

From Hyper-Surveillance to Sudden Abandonment: On Reconfiguring Black Motherhood in the Fourth Trimester

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Black infants face disparities in breastfeeding initiation and duration that ultimately increase their risk of future health complications. In Mississippi, Black mothers face unique structural and sociocultural barriers to breastfeeding including discrimination in health facilities, first food deserts, and limited familial and community support. This project aims to understand how sociocultural and historical barriers affect Black Mississippians breastfeeding practices. With an understanding of these norms, it aims to uncover solutions that exist at the intersection of community-based postpartum care and science-based evidence and answer the question: How do Black mother support groups in Mississippi bridge gaps in breastfeeding initiation and duration? To address this question, I conducted ethnographic research in Jackson, Greenville, Clarksdale, and Indianola, Mississippi from June-August 2019. Out of interviews with 50 study participants, five main themes emerged explaining sociocultural barriers to breastfeeding initiation and duration amongst Black mothers: (1) Misinformation in the Black community (2) Perception of breastfeeding as “nasty,” (3) Perception of breastfeeding as an indicator of poverty, (4) Breakdown of familial support in breastfeeding and (5) The positive impact of “Baby Friendly Designations” at daily institutions. Findings showed that postpartum initiatives that focus on normalizing breastfeeding are most effective when they ensure that daily institutions are “Baby Friendly.” Moreover, community support groups are crucial in empowering Black mothers to initiate and continue breastfeeding.

Introduction

“I think certain things like breastfeeding need to be pushed, especially if they are beneficial. The hospital does not do this enough. I do not think they really care. They rush us up out of the hospital after birth and they’re like, ‘*take the baby, bye!*’”

Thus, laments Rhonda, a Black mother from Mississippi on the dichotomy between the maternal healthcare in prenatal visits and the abrupt absence of postpartum care. Similar to Rhonda, many mothers highlight the paradoxical and fearful nature of this transitional period after birth. Known as the fourth trimester, this time often goes unnoticed and is battled with in silence—a stark contrast for mothers that had constant prenatal check-ups and visits with their OB/GYNs. This period has complex challenges, especially for single mothers. These include navigating the rocky and unequal terrain of childcare, hormonal changes that can often manifest in postpartum depression and for some mothers, all of these challenges lie atop a seemingly insurmountable buttress—breastfeeding.

In Mississippi, health disparities exacerbate these challenges for Black mothers. Mississippi has ranked 50th in states with the most health challenges faced by women, infants and children (United Health Foundation, 2019). More specifically, breastfeeding initiation and duration rates in Mississippi rank amongst the lowest in the nation (CDC, 2018). According to the most recent Breastfeeding Report Card released by the CDC, on average 70% of all infants in Mississippi initiate breastfeeding while only 38.6% continued breastfeeding at 6 months. Compared to nationwide rates of 84.1% infants starting breastfeeding and 58.3% breastfeeding at 6 months—Mississippi rates are low (CDC, 2018). For Black infants, the disparities worsen, in Mississippi white infants are breastfed at a rate, 25 percentage points higher than that of Black infants (Merewood 2019). In addition to factors associated with race, low income, receiving Special Supplemental Nutrition program for

Women, Infants and Children (WIC), and earning less than a college education, all decrease mothers’ likelihood of breastfeeding their infants (Thomson, 2017). Geographic disparities are also evident, as women living in the South have lower rates of breastfeeding initiation (Thomson, 2017). This is an especially significant problem because breastfeeding can offer health advantages that address health disparities in Black communities (Anstey, 2017). For example, epidemiological evidence indicates that breastfeeding offers benefits for infants including reduced risk for ear, respiratory, and gastrointestinal infections and decreased likelihood to develop asthma, obesity, and diabetes. In addition, benefits for mothers include lower risk for developing type 2 diabetes, hypertension, and breast and ovarian cancers (American Academy of Pediatrics, 2012). Given the wealth of benefits, it’d seem as though breastfeeding should be more common—so why is it not?

While most women in the US are aware that breastfeeding is the best source of nutrition for almost all infants, they lack knowledge about its specific benefits. In Black communities, the underlying factors associated with low breastfeeding rates are complex. In addition to this lack of knowledge on the health benefits, factors deterring initiation include structural racism, discrimination against Black women in health facilities, distrust of the medical system by Black communities, cultural deterrents/stigma, and limited familial and community support (US Department of Health and Human Services, 2011).

This paper explores these aforementioned factors in order to understand how sociocultural and historical barriers affect Black Mississippians breastfeeding practices. Moreover, through tracing breastfeeding norms in Black communities, this paper will demonstrate how medical recommendations can create implicit value judgements and assign moral pathologies to Black mothers’ bodies. It aims to uncover solutions that exist at the nexus of community-based postpartum care and science-based evidence.

Through juxtaposing community-based care with the fissures and discontinuities that exist in Black maternal care within the healthcare system, I explore further the sociocultural barriers within Mississippi that result in lower breastfeeding initiation and duration amongst Black mothers. Ultimately, I answer the question: How do Black mother support groups in Mississippi bridge gaps in breastfeeding initiation and duration?

Background

The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for at least 6 months after birth. Institutional neglect of the fourth trimester combined with distrust of healthcare professionals force many Black mothers to rely primarily on their families or friends for support while breastfeeding. This support often consists of education on breastfeeding techniques, how to ensure babies are sufficiently fed, how to feed babies that have difficult latching onto mother's breasts and how to pump breastmilk. However, when breastfeeding is not widely represented in mothers' communities, women that choose to breastfeed can face stigmatization and ultimately discouragement. Thus, the politics of breastfeeding in both Black communities and the way they collide, intersect, and align with recommendations in the healthcare systems must be analyzed. The following section unpacks this literature on the structural and institutional associated with barriers to breastfeeding for Black women.

Political connotations of breastfeeding

Before analyzing the healthcare statistics or cultural views surrounding breastfeeding, it is necessary to identify the two lenses by which breastfeeding can be viewed. Professor of the sociology of gender, Linda Blum theorizes that breastfeeding is at the intersection of "corporeal" and "cultural" (Blum, 1999). Differentiating between these terms elucidates the way political meanings have been inscribed on Black women's bodies.

The term "corporeal bodies" refers to physical bodies. Medicine utilizes indications of symptoms or abnormalities that can be pathologized and then associated with illness. There is a standard of care since what is healthy is determined by medical evidence. Corporal bodies are not imbued with value judgements. However, the term "cultural body" is more abstract and highlights that health choices or recommendations can be obfuscated by often invisible, yet structural biases shaped by culture (Blum, 1999). Cultural bodies are saturated with value-judgements, political implications and sometimes moral pathologies. For Black mothers, in many hospital settings in the United States, their bodies have been labeled, even subconsciously, with cultural and political judgements that impact the medical treatment of their bodies. Often, Black mothers in the United States are unable to simply receive treatment for their corporeal bodies, as their care is often tinged by racist perceptions of this cultural body.

Black mothers in the United States have been associated with stereotypes that implicitly assign moral value to their bodily choices. In *Birthing a Slave*, Marie Schwartz outlines the use of doctors and medicine to monitor enslaved women's reproduction and also conduct medical experiments. These experiments subsequently reproduced racist notions about pain, and obstetrical hardness that deemed Black women's bodies as more durable, less susceptible to feeling pain, more fertile (Schwartz, 2006). Medical experimentation

from slavery era to Jim Crow era and targeted sterilization and hysterectomies onwards produced incorrect medical observations that only promoted a racist notion of Black mother's bodies. While medical experimentation and slavery were the most salient representations of the way racial inferiority was reinforced by medical practice, recent studies show the manifestations of these modes of thought in healthcare practices today. A study by Cynthia Prather, out of the CDC National Center for HIV, Hepatitis, STD and TB Prevention, found current disparities in socioeconomic status, education and limited access to health continue to affect access to support for Black women (Prather et. al, 2018). In addition, unconscious notions and tropes that Black women are "hypersexual," contribute to the way many are not supported as mothers (Prather et. al, 2018). Linda Blum articulates the lack of support can also be attributed to the bias that since Black mothers are incorrectly viewed as hyper fertile, they are seen as naturals at breastfeeding, not needing of breastfeeding support (Blum, 1999). This underlying assumption is dangerous and only decreases the support Black mothers get in learning to breastfeed and even care for their children.

Historical evidence and current practices suggest that stereotypes continue to impact Black mothers' medical treatment and ultimately shape the support they receive from doctors or nurses in formal medical institutions. The next sections articulate the discriminatory practices in hospital rooms that occur immediately after childbirth.

Discrimination against Black women in health facilities

As the main location for new mothers to gain health education, hospitals play a pivotal role in destigmatizing breastfeeding. Yet, these same locales often exacerbate chronic stress or traumatic encounters in hospital room. Mothers' distrust stems from mistreatment that increases risk of health complications, decreases beneficial medical recommendations. On average, Black women report higher levels of physician distrust than White counterparts due to the unequal treatment (Armstrong, Ravenell, et. al, 2007). These bastions of care for many Black women become places imbued with fear or terror.

This distrust is grounded in both historic and present mistreatment. For instance, mothers that deliver at hospitals that serve high numbers of Black people are more likely to have serious complications including infections, birth-related embolisms and emergency hysterectomies — than mothers who deliver at institutions that serve fewer Black women (Creanga, 2014). In addition, for many Black mothers, racism and prejudice by healthcare workers, even subconscious, impact the way Black women's pain is perceived (Adams, 2017). In a study done by the World Health Organization analyzing mistreatment in maternity care in the US, Black mothers were more likely than white counterparts to experience mistreatment within hospitals such as loss of autonomy, being shouted at, scolded or threatened, ignored, refused or receiving no response to requests for help in delivery rooms (Vedam, 2019). These experiences of trauma impact postnatal mental health and family relationships (Reed, 2017).

In addition, disparities in medical interventions during childbirth increase risk of postpartum care complications amongst Black mothers. Black mothers are more likely to face complications in pregnancy that ultimately result in c-sections (Roeder, 2019). Consequently, medical interventions during birth, such as c-sections, increase the likelihood of formula feeding postpartum

and decrease mother's opportunity for immediate skin-to-skin contact with their child.

An added complication is that burgeoning research shows a link between increased c-section rates and the labor and delivery nurse patients assigned to mothers (Edmonds, 2017). Consequently, any bias that nurses have towards Black mothers can increase mothers' rates of c-section and therefore adversely affect breastfeeding initiation, milk supply and infant breastfeeding receptivity compared to vaginal deliveries (Hobbs, 2016). Therefore, greater risk of c-sections in Black births decreases mothers' breastfeeding likelihood.

Overall, this discrimination against women translates into decreased breastfeeding recommendations in hospitals. Anthropologist and law professor Khiara Bridges emphasizes the greater implications for this systematic discrimination through identifying the role healthcare professionals have in framing and defining risk in healthcare settings. She posits that the "risky population" often deemed as low-income, single Black mothers are objects and effect of regulation and management rather than recipients of sufficient care (Bridges, 2011). Bridges links medical staffs' negligence in encouraging breastfeeding to discriminatory practices that reduce Black women's agency (Bridges, 2011). She decries the judgment that many single Black mothers face in systems that label them as welfare queens that take advantage of social safety nets, or even selfish for daring to have children that healthcare professionals assume they cannot care for. In other words, these stereotypes aim to control Black mothers' behavior and bodily autonomy.

Consequently, anthropologist Dana-Ain Davis suggests medical treatment has become void of actual care and rather it has become intermingled with "racialized risk"¹ that intensifies surveillance and monitoring of infant safety, rather than mother's safety (Davis, 2019). It paints Black women as both being "at risk and they are risk" (Bigo, 2002; Davis, 2019). Therefore, despite healthcare professionals' presumable noble intentions, the unconscious bias and omissions of health recommendations may have detrimental effects on mother's perceptions of their own health.

Structural Racism and the Abundance of First Food Deserts in Mississippi

In addition, due to structural racism, redlining, and unequal distribution of resources in Black communities, Black mothers are more likely to live in first food deserts in which the availability of lactation, birthing and childcare resources are limited. First food deserts are geographic areas where social and economic dynamics unequally constrain breastfeeding when compared with other locations (Seals Allers, 2017). Similar to food deserts in which a city's infrastructure can make it difficult to purchase nutritious and affordable food, first food deserts are infrastructural inadequacies in which there is no access to breastfeeding support.

A study done by the Kellogg Foundation in Jackson, New Orleans, and Birmingham—found trends in racial and economic disparities, childcare support, and cultural beliefs (Seals Allers,

2017). The study found that major characteristics of first food deserts in these regions were no "Baby-Friendly hospitals" within 35 minute commute, 50% or more of employers have no breastfeeding policy or places to nurse/express milk; 30% or more of childcare facilities were untrained to handle expressed milk; 50% or more of the public reports feeling uncomfortable when seeing a woman breastfeed; and there is a persistent and widespread lack of culturally relevant healthcare support, peer support, and public spaces that facilitate breastfeeding (Seals Allers, 2017). Overall, these structural barriers make breastfeeding initiation difficult for Black mothers, even for those that desire to breastfeed.

In the United States, the rate of implementation of evidence-based maternity care practices supportive of breastfeeding is lower among maternity care facilities in neighborhoods with larger black populations. While hospitals have recommended maternity care practices known as Baby Friendly Hospital initiatives, hospitals serving Black people are less likely to implement these practices (Lind 2014). Baby Friendly standards outline ways hospitals can encourage mothers to breastfeed. Listed in Figure 1, these guidelines require standard recommendation of breastfeeding for mothers.

Figure 1. Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming in – allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

However, there are racial disparities in access to these recommended maternity care practices. Comparing maternity facilities serving primarily non-Black patients with those serving Black patients, facilities with primarily non-Black patients were about two times more likely to have practices related to early initiation of breastfeeding, limited use of breastfeeding supplements and allowing mothers and infants to remain together after birth (Lind, 2014). These recommendations all make non-Black patients more supported in breastfeeding education. Moreover, these structural disparities for Black mothers worsen by state. As indicated in Figure 2, a map of the percentage of births that take place in Baby-friendly facilities, show the number of hospitals nationwide that sufficiently promote breastfeeding is particularly low in Mississippi with only 12.5% of births occurring in Baby-friendly facilities (CDC, 2018).

Worse yet, these same locations have higher rates of infant formula distribution. In *Skimmed*, legal scholar Andrea Freeman outlined hospitals historic practice of dispensing free formula and discharging mothers before they can receive guidance and support for nursing their newborns for incentives (Freeman, 2020). Historically, infant formula manufacturers partnered with doctors, hospitals, and WIC in predominantly, Black and low-income areas to provide mothers with infant formula at higher rates in order to gain funding in return (Freeman, 2020, 11; Blum, 1999). Therefore, even Black mothers that desire to breastfeed, depending

1. "Racialized Risk" is a term Davis uses to identify the unique way risk has been racialized and gendered. She yields political theorist Didier Bigo's conception of a type of surveillance that targets specific identities of people to draw parallels to the way some doctors and nurses manage and surveil Black mothers' bodies instead of caring for their overall wellbeing.

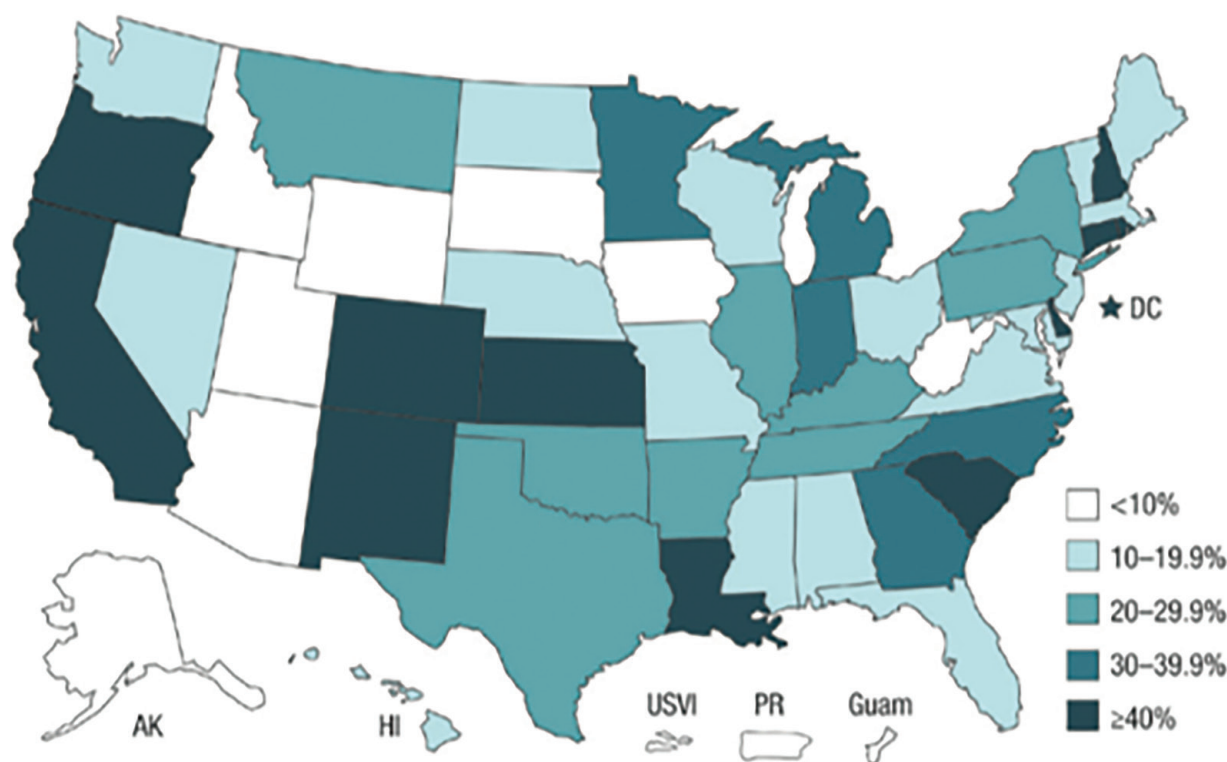


Figure 2. Percentages of births at Baby-Friendly facilities in 2018, by state (CDC, 2018)

on their environment already face structural barriers in their own communities.

Cultural deterrents to breastfeeding in Black communities

While aforementioned structural barriers decrease breastfeeding initiation rates, cultural barriers also create environments in which breastfeeding is uncommon, and stigmatized. Previous research on breastfeeding norms in Black communities identify cultural deterrents such as the stigma associated with breastfeeding, lack of family and social support in communities, and embarrassment. These cultural deterrents are among barriers that are “modifiable” along with lack of knowledge, social norms, lactation problems, and employment and childcare (US Department of Health and Human Services, 2011). Further research is needed to understand the way specific cultural barriers to breastfeeding manifest in Mississippi’s unique landscape.

For some Black mothers in the US South, breastfeeding is uniquely stigmatized because it conjures memories and legacies of wet nurses during slavery and Jim Crow era. The significance of intergenerational trauma in the discussion of breastfeeding is important in understanding the way the practice of breastfeeding education is passed down from grandmother to mother and mother to child. In *Granny Midwives and Black Women Writers*, literary scholar Valerie Lee recounts this painful history through an analysis of slave narratives that recall “female slaves bearing the pain of swollen breasts, not permitted to nurse their offspring due to laboring elsewhere on the plantation” (Lee, 1996, 75). She further connects this history to the way Black writers such as Angela Davis depict Black women’s milk as “flowing [alongside] blood” and Toni Morrison who discusses the commodification of mother’s milk and resistance to this commodification by displaying characters who reclaim their right to breastfeed only their own children (Lee, 1996,

75-76; Davis, 1983, 9). This commodification of Black mothers’ milk during slavery and wet nursing contribute to trauma and stigma surrounding breastfeeding practices. Legacies of wet nursing imbue breastfeeding practices with negative feelings and may impact breastfeeding initiation and duration.

Moreover, tropes that stereotype Black mothers as having natural abilities to breastfeed only decrease the support that mothers have when learning how to breastfeed their children. Tropes with origins dating back to slavery and Jim Crow era contribute to racial bias surrounding Black mother’s ability to breastfeed. The “Aunt Jemima” and “Black Mammy”² caricatures both suggest Black mothers were viewed as naturally being good at breastfeeding and family centered (Davis, 2019). These tropes are dangerous as they create an impression that Black mothers do not need support in breastfeeding which is not the case. In fact, this directly contradicts the low rates of breastfeeding initiation and duration among Black women. When Black mothers are stereotyped as being “naturals” at breastfeeding they are more likely to be given less psychosocial and physical support in learning how to feed their infants.

Historically, doulas³ have been effective in providing psychosocial support that Black mothers. Doula help reduce the rate of c-sections, interventions during childbirth, and increase the rate of breastfeeding (Rab, 2019). Moreover, they alleviate some of the socioeconomic factors that contribute to poor maternal health, such as limited access to education or social support networks. Even yet, there is minimal research on the viewpoints of midwives and

2. The “Mammy” caricature arose as a depiction of the Black woman as a loyal servant in White households forced to care for White children and ultimately neglect her own (Clinton 1982).

3. Doula are trained companions who are not healthcare professionals and who support individuals through health-related experiences

doulas on support mothers in breastfeeding. In this paper, while midwives and doulas often work within medical establishments, this study garners their voices and places them as belonging at a unique intersection where the healthcare system and mothers' home lives meet.

In addition, research on breastfeeding initiation and duration highlights that minimal research has been done to acknowledge these aforementioned sociohistorical factors that impact breastfeeding rates amongst Black mothers (De-Vane Johnson, 2018). Therefore, the goal of this research is to further unpack these sociocultural and historical deterrents to breastfeeding for Black Mississippians and the way social support networks motivate mothers to breastfeed their children.

Research Methods

Study Design and Recruitment

From June to August 2019, I conducted an ethnographic study that began in Jackson, Mississippi and ultimately spread to the cities of Greenville, Clarksdale, and Indianola, Mississippi. Participants were recruited informally through word of mouth after establishing connections with grassroots reproductive justice advocates, doulas and a local Baby Cafe primarily serving women on Medicaid/WIC and working with a grassroots political campaign. Inclusion criteria for this study included: Black mothers at least 18 years of age; grassroots organization or non-profits that supported prenatal or postnatal maternal care, healthcare providers, reproductive justice advocates, doulas, and/or midwives. These criteria ensured an understanding of the role of community-based organizations outside the purview of healthcare systems and medical establishments and the role doctors have in breastfeeding recommendations. Furthermore, doulas and midwives were included in this sample population because a key element of this research included analyzing the displacement of traditional birth workers. Data from study participants were collected as part of ethnographic fieldwork with the purpose of understanding barriers to breastfeeding initiation and duration in Black birthing communities.

Data Collection

An ethnographic approach to generating data was chosen including the use of life history methods, participant observation and unstructured interviews. This approach was employed in the present study because qualitative methods focus on mothers' unique breastfeeding and postpartum experiences and perceptions of maternal healthcare while garnering the unspoken and often encoded meaning surrounding Black birth stories that go unheard. Detailed field notes were taken in each observation session. To supplement observational data gathered in community settings, in-depth unstructured in person interviews were conducted with 50 study participants in Mississippi to assess women's attitudes, beliefs, and perceived support of breastfeeding amongst Black community members. These interviews were all recorded and detailed notes were taken during each. Interview questions aimed to understand how Black mother support groups in Mississippi and bridge gaps in breastfeeding initiation and duration. Example interview questions included: What location do you go for maternal health location? How do you define satisfactory maternal care? Where do you get maternal care that is satisfactory? How do you family members support postpartum care? Further questions

probed mothers' experiences gaining maternal health education and overall experiences in the birthing process.

Setting and Participants

More specifically, this ethnographic field research was conducted in the cities of Jackson, Greenville, and Clarksdale, Mississippi. Through a mix of participant observation, site visits, and interviews, this study observed locales in which Black mothers seek psychosocial support during pregnancy and postpartum care. Ethnographic fieldwork was conducted in 4 types of locations: Participants' homes, Baby Cafes in Jackson, Greenville and Indianola, Diaper Bank of the Mississippi Delta in Clarksdale, and Hypno-birthing yoga studios. Much of data collection came from interviews and in-depth notes taken during weekly attendance of Baby Cafe breastfeeding and birthing support groups in which predominantly Black mothers on WIC/Medicaid met weekly to gain free resources and education on birthing, breastfeeding and motherhood. 50 people were interviewed for approximately 1 hour, in either home settings, Baby Cafes, local gathering spaces such as coffee shops or the Jackson Medical Mall.

Ethical considerations

This study was subject to ethical review and approval through the Harvard Institutional Review Board (IRB) of the Harvard University-Area Committee on the Use of Human Subjects under IRB protocol case number IRB19-0862. Participation was voluntary and based on informed consent, with confidentiality and anonymity assured unless specifically requested. To request full identification, participants were given the option to opt-in to use their real name on the informed consent form. This was particularly important in Mississippi, given the history of research, especially health related research in which Black individuals were not given the opportunity to consent to experimentation or were not attributed ownership over their own narratives. Moreover, given the sensitivity around reproductive justice and pregnancy care, support services including social worker contact numbers were kept on file at each interview in the case of emotional distress caused by discussion of birthing experiences. Finally, all interviews were audio-recorded, and notes were taken through password protected software.

Data Analysis

The audio recordings were transcribed verbatim following each interview and checked with field and interview notes for accuracy. The material was read through several times and then coded. The codes were further collapsed into themes, allowing construction of an exploratory theoretical framework. Moreover, to undergird research, data was analyzed with anthropological theory based primarily in the works of medical anthropologists with a focus on Black feminist theory.

Moreover, each participant was given their individual interview recordings after interviews and were given the opportunity to read anonymized data analysis and provide feedback. Moreover, in August 2019, all participants were included in an in-person read out and presentation of findings based on their interviews. They were given the opportunity for further discussion in this presentation and to verify accuracy of these findings. By July 2020, participants were given all data and analysis collecting in this study to share feedback and distribute in their communities. This was particularly important given the sacredness of each individuals' story and to combat the often-extractive nature of research.

Results

Analysis of the interview transcripts revealed 5 main themes affected to breastfeeding initiation and duration. Three themes addressed barriers to breastfeeding initiation and two themes addressed barriers to breastfeeding duration. Themes that arose pertaining to breastfeeding initiation included (1) Misinformation in the Black community that configured breastfeeding as dangerous, (2) Perception of breastfeeding as “nasty,” and (3) Perception of breastfeeding as an indicator of poverty in Black communities. While the themes related to breastfeeding duration were (4) Breakdown of familial support in breastfeeding and (5) The positive impact of “Baby Friendly Designations” at daily institutions. The themes are highlighted and discussed through the use of direct quotations and responses from participants.

Theme 1: Misinformation on the dangers of breastfeeding

This theme encompasses two main subcategories that contributed to this configuration of breastfeeding as a dangerous act: first discriminatory health recommendations for Black women by healthcare professionals that discouraged or omitted breastfeeding education; as a result, misinformation in Black communities passed down intergenerationally.

First, all 50 participants interviewed shared negative experiences they have witnessed with healthcare professionals. One mother in particular was Chanel, a Black single mother on WIC who was a client of Shanina, a Black certified lactation counselor (CLC). In 2018, Shanina received an unexpected call from Chanel, who was hysterically crying, saying the hospital was not letting her see her newborn baby. Shanina remembered getting off the phone and thinking, “what, that makes absolutely no sense.” Confused but enraged, Shanina immediately drove to the hospital to assist Chanel. After interrogating nurses and hospital staff, she discovered that, “the nurse on staff the night of Chanel’s birth ‘was just being lazy,’” according to another nurse Shanina spoke with. Chanel had a c-section and several health issues post-pregnancy that made breastfeeding difficult, but because of what she’d learned at Baby Cafe support sessions, she still wanted to breastfeed her child. The delivery nurse would have had to supervise Chanel and teach her to breastfeed for a few days and did not want to. Shanina even found that nurses had been giving formula to Chanel’s baby. This instance shows clear negligence and indifference in a healthcare setting. However, it seems that the hospital staff was more than simply incompetent. Why would medical professionals do everything in their power to prevent Chanel from breastfeeding her child when both breastfeeding and skin-to-skin contact are medically recommended? The hospital staff’s disregard for a scientifically-grounded medical necessity, suggest the low rates of breastfed Black infants is more complex than neglect.

For another Black mother named Latisha the answer to the aforementioned question is bias towards Black mothers. Latisha said that she “was never asked if she wanted to breastfeed and was never given this option after her delivery.” Nurses even assumed she was on WIC, despite Latisha’s direct response that she did not qualify and also did not include her husband on her child’s original birth certificate. They incorrectly assumed Latisha was a Black single mother on WIC. Latisha’s experiences suggest the immediate assumptions that some healthcare professionals have when they have Black female patients. Another mother of four named Rhonda

experienced this trend firsthand and said, “in hospitals, they want the easy way out, so they give babies bottles,” alluding to the limited attention or psychosocial support mothers receive after birth. Overall mothers found even if they wanted to breastfeed, when healthcare professions do not recommend breastfeeding or support it in delivery rooms, initiation becomes increasingly difficult. Postpartum care immediately after birth, impacts infants’ lives and mothers’ future ability to feed their children.

One participant echoed the insidious nature of discrimination in postpartum care and the way it propagates economic injustice. Alex works at a nonprofit that addresses food insecurity in the Mississippi Delta. He said, “in rural areas, such as Sunflower County they have no access to baby formula, yet when they go to the nearest birthing hospital which is more than 100 miles away, they are told not to breastfeed and are recommended baby formula.” Though breastfeeding after birth is the most inexpensive option and the most physically accessible option for mothers, hospitals still opt for recommending formula. This practice is both discriminatory and dangerous as it leads to food scarcity for children, as buying infant formula in existing food deserts is unsustainable.

While 49/50 participants outlined the instances of discrimination and mistreatment they or birthing clients have faced in medical establishments, one woman pointed to the greater culture of bias in the medical field. Black mother and Black gynecologist at the University of Mississippi Medical Center named Dr. Jones, argued “the problem is, Mississippi just has so many sick patients. People with diabetes, obesity, hypertension, and first place in heart disease. These are all illnesses that complicate pregnancy. You also see more medical roles and resources in a single cubicle in Boston or New Haven than here. It’s just hard.” While she admitted to knowing many doctors and nurses with strong racial prejudice, Dr. Jones added that the hospital is a place where racial bias can manifest in health guidance, especially when hospitals are understaffed and resourced. The limited resources combined with a greater culture within “risk-management” removes the psychosocial support that Black mothers need to validate their concerns and desires.

Many Black participants acknowledged that they internalized these recommendations that promote infant formula over Black mother’s own breastmilk. Several mothers noted that the fact that doctors and nurses did not support their breastfeeding practices in the hospital, which made mothers question how safe their bodies were for their own children. Mothers interpreted these medical recommendations against breastfeeding as their own moral failings. Consequently, many mothers avoid breastfeeding because they thought the very act of breastfeeding their child was “dangerous for their children”. Participants noted this misinformation was passed down intergenerationally. For instance, Jameyshia, the director of the Mississippi Birth Coalition said, “breastfeeding began to become popular amongst African American mothers in 2015 in Mississippi. The norms were that in hospitals, doctors would not give Black mothers skin to skin time with their infants, so mothers were not used to that and mothers were not given the option to breastfeed, so they did not think breastfeeding or skin to skin were natural. Before, mothers would have to ask for skin-to-skin—fight for it.” This example of health recommendations’ impact is momentous and has the potential to shape birthing epistemologies on what is perceived as “natural” to Black mothers about their own bodies.

Finally, amongst participants, the phrase “trust” was used in 12 different interviews, primarily when comparing the way mothers

were treated in hospital settings and in support networks like the Baby Cafe. The dialectic of trust and distrust existed hand in hand within every interaction participant had with medical establishments. There was inconsistency in the message that is being sent to these mothers on the topic of breastfeeding and this primarily comes from their doctors and nurses that have been the authority on maternal health. As a result, mothers begin to internalize negative perceptions of their own bodies and their relationship to newborns. Misinformation about breastfeeding within communities made mothers less likely to breastfeed and without correction by doctors or nurses in hospital settings, many mothers continued to view breastfeeding as abnormal.

Theme 2: Perceptions of breastfeeding as “nasty”

While all participants acknowledged the health benefits of breastfeeding and would quote a common mantra, “breast is best,” more than half of study participants noted the pervasiveness of negative perception of breastfeeding in their communities as nasty, risky or unnatural. Jackie, a Black mother and founder of a Black mother’s support group discussed the perilous nature of including breastfeeding in the name of her initiative, she said “I named my support group, ‘Let’s talk...baby’ because I knew no one would come if I said, ‘Let’s talk about breastfeeding. Women don’t breastfeed for so many reasons. Some think it is nasty... the history of breastfeeding here is one where women just don’t want to take the chances.’” Jackie outlined the several reasons for low breastfeeding initiation rates in Black communities but highlighted the points of it being “nasty” and a risk to Black mothers. This perception was further grounded by several Black mothers’ experiences of harassment when they decided to breastfeed.

At a Baby Cafe session, a Black mother named Taya expressed that she felt discouraged by family and friends who thought breastfeeding was “nasty.” She exclaimed, “if you see horses, giraffes, dogs they breastfeed, why can’t we?” Another mother named Julia described how she heard a Black employer tell a woman she could not breastfeed in public, though the employer herself was a clinician and a woman. She added, “people are only against displaying breasts when it is for breastfeeding, but you don’t see them telling ‘Ms. Cha Cha’ over there to stop and cover up.” Both mothers raise the ways the sexualization of women’s bodies has created a complicated dilemma for Black mothers. In a conservative state such as Mississippi, breastfeeding in public, while a legal right, is still viewed with judgement. Black mothers that dare breastfeed incur greater social stigma both in public settings and even in private settings with family and friends.

Theme 3: Breastfeeding as a symbol of poverty in Black communities

While the aforementioned themes were most associated with misinformation on the benefits of breastfeeding, the theme of poverty is particularly insidious because the link between poverty and breastfeeding is based in cultural lore, historic wounds and present-day classism.

Kandiss, a Black mother of two children and pharmacist talked about how low breastfeeding rates, “date back to slavery times when women were wet nurses and cared for other people’s kids. So now [breastfeeding] is a symbol of poverty.” She unpacked Black women’s reception to coercive and racist infant formula marketing techniques that targeted Black mothers and said, “Black mothers buy formula

just to show that they can take care of their kids. Even though we know that it is healthier for our kids.” Kandiss concluded, “because we don’t need to breastfeed, we don’t.” Kandiss unpacked how the stigma associated with breastfeeding has led to its association with poverty. Michelle, a Black doula and reproductive justice advocate expressed empathy towards Black mothers that choose formula. She said, “due to the trauma that they have faced, since historically, Black women who breastfed, had to feed master’s child before they fed their own, many grandmothers did not breastfeed their children.” Michelle’s account illuminated the nuances in breastfeeding that connect trauma and memory to Black mothers breastfeeding rates in present day Mississippi. This intergenerational trauma that is unspoken between mothers and daughters manifests itself in discouragement of breastfeeding and tension between daughters who want to breastfeed and mothers who discourage it.

Theme 4: Breakdown of familial support in breastfeeding

Amongst my study participants, those that overcame barriers to breastfeeding initiation were met with obstacles when garnering familial support while breastfeeding. They found that on many occasions their home environments were discouraging and derailed their progress. Therefore, breastfeeding while balancing jobs and convincing family members not to feed their newborns infant formula all decreased breastfeeding duration. One woman named Charnice said, “When I first had my daughter Eliora stay with my mother, while I was at work, she gave her formula even though I told her not to. I stopped letting Eliora stay with her after that.” Similarly, another participant named Maggie, who was the director of a Baby Cafe in Greenville, acknowledged this norm in a support group meeting. She said, “Black women need to breastfeed more or find these support groups because often it can feel like we are the only one in our family breastfeeding—but you’re not alone.” This reassurance was important to the 16 women at the meeting because when each woman was asked if they had an environment outside of the Baby Cafe that was supportive of breastfeeding, the response was a resounding, “No.” Many stated that their mothers and relatives were not aware of the health benefits associated with breastfeeding and tried to feed the newborns baby formula.

One participant named Ruth, the director of the Baby Cafe in Jackson, provided an explanation for this generational divide and extra hurdle that present-day mothers are facing in Mississippi. She said, “there is a whole generation without breastfeeding because it stopped being promoted in the 1960s. The worst part is, people think it’s sexual or incestual, but this just is not true. The solution is changing the culture of how people look at breastfeeding.” Participants, especially single mothers who depended on family members for childcare, emphasized the specific difficulty of having unsupportive mothers. Breastfeeding while balancing work was difficult, but it was near impossible to make sure that family members respected their wishes not to feed their children baby formula. Only one mother in this study found breastfeeding continuation easy. When Kira was asked about the reason for her success she said, “I didn’t have a choice but to breastfeed.” She explained that her mother and grandmother had all breastfed their children, so it is something that was a given for her. This divergent and rare occurrence amongst study participants reiterated the impact familial support has on breastfeeding duration and the reason many depend on a community of like-minded mothers for support.

Theme 5: Positive impact of Baby Friendly designation at daily institutions

Baby Friendly designated institutions, though increasingly ubiquitous, are burgeoning developments in Mississippi that aim to normalize a culture that supports breastfeeding mothers. These are institutions with specific areas for mothers to express milk. In the Baby Cafe of Jackson, the director Ruth ensured that mothers knew the breastfeeding mandates in their workplaces. She would ask every single mother in each session, “does your workplace have a place to express milk because it is required by law that they do.” If the answer was no, Ruth would make calls right after the session to employers and send emails to ensure that the workplace was compliant. Mothers that attended the Baby Cafe were particularly grateful and one mother name Carey said, “the Baby Cafe reaches out to businesses and my work to make sure they are baby-friendly, which is great.” Ensuring that Black mothers had a space that was supportive of breastfeeding was particularly important for Ruth who understood the gravity of spaces for Black women. She spoke of her childhood and mentioned, “my mother and father always told me that own your own space. They did what they could and owned their own house and plot of land in the Delta. I learned it from them that to change anything and be in control of outcomes, it’s all about space.” Ruth alludes to the particular gravity of land ownership and autonomy in the context of Mississippi with legacies of slavery, Jim Crow, and other ways land ownership has not always been a right for Black populations. Ruth linked this concept of spatial ownership to a feeling of belonging. She knew that mothers were more likely to continue breastfeeding if they had peer, familial supports and workplaces spaces for expressing milk.

Participants aligned on this aforementioned point and agreed that to promote Black motherhood, it is important to normalize breastfeeding in commonly attended institutions such as churches, schools, classrooms, grocery stores and other places of daily life. One mother named Charnice said “I really enjoyed when we went to the museum as a group during MOB (Mothers out Breastfeeding). I felt confident with other mothers.” MOB is a program that allowed Black women to breastfeed in public areas from museums to grocery stores and while many faced criticisms, they began to destigmatize this practice and encourage community support for mothers. The significance of normalizing culture around Black mothers breastfeeding is particularly important in rural areas of Mississippi Delta. One mother at a Baby Cafe in Greenville noted that “the church is not helpful when it comes to this because they are judgmental.” She talked about how she grew up in an AME (African Methodist Episcopal) church and that “they judge people and do not promote breastfeeding. But the church is a public institution since it is state funded, so it should be treated that way, and they should have to promote breastfeeding and healthy practices.” Her point introduces an approach to promoting healthy motherhood at the nexus of daily life and healthcare institution.

Another breastfeeding advocate named Jamila echoed this sentiment and said, “we operate in tribes in the Black community. We are just not very trusting of different cultures or people we do not know. And rightfully so, we have a history of people we cannot trust in the healthcare system.” Jamila emphasized that medical institutions are not the only locales of care to blame, but also women’s own families who judge breastfeeding and perpetuate stigma.

Instead, groups such as the Baby Cafe bring scientific

evidence-based education to supportive culturally grounded communities of Black mothers. The Baby Cafe also provided education that made mothers feel confident in their decisions for their children. For example, many mothers stated that they did not have much exposure to breastfeeding before the Baby Cafe and enjoyed the following topics the most: health benefits of breastfeeding for mothers and infants, breastfeeding as birth control, breastfeeding positions, baby sleeping positions, latching positions, birthing positions in labor, hospitals do’s and don’ts, and baby CPR. One mother named Jule in particular said at the Baby Cafe, “I learned to advocate for myself and be firm in whatever decision I have for my child.” In the auspices of the Baby Cafe, mothers noted that they felt at “home.” Another mother named Kim said, “before this group, when I was pregnant, I felt alone. I was told by my sperm donor that he wished something bad happened to my baby...As a single parent, it is lonely, so this place gave me the support I needed and gave me hope.” While another mother praised the Baby Cafe and said, “I am grateful for a community of people I can rely on to make sure my baby and I feel okay.” Finally, Charnice, the mother who has enjoyed the MOB trip said, “The Baby Cafe, provides more than breastfeeding—it’s like therapy.” Overall, there was astounding support for Baby Cafes in changing the culture around motherhood for participants and making it an experience bolstered with psychosocial support and a community of peers.

Jackie, founder of the “Let’s Talk—Baby” support group, echoed the significance of these support groups succinctly, “there are so many conversations that we can have that doctors do not hear because women do not tell their doctors. They rely on fellowship with one another and gain advice from discussing with each other.” Given this history and inaccessibility of healthcare Jackie proposed for a turn to community based psychosocial care. She said that there’s a saying she heard, “anything that you need, you’ll find it in the community.” Indeed, the knowledge and expert support combined with culturally relevant and relatable dialogue helped mothers feel informed, engaged and empowered.

Discussion

This paper emphasized the necessity for structural changes to postpartum care and cultural changes in Black mothers’ daily sectors of life. The utility of the Baby Café and Baby Friendly institution designations aligns with previous research that shows integrated models of maternal care are effective in long-term improvements in population health (Reis-Reilly, 2018). Specifically, integrated public health interventions that use a socioecological model to identify systems-level factors that affect both individual and community health have been shown to be most effective in creating sustainable organizational and community shifts in maternal health care (Reis-Reilly, 2018). In other words, campaigns that designate daily spaces such as classrooms, workplaces, hospitals, churches, and grocery stores as Baby Friendly, work to address these community level barriers to breastfeeding and successfully shift cultural practices. Ultimately, both grassroots support groups such as Baby Cafes and daily institutions that give mothers spaces to express milk or teach breastfeeding education, can help to normalize breastfeeding amongst Black mothers.

Furthermore, these findings bolster previous research that show inadequacies in focusing solely on individual health behavior in addressing the needs of communities (Reis-Reilly, 2018).

This research illuminated the multifaceted barriers that Black mothers face in breastfeeding initiation and duration including discrimination in hospitals, misinformation in communities, cultural beliefs around breastfeeding and lack of support. These barriers all focus on the way Black mothers in Mississippi interact with their local healthcare professionals, family members, breastfeeding landscape, and respond to stressors and disparities in care, as opposed to their own individual beliefs. In this way, this research focuses primarily on changing systems and community norms as opposed to individual beliefs. Consequentially, this work provided a lens into the different elements of Black Mississippians' maternal health landscape that make psychosocial support while breastfeeding often unattainable.

Finally, this research presented distinct and nuanced relationships between intergenerational trauma, legacies of wet nursing and historical perceptions of breastfeeding that deterred Black mothers from breastfeeding. This discourse bridged gaps in existing literature that acknowledge the need for studies on Black breastfeeding practices to pay particular attention to the embodied experience of historical trauma (De-Vane Johnson, 2017). This work emphasizes the need for sensitive and culturally relevant approaches to both research and public health interventions.

Overall, mothers' postpartum experiences must be fully integrated and accepted by their communities. Breastfeeding must be openly discussed in Black mothers' workplaces, gathering spaces and day to day lives. Given the mistreatment in hospitals by doctors and nurses, mothers must seek other methods of gaining the lactation education and support they need. Instead, community spaces need to normalize mothers out breastfeeding and more programs that embrace public and unapologetic breastfeeding and other aspects of mothering.

The depth of participant interviews and analysis of perceptions of breastfeeding are some of the study's greatest strengths as these rich anecdotes allowed for documentation of shifts in cultural norms. However, several limitations bear mentioning as well, particularly the small sample size that spanned across multiple cities in Mississippi. Data collection offered a wide variety of socioeconomic status, but given participants were recruited word of mouth, this method self-selected for mothers with similar birthing experiences that were often negative. Finally, the variability in familial support amongst participants may limit the generalizability of these study results given mothers depend on these institutions to different extents given their family background.

Conclusion

These findings point to the significance of grassroots spaces embedded in Black mothers' daily lives that allow for peer support during breastfeeding. While disparities faced within hospitals are necessary areas of improvement, expansion of Baby Friendly Initiatives in institutions nationwide holds great promise for normalizing breastfeeding and advocating for mothers.

Future work would include the disparities faced by Black mothers in attaining childcare services and workplace policies on breastfeeding. The same structural inadequacies within workplaces that do not offer sufficient maternal leave or financial assistance for childcare plans also minimize the ability of mothers to breastfeed for the full recommended 6 months to 1 year. In addition, it is critical that workplace dynamics be explored further. Through encouraging

breastfeeding in everyday spaces, this signals to communities that Black motherhood is important and must constantly be acknowledged, embraced and accepted. Ultimately, hospitals must begin by standardizing breastfeeding recommendations across all patients and daily institutions must continue the work to normalize supporting new Black mothers in communities.

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