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BFREE Newsletter

Breastfeeding Resiliency, Engagement, and Empowerment (BFREE)

"Empowering mothers to breastfeed every step of the way"

IN THIS ISSUE

Letter from the Editor

Dear BFREE Coalition & Community Members,

As summer turns into fall, our BFREE team hopes that you and your families are remaining safe. The collision of multiple pandemics – coronavirus, racial inequities, and police brutality – all at once highlights the urgent need NOW for real, concrete change to address this unique storm of unprecedented challenges in the US.

Our latest newsletter focuses on increasing understanding and awareness of historically-rooted racial breastfeeding disparities. We emphasize how health care workers, lactation experts, and extended social networks can increase their support of the breastfeeding journeys of Black women. We are so thankful that several voices from the Black community have graciously shared their perspectives and insights in this edition. First, we hear from Chanel Jones, a mother, birth doula and child care educator, about her breastfeeding journey (pg 3). We also hear from Mabel Origho, MD (pg 6) and Janice Campbell, MSN, RN, LCCE, IBCLC (pg 7) who further discuss barriers to breastfeeding and highlight solutions for reducing disparities among the Black community. Please join us in learning from them, as we continue to try to advance our cultural competence and support of Black mothers.

As always, we are sincerely appreciative to this edition's contributors, to the entire BFREE Steering Committee for its active engagement and sage advice, and to each of you, our many collaborators, for your collective passion in support of breastfeeding.

Please email us at BFREE@northwell.edu to share feedback and any potential contribution ideas for future newsletters!

Sincerely,

Henry H Bernstein

Dr. Henry Bernstein

October 1, 2020

Success Spotlight

The BFREE Team would like to recognize a special mom who frequently attends our weekly virtual Baby Cafes, and who went above and beyond during Hurricane Isaias, to support a fellow breastfeeding mom! While the storm took out power in many areas of Long Island, breastfeeding moms were faced with the challenge of continuing to pump and store breast milk without electricity. One mom, who still had partial power, decided to take matters into her own hand, offering to store breast milk for her friends, so that they could continue to feed their babies, despite the storm. We celebrate this mom, and the many others, who pulled together during the storm to support each other in their breastfeeding journeys!

This quarter, the BFREE Team is also excited to share that two practices in Suffolk County, Peconic Pediatrics and Hampton Pediatrics, achieved Breastfeeding Friendly designation through New York State Department of Health! Despite the additional challenges that both practices faced maintaining health service accessibility during the COVID-19 pandemic, Peconic Pediatrics and Hampton Pediatrics remained committed to promoting breastfeeding. We would like to thank our site champions, Dr. Jenn Shaer, Dr. Lisa Visentin, and Ms. Alison Johnson of Peconic Pediatrics, and Dr. Nadia and Ms. Kacey Pryzby of Hampton Pediatrics, for working tirelessly to support mothers and employees at their practices. Though we will be postponing our in-person celebration of the wonderful accomplishments of Hampton Pediatrics and Peconic Pediatrics, we were able to do a virtual celebration with the team at Peconic Pediatrics! Joined by Dr. Shaer and Dr. Visentin in PPE at Peconic Pediatrics, Brianne Chidichimo of Adjuvant Health, and Heather Edwards of Allied Foundation, the BFREE Team enjoyed celebrating Peconic Pediatrics' breastfeeding friendly designation via Zoom.

This work is supported by a NYSDOH "Creating Breastfeeding Friendly Communities" grant, which aims to expand community-based breastfeeding partnerships and reduce disparities in the rates of breastfeeding across New York State. Congratulations to Peconic Pediatrics and Hampton Pediatrics on being recognized for all your hard work, and thank you for collaborating with our team! A list of Breastfeeding Friendly Practices in New York State can be found at: https://www.health.ny.gov/prevention/nutrition/cacfp/bfpraclst.htm

Allied Health Foundation Breastfeeding Warmline: 1-866-211-0404

Visit us on Facebook at: https://www.facebook.com/BFREE.Coalition/

Check out our website for more resources: bfreecoalition.org

This project is supported by NYSDOH Grant #530390. The content of this newsletter is the responsibility of the BFREE Team and does not necessarily represent the opinions and interpretations or policy of the New York State DOH.

Cohen Children's Medical Center
Northwell Health

NEW YORK STATE | Creating Breastfeeding Friendly Communities

BFREE

Mother's Perspective

By: Chanel Jones

Chanel Jones is a birth doula, childbirth educator, and a valued member of our BFREE Steering Committee. You can connect with her and find more information about her doula services, Chanel's Comforting Doula Care, at wwww.chanelscomfortingdoulacare.com.

Twelve years ago, I had my daughter during my junior year of college. It was an unplanned pregnancy, with very little support, along with the baggage of a toxic relationship. Overall, it was a "topsy-turvy" time in my life. Thankfully, despite all of this, I remember being very optimistic about making the most out of my circumstances and taking the proactive approach to preparing myself for labor and life as a mom and student. I had plans to have a natural birthing experience and made my intentions to breastfeed very clear to all medical professionals and staff that came my way.

Overall, I had a very healthy pregnancy. Since I was a student without a car, I walked regularly, did my pregnancy yoga daily and swam 2-4 days a week. I guess my daughter was so comfortable that she decided to stay in an extra 2 weeks after her original due date. Unfortunately, during the last week before her birth, my daughter decided to change positions, so her head was no longer perfectly placed. This created complications for me later during the laboring process. The day before her birth, I recall going to see my OBGYN, where we confirmed plans for an induction to take place the very next day. However, that same day I got into a huge argument with my daughter's father; during which I banged my fist against the door, causing immense pain in my stomach. I am pretty sure the argument and sudden noise upset my daughter. This was not the first time I experienced stomach pain after one of our many arguments. Shortly after this incident I went to lay down, and that is when I felt it. My water broke. I slowly got out of bed and made my way over to the bathroom, to find meconium in the amniotic fluid.

I lived on campus and decided to walk across the street to the hospital to let them know I was in labor. Since meconium was present in the amniotic fluid, they gave me 24 hours to push her out naturally, otherwise I was going in for a c-section. During that time, the baby had to be monitored, so I was unable to get up or move around. All of this was very mentally and emotionally taxing since I had planned to have an intervention-free natural birth. After 24 hours of laying on my back, I was brought in for an emergency c-section, and my beautiful baby girl was delivered.

I was so determined to breastfeed that I requested that doctors to pull me into a side hallway before reaching my recovery room so I could get my daughter latched right away. I remember fearing that someone would secretly place a pacifier her in her mouth or sneak in some formula along the way. Either way, I was so glad that on the first attempt, my daughter latched perfectly. She was a great eater, and we had no problems breastfeeding at all. This was such a relief since all my other plans had previously fallen apart. I was just so grateful to have this breastfeeding victory.

A few days later, just a couple of hours before my official "3-days" waiting period in the hospital expired, I was released early with a low grade fever; only to end up back in the hospital 3 hours later with 103.5 degree fever. Post c-section, I was septic due to the meconium in my amniotic fluid. I also had a double lung infection of pneumonia from spending hours stuck on my back, lying in bed, during the laboring process. It was the beginning of summer, and the hospital was full, so I could not be readmitted to the maternity floor. I was told I could not have a healthy baby on the sick children's floor where they had placed me. I

almost lost my life that night. No one was sure I would make it through; but thank God I did!

After 3-4 days in the hospital, separated from my newborn baby girl, I convinced the doctors to let me go home for my health. I was retaining water, my blood pressure was rising, and I had developed white coat syndrome. My breasts were engorged, and the milk was bloody from all the knots in my breasts. Mentally and emotionally I was a wreck because I could not see my baby. Thankfully, the doctors' listened to my pleas, and I believe in the process saved my life. They released me and prescribed antibiotics. However, the antibiotics given to me, kept me from being able to breastfeed my daughter for 2 weeks.

Those were the longest 2 weeks of my life. I almost lost my milk supply from the stress of it all. I went from pumping and dumping 8 ounces per breastmilk down the drain at the hospital, to 1.5 ounces within a week of being home. The hardest part was hearing my baby cry and scream all the time because she could smell the milk on me and could not be bothered with the formula. Thankfully, I had the support of a friend who encouraged me in my pursuit of breastfeeding. She supplied me with resources and advice on how to keep my milk supply up. Through hard work and dedication, I was able to get my milk supply back up, and slowly but surely.

The day that I was able to breastfeed again, was a greater victory than the first time she latched after birth. I was so filled with joy that I cried. I was so happy to be able to provide her my milk and it gave me such a peace. However, I did not know it then, but my daughter was severely tongue tied. This was struggle in and of itself. Ultimately, I was able to persevere and breastfeed until my daughter was 14 months old!

Throughout all of this I believe I suffered from postpartum depression because of all the events leading up to birth and the trauma I suffered during and after. I loved being a mom, and I loved my daughter, but she also had the resemblance of her father. At the time of her birth I was no longer in a relationship with her father, but he was still the continuous source of my emotional and mental trauma. It was a very dark time in my life. I felt helpless and alone. I remember agonizing over the thoughts that ran through my head, which were both confusing and terribly intrusive.

The only thing that kept me moving forward through all of this was knowing that my daughter did not ask to be here, and that she deserved nothing but the best from me. She was my light in the darkness, and she gave me the motivation to climb out from the dark places I continually found myself in. She was my miracle baby, an answered prayer, and I thank God for her every day. Thankfully, I made the choice to seek counseling and support to help get me to a better place. This allowed me to come out of my depression and become optimistic and focus on providing a better future for my daughter and me.

After years of hard work, I obtained a bachelor's degree in Business Management, with a concentration in Operations Management and a Minor in Social and Cultural Anthropology from Stony Brook University, as well as a Graduate Certificate in Health Information and Technology Management. I am currently working on a master's degree in Health Administration, with an expected graduation date of May 2023.

My daughter is happy, healthy, and enjoying the carefree life of a preteen. I thank God that I have been blessed with the opportunity to take my experiences and help other women avoid some of the traumas I experienced myself. I was inspired to do more, and now I am the founder of Chanel's Comforting Doula Care, where I provide birthing/labor support and childbirth education services. I received my doula certification from LIDA [the Long Island Doula Association] and participate in the organization's BMWC [Black Maternity Wellness Collective] and CSF [Community Support Fund]. I volunteer as an advocate for the Postpartum Resource Center of New York and participate in the Moving on Maternal Depression Project (MOMD)– New York Voices Workgroup. Additionally, I recently obtained a volunteer position with the BFREE [Breastfeeding, Resiliency, Engagement, and Empowerment] initiative with Northwell; where I am an active member on their Steering Committee and participate in projects like their Baby Cafes and Breastfeeding Awareness Month.

I look forward to continuing to make a difference in the lives of those around me, and beyond. It brings me great joy knowing that I can help someone find their way out of a dark place. I have made it my mission to help support mothers everywhere and help them learn the importance of knowing that they are not alone, and they do not have to suffer in silence.

Thank you for reading my story.

Historical Roots of Breastfeeding Inequity

By: The BFREE Team

Several historical factors contribute to today's low breastfeeding rates among Black women in the United States. Roots of systemic racism can be traced back to the enslavement of Black women, who were forced to serve as care laborers in White homes. Inaccurate perceptions about Black women began when European colonizers referred to West African women's breasts as "dugges," the equivalent of a brute animal's teat[1]. The animalization of Black women led to their exploitation and sexualization, and the construction of erotic images of enslaved wet nurses by slaveholders. Black women were exploited as wet nurses and breastfed the infants of White women who believed Black women produced more milk, and perceived breastfeeding to be inconvenient, dangerous, and not aesthetically pleasing.

The historical exploitation of Black women led to the emergence of the "Mammy" stereotype. This stereotype referred to "ideal domestic female slaves" who were forced to abandon their motherhood commitments to their own children, in order to be loyal, caring, proxy mothers to White children.

Motherhood was stolen from Black mothers and commoditized by slaveholders, contributing to intergenerational trauma. Enslaved Black women were simultaneously seen as both "breeders" and "Mammy"[1]. They were expected to birth the next generation of enslaved people and devote all of their time and milk to the children of their slaveholders. Enslaved women were forced to spend less time with their own children, setting a foundation for the modern stereotype of the "lazy Black mother" and the "welfare queen," a Black, young, uneducated, single mother, who only had children in order to receive government benefits[2].

Although slavery was abolished, Black women were not freed from stereotypes and oppression. The lack of economic mobility and institutional support constrained Black women to continue wet nursing or settle for low-paying, time-consuming jobs that forced them into poverty and limited their ability to be at home with their children[2]. Black mothers were labeled as "lazy" and "uncaring" while White mothers were seen as "empathetic" and "warm." The "lazy" stereotype has led to a disproportionately high number of Black women being charged with homicide and negligence after their infant died while they were exclusively breastfeeding. Courts claimed that these Black mothers were unfit caregivers, when in reality they had not received proper instruction and support from medical providers who failed to inform them that prior medical conditions inhibited their ability to breastfeed exclusively[3].

Breastfeeding confers health benefits to both mother and baby, and it is a matter of equity and justice, contributing to a fair start in life. However, Black mothers and their children continue to face injustices due to the increased promotion of formula targeted at Black families. The world's first surviving Black quadruplets, known as the Fultz Quads, were exploited by the Pet Milk formula company in the 1970s as an advertising strategy to sell formula to Black families, who had previously been overlooked by the formula industry[3]. The lack of advertising regulations in the United States enabled formula companies to limit images of Black women breastfeeding and normalize images of Black women using formula. Additionally, welfare agencies catering to a predominantly Black population freely distributed formula. Structural racism forced a disproportionate number of Black women into low-paying jobs with longer work hours which made breastfeeding nearly impossible. Formula companies capitalized on this job inequity and developed campaigns that promoted formula as an easy and safe alternative, that promised a "happy family"[3].

Even today, on average, Black mothers return to work at eight weeks postpartum, which is earlier than women from other racial and ethnic groups. Once at work, Black women are more likely to encounter more challenges such as inflexible work hours and are thus less likely to exclusively breastfeed in comparison to mothers who return after 12 weeks postpartum[4,5]. Currently in the United States, Black women are nine times more likely to receive free formula from hospitals and health providers due to provider bias. The legacy of slavery constructed a harmful narrative about Black women's capabilities as mothers, which has resulted in the "first food injustice" and the never-ending struggle to overcome structural racism throughout their breastfeeding journeys. Acknowledging the origins of breastfeeding disparities among Black communities is the first step in uplifting and supporting Black mothers in meeting their breastfeeding goals.

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Behind the Numbers: Black Maternal Health

By: Dr. Mabel Origho, MD

Dr. Mabel Origho is a physician and a valued member of our Steering Committee. She has experience working internationally as a physician and domestically in research, and is currently working to complete her MPH.

There are striking disparities in maternal mortality rates between races. The 2018 National Center for Health Statistics (NCHS) on maternal mortality showed wide gaps between racial and ethnic groups, with non- Hispanic Black women (Black) having 37.1 deaths per 100,000 live births, non- Hispanic white women (white) with 14.7 per 100,000 live births, and Hispanic women with 11.8 deaths per 100,000 live births. Black women are three times more likely to die in childbirth than women of other races, despite similar socioeconomic factors. Not only this, they are more likely to experience pregnancy related illnesses and comorbidities. This is an indicator of the standard of healthcare rendered to Black women. Studies have shown that Black women develop pre-existing conditions like metabolic diseases even before pregnancy due to the health disparities they experience, and this further affects their health during pregnancy. An improvement of postpartum care is paramount to improving outcomes in maternal mortality for Black women and closing these disparity gaps.

Racial and ethnic disparities also exist in breastfeeding initiation and exclusivity rates. When we define breastfeeding initiation and exclusivity, we refer to when a mother begins to breastfeed her infant at birth and continues to feed solely with breast milk - no water, solid food, or other liquids. The American Academy of Pediatrics recommends that infants be exclusively breastfed for the first 6 months, after which mothers should continue to breastfeed while introducing complementary food until 1 year of age or older. Generally, women in the United States do not meet the recommended breastfeeding rates and goals set out by the Healthy People 2020 (an initiative that looks at improving key health indicators, to create the healthiest population in the United States). While there are different breastfeeding initiation rates across races and ethnicities, these numbers vary from state to state in the United States. Breastfeeding rates and continuation at 6 months and 12 months are much lower in non-Hispanic Black infants compared with non-Hispanic white infants, with significant disparities seen over 23 states, according to the Centers for Disease Control and Prevention (CDC).

Black women, however, face certain barriers that unequally affect breastfeeding initiation, exclusivity and duration, and these multiple factors influence their decision to start or continue breastfeeding. Low income, lack of social support, lack of breastfeeding education, unsupportive cultural and social norms, lifestyle choices and unhelpful work environments make it challenging for Black women to meet the recommended breastfeeding goals. It's important to take into account the historical challenges Black women faced in the past, which may have created a negative perception on their views towards breastfeeding, and in turn contributed to lowered rates of breastfeeding in the Black community. The jobs available to low income Black women pose a barrier to breastfeeding, where not enough maternal leave time is allotted by some organizations and/or Black women have to work multiple jobs to make ends meet.

Breastfeeding of infants has long-lasting health benefits for both infant and maternal health. In breastfed infants, there is a decreased risk of upper respiratory tract infection, ear infection, gastrointestinal infections and infants may be less likely to develop asthma as a mother's milk provides secretory antibodies to support the infant's immune system. It also can help prevent infantile obesity, diabetes and can be easy on the stomach of newborns. Breastfeeding mothers gain health benefits as well, including a lower risk of developing type 2 diabetes, hyperlipidemia, cardiovascular disease, hypertension, breast cancer and ovarian cancer. Breastfeeding also helps mothers lose weight after pregnancy and creates a bond between mother and infant. Since Black women are disproportionately affected by adverse events of pregnancy, supporting and promoting breastfeeding for Black mothers is a key component of postpartum care, helping to lower those risks.

Solutions for improving breastfeeding rates in Black women include:

- Working actively to improve social determinants of health, creating more programs to educate Black women about breastfeeding and its benefits, and advocating for policies supporting increased maternal leave and financial aid offered to women who earn lower income, in order to further encourage breastfeeding initiation and exclusivity
- Prenatal education & increasing representation in the field of lactation.
- Ensure that programs, such as the Special Supplemental Nutrition Programs for Women, Infant and Children (WIC), continue to encourage breastfeeding initiation and exclusivity.
- Lastly, sensitivity surrounding infant feeding beliefs in the Black community needs to be addressed. We must create a trust-promoting process of engagement by giving room to a feedback loop for Black women that is based on listening to their experiences.

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Why talk about Breastfeeding Disparities?

By: Janice Campbell, MSN, RN, LCCE, IBCLC
Coordinator Parent-Child Education/ Lactation Resource Center - Mount Sinai South Nassau
Founder of We Breastfeed – Black Breastfeeding Coalition of New York

When we think about Black women in the context of lactating mothers, we also need to consider how disparities in maternity and infant outcomes remain a prevalent and significant issue in the United States. Although substantial evidence exists documenting the superiority of breastfeeding and breast milk for mothers, babies, and society, increasing breastfeeding initiation and duration rates has been a constant challenge.

What are the real barriers to successful breastfeeding among Black women? Studies show that breastfeeding struggles appear at different levels of social existence. Some women feel discouraged about breastfeeding from their family members, usually, mothers and grandmothers, who often verbalize that, we do not breastfeed, we don't have to do it. As a lactation nurse, I noticed that some mothers end up deciding between breastfeeding or not breastfeeding their babies late in pregnancy or even after the babies were born. Although health care providers can be very influential in a mother's decisions for infant feeding, education and support, very often, come too late if at all. In terms of timing, I see the gap in breastfeeding education and support during prenatal care visits, and during the crucial first three days after giving birth. Physiologically, women can achieve optimal milk production and maintenance, depending on how these women and their babies are treated during the perinatal period.

To reduce breastfeeding disparities, we must be mindful of the fact that emotional and physical trauma suffered by women at different ages of life, during pregnancy, labor & delivery, or right after giving birth, can negatively impact a mother's desire and ability to breastfeed her infant. It is also important to stage the Black woman at the center of the breastfeeding movement by applying the Black Feminism Theory in Public Health, by respecting individuals' right to self-definition, and by carefully choosing the images that we use to support and educate women regarding breastfeeding. In order to move in the right direction, we should think about race, class, gender, and unconscious bias, that way, we will have a bigger picture of every woman's unique life experiences.

We need to understand how the matrix of domination is represented in the breastfeeding scenario by systems such as family, social and health services, politics, education, and economics, impact breastfeeding decisions. The Black Feminism Theory in Public Health also highlights the need for changes to be made by organizations and individuals to create optimal levels of maternal health and well-being. According to this theory, we also need to think about different realities, roles, and relationships that may influence Black women's breastfeeding journeys. Yet we also need to bring to the table the importance of rigorous research and responsible application of evidence-based practices, and the usage of dynamic strategies to solve problems associated with Black mothers and breastfeeding. In the end, Gentry (2013) invites us to think about empowerment, activism, and social justice.

When I think about empowerment and social justice to eliminate breastfeeding disparities, I also think about the professional development of African-American women in the lactation field, which will increase the community resources, maintain our activism productively, and, as an outcome, we will see social justice. Another conceptual framework is the Life Course Theory, that helps us to understand how health disease and disparities patterns among different population happen over time. Through the lens of the Life Course Theory conceptual framework, we understand that early life exposures influence future health outcomes, therefore, breastfeeding provides several benefits for infants and children including nutritionally, immunologically, and emotionally in both short-term and long-term stages of life.

When healthcare professionals and members of society, understand the complex experience of breastfeeding among Black women, we will be able to improve infant feeding inequalities. Being able to break the cycle of maternal violence, anxiety, and depression, perpetuated by racism, will also open doors to Black women to be successful in breastfeeding and prevent them from weaning their babies from breastfeeding prematurely. There is also evidence that breastfeeding struggles can lead to postpartum depression and, to prevent this from continuing, let's bring Black women to a level of happiness through the support they receive, let's commit to providing high quality breastfeeding advice, and let's remind healthcare professionals about the nature of interpersonal interactions focused on encouragement, support, empathy, and respect.

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BLACK BREASTFEEDING WEEK HIGHLIGHTS
August 25, 2020-August 31, 2020

- Black Breastfeeding week was founded by 3 Black women: Kimberly Seals Allers, Kiddada Green, and Anayah Sangodele-Ayoko in 2013
- The initiative was started to "address the high Black infant mortality rate, high rates of diet-related disease, the lack of diversity in the lactation field, unique cultural barriers among Black women, and the desert-like food conditions in Black communities."
- The theme of Black Breastfeeding Week 2020 was Revive. Restore. Reclaim.

Though Black Breastfeeding Week is over, we hope you'll join us in continuing to educate ourselves on how to best support Black mothers.

RESOURCE CORNER

Click the links below to learn more!

- **B.L.A.C.K webinar**
- **B.L.A.C.K lactation training course**
- **Chocolate Milk: The Documentary Website**
- **Mini Documentary titled "The African American Breastfeeding Project" from Chocolate Milk: The Documentary Series**
- **Reaching Our Sisters Everywhere (ROSE)**
  - They also have virtual Baby Cafes!
- **Lactation Equity Scholarships:**
  - **Rising Tide (Applications open: July-August)**
  - **Milky Mama (Applications open: September)**
  - **NYS Breastfeeding Coalition (Applications open: January)**
  - **USLCA (Applications open: Twice a year)**
- **We Breastfeed – Black Breastfeeding Coalition of New York**
  - **Sign up for support groups here:** https://forms.gle/WjvEDgafKMLvU7L17
- **Black Maternity Wellness Collective**

Join us for BFREE Baby Cafes!

Tuesday
1:30-3pm (English)*
http://bit.ly/sshbabycafe

Tuesday
7-8pm (English)
http://bit.ly/bfreebabycafe

Thursday
10-11 am (Spanish)
11am-12pm (English)
http://bit.ly/bfreebabycafe

Prenatal Classes (Caring for two)

1st Thursday of Every Month
10 am-12pm
(English, Spanish Translation available)
http://bit.ly/bfreebabycafe

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