Equity in Breastfeeding: Where Do We Go from Here?

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Provision of accessible, high-quality, best-practice support for all people who want to breastfeed is a sound investment by society at large. As our basic scientific knowledge has grown, the evidence that justifies such investments now extends beyond the powerful breastfeeding protection against infectious diseases in early childhood to include protection against the development of chronic diseases in later adulthood. In addition, breastfeeding also offers protection to the mother against the risks of breast and ovarian cancer, hypertension, cardiovascular disease and type 2 diabetes. As a result, effective interventions to improve breastfeeding outcomes are highly cost-effective.

The evidence for the health and economic benefits of breastfeeding to families and society as a whole is now so strong that access to breastfeeding protection and support has also been framed as a human right with issues of social justice and equity becoming paramount. Social justice in breastfeeding requires fair access for all to the multilevel intersectoral infrastructure needed to protect, promote and support breastfeeding so that individuals, families and society can partake in the numerous benefits derived from breastfeeding.

Breastfeeding equity requires the involvement and participation of all people and stakeholder institutions in the support and benefits derived from breastfeeding, regardless of income, ethnicity, education, religion, country of origin, gender, sexual identity, and age, among many other dimensions of diversity within populations. Put differently, any social, economic, political, legal, or biomedical factors that prevent women from implementing their choice and right to breastfeed can be framed as a fundamental social injustice that needs to be understood through an equity lens.

As this “Equity in Breastfeeding” special issue indicates, identifying inequities in access to support for breastfeeding and finding effective ways to address them needs to move to the forefront of global and local research, policy and advocacy agendas. Health practitioners and civil society are becoming more aware of the unique health benefits that breastfeeding offers throughout the entire life course. Yet, huge disparities in breastfeeding indicators have emerged both within and between countries which require urgent analysis and action to reduce. Improving breastfeeding matters because of its enormous value in building human and social capital, health and social well being. Emerging breastfeeding equity issues challenge us to reflect on the pressing need for better strategies to ensure the benefits of breastfeeding are accessible to all through equitable support and knowledge exchange and translation. The contributions in this special issue collectively shed light on key equity dimensions and provide diverse examples of the power of an “equity lens” in framing the issues, identifying barriers to breastfeeding that demand action, and map the evidence base into dynamic multilevel systems frameworks such as the breastfeeding gear model.

This model calls for highly integrated and well-coordinated evidence-based advocacy, political will, legislation, funding, human capacity formation, breastfeeding promotion, and research and evaluation for large-scale breastfeeding programs to work for all.

Space is taken in this issue to print echoes of voices from the underserved and the under-represented, or those with power and privilege who attempt to advocate for them. Achieving breastfeeding equity demands access to funding and infrastructure, which are essential for the ability of countries to properly train the breastfeeding professional and paraprofessional work force. Long and Bugg highlight the need to address class-based access to the lactation support professions to bring them to be representative of the diverse societies they aspire to serve. This is consistent with Payne’s previous call to take on the challenge of disparities in part by finding pathways to equity in lactation consultant training.

Equity requires addressing the needs of underrepresented communities through an in depth understanding of power structures. Farrow makes clear the case for integration of inclusive knowledge about effective breastfeeding support among historically under-represented communities, with strong emphasis on LGBTQI families. Good Mojab suggests pathways through which institutional oppression can be countered through actions that expose and begin to diminish the “devastating effects” of privilege and power that hinder breastfeeding practices. Singleton, in her 2014 ILCA address reprinted in this special issue, outlines a vision for creating a “culture of breastfeeding,” founded on building equity.

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self-esteem and self-efficacy in the young, especially those growing under strong socioeconomic deprivation.15

Achieving breastfeeding equity will take political will and leadership at a high organizational level, to create an enabling policy and legislative environment to support grass-roots diversification in access to breastfeeding support.7 A common theme highlighted in each of the evidence-informed commentaries and by others before,7 is that evidence-based advocacy is key to address the breastfeeding needs of diverse, vulnerable communities. International health organizations continue to play a crucial role, creating political will through dissemination of their evidence-based approaches to protect, promote, and support breastfeeding. In this issue, Zamora and colleagues from the World Health Organization describe the importance for policy makers to have a holistic view of what is needed for breastfeeding scale-up.16 This commentary as well as four articles in this special issue highlight the importance of legislation and intersectoral collaboration to facilitate the right that women employed in the formal sector have to implement their decision to breastfeed.17-20 Collectively, these articles call for improving maternity leaves and breaks during the working days for women to breastfeed or extract their milk in appropriate and private environments. As indicated by Atabay et al, a particularly vulnerable population that has been identified as needing additional protection for implementing their breastfeeding choice is the large number of women working in the informal labor sector in low- and middle-income countries.17

There is now extensive knowledge on key obstacles preventing low-income women from practicing optimal breastfeeding behaviors and on how best to improve breastfeeding behaviors at the facility and community level.6,7,9 As this special issue illustrates, this knowledge extends to breastfeeding challenges faced by indigenous communities in diverse geographical locations,21,22 African American and other low-income communities in the United States,23-26 primiparous women,25 women in the military,27 and HIV positive women.28 Although less is known about the breastfeeding protection and support needs of the LGBTQI community, this special issue clearly illustrates that a body of evidence has emerged calling for much more research in this area, including the need to understand the process of induced lactation among lesbian mothers feeding adopted children.29 Indeed, induced lactation needs to be understood not only from the milk volume perspective but also through a better characterization of the composition of the milk being produced.30

Some specific biomedical obstacles persist and are becoming stronger, having an impact on breastfeeding inequities. These include increasing rates of cesarean section, and high prevalence of preterm delivery and low birth weight. In Latin America and the Caribbean, Boccolini et al document the very high rates of cesarean section deliveries and of milk-based prelacteal feeding, and also the fact that the risk of introducing milk-based prelacteal feeds are much stronger among the poorest versus the richest women.31 There is often no medical reason for women that deliver via cesarean section and are planning to breastfeed to introduce prelacteal feeds. Indeed, the knowledge on how to effectively support women with their breastfeeding needs after a cesarean section is well documented.31 The well-being of mothers and newborns immediately after birth and being born with a very low birth weight have been causes for concern for health care providers in the past, and as a result measures that hinder human milk feeding or breastfeeding have been implemented in medical facilities. As illustrated by Davanzo et al and Dereddy et al in this special issue, adequate in-hospital infrastructure and support allow for safe maternal–newborn skin-to-skin interactions to be performed immediately after birth (including breastfeeding). Even very low birth weight babies fed human milk end up being successfully breastfed if their mothers are provided with adequate lactation management and social support.32,33

Given how much knowledge we have, as illustrated in this special issue, an important question becomes: Why is this knowledge that can effectively address breastfeeding inequities in vulnerable subgroups not being put into widespread practice? As indicated by Zamora et al and Srinivas et al, a major part of the challenge continues to be the difficulty in many countries to rein in the efforts from infant formula companies to promote their products.10,15 This is indeed a very serious cause for concern because, as the previously described breastfeeding gear model indicates, these practices have a strong negative influence on the ability of the gears of the breastfeeding engine to function properly. This is why global implementation and enforcement of the World Health Organization Code for the ethical marketing of breast-milk substitutes should be a global priority.7,16,34

In closing, this special issue clearly illustrates that we have a wealth of knowledge that could be immediately put into practice to address breastfeeding inequities globally. Unfortunately, investments in breastfeeding scaling-up research that takes equity issues into consideration continues to be extremely limited.1 It is time we move forward with the design, implementation and evaluation of programs that address the breastfeeding needs of all.6,7,9,10 Until this work is done the world will continue to lose out on the myriad benefits from one of the most precious commodities in the public health marketplace, breastfeeding!

References


