y-old pregnant woman; Jensen 1998: 158)

DISCUSSION

We have applied a social ecological framework to breastfeeding and provide supportive data from a sample of low income, African-American women living in Baltimore. We posit that macrolevel factors, such as the media, aggressive marketing of breastmilk substitutes, welfare reform, hospital policy and breastfeeding programs and policy, interact with microlevel factors to influence a woman’s decision to breastfeed. These microlevel factors include features of the community, neighborhoods, workplaces that support or discourage breastfeeding, social and personal networks and cultural norms and individual beliefs. We also discuss how power operates at each level to influence women’s choices.

The complex reasons for the large disparity between African-American women and other ethnic groups in breastfeeding can be examined at each level of the framework. Factors within each level can either reinforce or discourage a woman’s decision to breastfeed. At the macrolevel, welfare reform legislation may change child care patterns and require women with small infants to work outside of the home. The requirement to work may interact with women’s ambivalence about breastfeeding. The logistical difficulties of pumping in a workplace environment that does not support breastfeeding, and the lack of social support or role models, may find a simple solution in a decision to stop breastfeeding. Media representations of the dangers of breastfeeding, such as was depicted in the Chicago Hope episode, or representations of the breast as sexual, powerfully interact with beliefs about the inappropriateness of breastfeeding in public, or with beliefs that “breasts are for sex.”

We believe this model provides a powerful analytical framework for research and policy. There is a need for data that link macrolevel factors (such as exposure to mass media messages about breastfeeding) to microlevel factors and outcomes. Individuals who work at the level of programs or policy may find that this framework enables them to identify opportunities for intervention or advocacy. For example, the influence of grandmothers, fathers and health providers on a woman’s decision to breastfeed suggests the importance of including these individuals in program and policy initiatives.

Finally, we emphasize the value of ethnographic data in breastfeeding studies. The narrative data provide important information that can be used to enhance intervention efforts. In this population of low income women, where breastfeeding role models are few, beliefs that discourage breastfeeding are many; moreover, where everyday life is full of danger and fear, it is understandable that breastfeeding is not considered practical. To achieve the breastfeeding goals of Healthy People 2010, and to support breastfeeding for all women, there must be a shift in cultural norms and structures at all levels.

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