Committing to Breastfeeding in Social Work

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This article addresses the importance of breastfeeding for the social work profession. Because breastfeeding is a critical component of maternal and child health, persistent racial and socioeconomic breastfeeding inequality is a social justice issue in need of social work commitment. Even while breastfeeding rates have been increasing in the United States there are some groups of mothers who initiate breastfeeding less frequently or have trouble with sustaining breastfeeding for recommended lengths. These mothers and their babies thus miss out on the ample benefits of this nurturing interaction. Using social work's unique disciplinary perspective and commitment to social justice, the authors place essential understanding of breastfeeding health benefits within the core values of the National Association of Social Work ethical code. The practice context for early breastfeeding intervention with mothers and families is discussed with acknowledgment of the maternal–child health focus at the root of the profession. Recognition of the potential of contemporary social work to advance breastfeeding equity through practice, scholarship, and action positions breastfeeding support activities as integral to meeting the grand challenges of the social work profession.

KEY WORDS: *breastfeeding; health disparities; health equity; health policy; social justice*

Breastfeeding, one of the first nurturing interactions between a mother and child, has long been recognized scientifically as the healthiest infant feeding method for the child (American Academy of Pediatrics [AAP], 2012; Victora et al., 2016) and more recently for the mother as well. Breastfeeding rates in the United States continue to increase, supported by public health promotion efforts and changing cultural understandings and acceptance for this embodied act of mothering. Even so, disparities remain; mothers who are poor, young, African American, or with less education are less likely to initiate and sustain breastfeeding (Allen et al., 2013).

Expert recommendations for exclusive breastfeeding for the first six months of life, with continued breastfeeding to age one or two years and beyond (AAP, 2012; World Health Organization [WHO], 2017) present idealistic goals out of reach for many mothers for whom adequate community and policy supports are not in place. This challenge, coupled with the well-intentioned public health messaging strategy that "breast is best," may inadvertently marginalize women who endorse the superiority of breast milk but are unable to provide it. A woman who wishes to breastfeed may face individual, cultural, and structural barriers, which are particularly pronounced for low-income women and women of color. Thus, breastfeeding represents a critical social justice issue warranting social work attention.

Breastfeeding is a significant aspect of sexual and reproductive health for mothers (Alzate, 2009; Wright, Bird, & Frost, 2015). Breastfeeding research is typically conducted in disciplines such as nursing, public health, and medicine. Scholars and practitioners from these fields are not necessarily trained to recognize the environmental context within which women reside or to harness the strengths that marginalized populations draw on. This article addresses the importance of breastfeeding, grounding it within core social work values articulated by the National Association of Social Workers (NASW) and demonstrating how breastfeeding support aligns with the American Academy of Social Work and Social Welfare's (AASWSW) Grand Challenges for Social Work.

HEALTH BENEFITS OF BREASTFEEDING

Breastmilk is a complete and perfect food including fatty acids, nutrients, and dynamic immunological components conferring scientifically well established, far-reaching effects on infant and child well-being (AAP, 2012; Victora et al., 2016). Breastfed infants have a strengthened immune system, even demonstrating a higher antibody response to vaccines

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(Silfverdal, Ekholm, & Bodin, 2007). They are less prone to respiratory infection, have a decreased probability of sudden infant death syndrome (AAP, 2012) and postneonatal mortality (Khan, Vesel, Bahl, & Martines, 2015), and are less susceptible to allergies and eczema (Moss & Yeaton, 2014). Diarrhea, the second leading cause of death in children under the age of five, is considerably less common among breastfed infants due to the high levels of lactose in breastmilk that supports growth of healthful bacteria in the gut (Andreas, Kampmann, & Le-Doare, 2015; Turin & Ochoa, 2014). Endorphins in breastmilk contribute to a higher pain tolerance, increasing an infant's ability to combat the negative effects of stress and potential hardship (Harrison et al., 2014). Benefits of breastfeeding continue into childhood with breastfed children demonstrating lowered risks of acute leukemia (AAP, 2012); decreased likelihood of developing obesity or diabetes; and fewer psychological, behavioral, and learning problems (Binns, Lee, & Low, 2016). Many of these outcomes are a direct result of a decrease in the human stress hormone cortisol during critical periods of infancy related to attachment that stems from breastfeeding and direct skin-to-skin contact (Neelon, Stroo, Mayhew, Maselko, & Hoyo, 2015).

Benefits of breastfeeding for the mother have also been established (AAP, 2012). After giving birth, oxytocin released during a newborn's first latch initiates contractions that force the uterus back to its original size, leading to less blood loss after birth (Abedi, Jahanfar, Namvar, & Lee, 2016). Calcium is absorbed at a higher rate when a woman is lactating, contributing to stronger bones and a decreased propensity for osteoporosis. Women who have ever breastfed are also less likely to develop breast or uterine cancer (AAP, 2012). According to Mezzacappa (2004), breastfeeding is associated with an attenuated sympathetic cardiac nervous system response to stress, an increased parasympathetic nervous system modulation, decreased neuroendocrine response, and decreased negative mood. Breastfeeding mothers report feeling less life stress and depression and enhanced physical and mental health than nonbreastfeeding mothers (AAP, 2012). Furthermore, the release of oxytocin promotes warm maternal behavior and attachment to the infant, leading to positive parenting practices (Heinrichs, Neumann, & Ehlert, 2002).

BREASTFEEDING AND POLICY

Women do not breastfeed within an isolated context; rather, they live within larger social and structural contexts that affect their breastfeeding behavior. Although breastfeeding is often presented as natural and instinctual, many women struggle with establishing and maintaining a breastfeeding relationship with their infants. When problems arise, they need active support for breastfeeding (WHO, 2017). Such support is often provided by a lactation counselor, a physician, or a pediatrician (Amir, 2014). Thus, for many women, their breastfeeding relationship is mediated by their access to medical care, their trust in medical providers, and their care provider's knowledge and attitudes about breastfeeding. If a care provider is ill informed or has a negative attitude about breastfeeding (Mass, 2015; Szucs, Miracle, & Rosenman, 2009), or if a mother has reason to mistrust health authorities, initiation and duration of breastfeeding may be affected. Although the excellent supplemental nutrition support program for pregnant mothers and young children, Women, Infants, and Children (WIC) effectively supports breastfeeding through information and food packages (Panzera et al., 2017), the program also provides free formula for the infants of many of the nation's low-income families, which may undermine breastfeeding (Jensen & Labbok, 2011; WHO, 2017).

Given the relatively inadequate family leave policies in the United States, many women, particularly low-income women, are returning to work before their milk supply is well established. Work concerns are associated with lower levels of breastfeeding initiation and shorter breastfeeding durations (Ogbuanu, Glover, Probst, Liu, & Hussey, 2011). For many women returning to low-wage jobs, taking breaks to express breastmilk may be stigmatized and discouraged, making breastfeeding difficult if not impossible (Rojjanasrirat & Sousa, 2010; WHO, 2017). Prioritization of protection for breastfeeding in our health policies is critical for protecting a woman's right and ability to breastfeed (Bruk-Lee, Albert, & Stone, 2016).

The Patient Protection and Affordable Care Act (ACA) has provisions in place to do just this, ensuring that women have access to breastfeeding support and breast pumps and working to legally protect a woman's time and space to breastfeed in the workplace (Drago, Hayes, & Yi, 2011). The future of the ACA is uncertain, but social workers

should continue to advocate for the protection of breastfeeding rights and ensure that low-income women have equitable access to benefiting from these breastfeeding policy provisions (Hawkins, Noble, & Baum, 2017). Social workers can empower women to be aware of their legal breastfeeding rights (Hurst, 2012), connect them with breastfeeding counselors, and help them secure access to a breast pump, as needed. This work is aligned with social work core values and was historically within the scope of social work practice in maternal and child health (Combs-Orme, 1988).

BREASTFEEDING AND THE CORE VALUES OF SOCIAL WORK

Breastfeeding support fits within the profession's primary mission to "enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (National Association of Social Workers [NASW], 2017, para. 1). Ethical emphases of the social work profession are summarized in six core values that guide social work practice: service, social justice, importance of human relationships, dignity and worth of the person, integrity, and competence.

Service

Social workers seek to help people in need and address social problems (NASW, 2017). Given the benefits of breastfeeding, differential rates of breastfeeding based on race and socioeconomic status reveal pervasive injustice. Breastfeeding disparity is a social problem worthy of targeted attention. Social work researchers and practitioners are needed to uncover structural arrangements and other factors impeding disadvantaged women's breastfeeding success and to assist them in initiating and sustaining breastfeeding, should they so choose.

The imperative for social work to address this health inequity is not a new concern for our profession; maternal and child health was once a central priority for social work (Combs-Orme, 1990; Uehara et al., 2015). In fact, due in large part to the efforts of social workers beginning in the progressive era, the United States saw a significant, and lasting reduction in infant mortality rates (Combs-Orme, 1988). The social work promotion of breastfeeding was an integral part of these efforts. Settlement house social workers Julia Lathrop, Florence Kelley, and Grace Abbott forged a concern for maternal and child health improvement and launched the Children's Bureau (Sorensen, 2008). Kelley's policy expertise contributed to the passage of the Sheppard-Towner Maternity and Infancy Protection Act in 1921. Just as these pioneers once understood maternal and infant health to be a keystone of the health of our nation, present-day social workers can also engage breastfeeding as a health practice with a cascade of proven benefits.

Social Justice

Social workers pursue social change on behalf of vulnerable and oppressed groups of people, striving to ensure access to needed information, services, and resources to address injustice (NASW, 2017). Low-income women have lower rates of breastfeeding as do African American women. For African American women, this disparity persists across all socioeconomic levels (Allen et al., 2013; McDowell, Wang, & Kennedy-Stephenson, 2008). It would be easy to dismiss this as the result of personal preference, were it not for the contrast between breastfeeding intention rates during the prenatal period and breastfeeding initiation and continuation rates in the postpartum period. Lee et al. (2005) found that more low-income African American women intended to breastfeed in the prenatal period than their non-Hispanic, white counterparts, but Allen et al. (2013) reported that fewer African American women initiate breastfeeding in the hospital and have a lower average duration of breastfeeding.

Personal, cultural, and structural breastfeeding barriers during pregnancy and the postpartum period affect breastfeeding among African American women (Reeves & Woods-Giscombe, 2015). These barriers are an outgrowth of the racialized history of the United States, especially the marginalization and oppression of African American women related to reproduction and maternal health (Roberts, 2016). African American women were used as wet nurses during slavery (Golden, 1996). Medical experimentation on black bodies without consent has multiple examples, from the Tuskegee syphilis study to the use of Henrietta Lacks's genetic material (Skloot, 2011). More recently, while eugenics laws were in effect, numerous involuntary sterilizations were committed against African American women, continuing into the 1970s (Roberts, 2016). Furthermore, medical associations worked diligently to

undermine and eradicate the practice of midwifery in African American communities (Goode & Katz Rothman, 2017). All of this reflects a deeply troubling history of suffering at the hands of the medical establishment, particularly related to reproduction, throughout American history (Russell, 2016). African Americans have reasons for a deep and enduring mistrust of the medical establishment, but this attitude negatively influences health-seeking behaviors and compliance with physician recommendations (Randall, 1995).

Emerging epigenetic research suggests that both historical and present-day racial injustices affect human health. Geronimus, Hicken, Keene, and Bound (2006) demonstrated that coping with toxic stressors associated with race and racism can result in negative impacts on health, as measured by allostatic load. Allostatic loads are measures of cumulative wear and tear on body systems resulting from stress, and African American women have demonstrated the highest allostatic loads of all groups, including higher allostatic loads than African American men. Because black mothering matters, more research is needed to determine how allostatic load affects breastfeeding and whether breastfeeding can mitigate some of the cumulative negative impacts of toxic stress.

Importance of Human Relationships

A child is born with the instincts to connect to other humans. One of the earliest opportunities for connection happens within moments following birth, when the mother and child first see each other face-to-face. WHO (2017) endorses breastfeeding initiation within the first hour postbirth, which often happens without intervention as newborns are elegantly programmed to respond to the breast just minutes after birth. Without aid, the newborn can successfully find the breast and latch on, initiating a symbiotic relationship with long-lasting benefits (Klaus, 1998). With this, the act of breastfeeding often becomes a central part of establishing a nurturing relationship between mother and child.

Breastfeeding over the early weeks can assist a mother in reading the unique signals of hunger or distress that her baby communicates. Breastfeeding empowers her to comfort and calm her baby. It is a method of infant care with profound biopsychosocial–spiritual synergies. As the mother suckles the infant and holds the child skin to skin, the baby is assisted with regulation of distress. The milk let-down reflex, prompted by the "love hormone" oxytocin in the mother's body, helps her calm and relax as well (Heinrichs et al., 2002). A breastfeeding dyad that has established a successful breastfeeding rhythm move together as partners in this duet of attachment, grounding and soothing each other.

A majority of mothers in studies exploring maternal breastfeeding attitudes perceive breastfeeding as a way to facilitate bonding (May et al., 2015; McCann, Baydar, & Williams, 2007), and breastfeeding is culturally associated with positive enactment of the mothering role. What happens when the ideal beginning does not happen? Breastfeeding is a natural part of the childbearing cycle, yet it is also a behavior that a mother needs to learn and persist in within the context of her other relationships (WHO, 2017). When breastfeeding goals are not met, a mother may be disappointed, even self-blaming, with her sense of efficacy as a mother affected. Thus, breastfeeding can facilitate human relationships, but when not adequately supported, it can also strain relationships or become a source of frustration and disappointment.

Dignity and Worth of the Person

Belief in the dignity and worth of each person in every complicated intimate family situation is needed to respect self-determination regarding breastfeeding. This core responsibility sensitizes the social worker to listen with compassion to clients as the experts on their own lived experiences. Emphasis on the importance of breastfeeding may raise concerns about excluding parents who do not want to breastfeed, cannot breastfeed, or wean early for any number of reasons. Breastfeeding is not an inclusive option for everyone; biologically, it is most available for the woman who gives birth to the child. Women's experiences with lactation vary. For example, some women who have experienced sexual trauma may find breastfeeding uncomfortable (Núñez, 2016). Other women find the time-consuming nature and physical demands of breastfeeding overwhelming (Elfgen, Hagenbuch, Gorres, Block, & Leeners, 2017).

From adoption and surrogacy scenarios to including fathers as primary caregivers, social workers can assist clients with informed choices regarding breastfeeding and the provision of human milk. People may individually ascribe meaning to their acts of breastfeeding that help them navigate the profound transitions required of them with a child's entrance into the world. Birth mothers placing an infant for adoption may be comforted by breastfeeding for a brief time. Open adoptions may facilitate the sharing

of pumped milk. Nonbiological mothers sometimes seek to stimulate the production of their own milk supply to assist with bonding with a child. This is physically possible and regularly achieved by adoptive mothers as well as mothers receiving a child from a surrogate birth arrangement (Newman & Goldfarb, 2015). Even fathers who parent without a birth mother may have an interest in banked breastmilk.

Accurate knowledge of breastfeeding is relevant for practicing social workers in instances where breastfeeding may be contraindicated for medical reasons. Women who are undergoing cancer treatment, are taking certain psychotropic medications, are HIV-positive, or have other active infectious states may be medically advised against breastfeeding (AAP, 2012). In addition, for women using illegal drugs during or after pregnancy, breastfeeding may be inadvisable. Social workers must be mindful of such advice and assist the mother with information regarding expressing milk if the concern is short-term, so that return to breastfeeding could occur when medically safe to do so (AAP, 2012).

It is the role of the social worker to respect the woman's self-determination, listen to her preferences regarding her infant feeding method, and—if she is open to discussion—her rationale behind that decision. Breastfeeding is best for the infant, but it is not necessarily the best for every woman. By being open and nonjudgmental, a social worker can create the space to discuss a woman's infant feeding choice and ensure that she understands the benefits of breastfeeding, helping to address any barriers to breastfeeding if the woman so wishes.

Integrity

Social workers must act honestly and in a trustworthy manner, upholding the values of the profession (NASW, 2017). Maintaining cultural competence and respect for diversity is an important ethical responsibility toward clients. Moral judgment regarding good mothering can easily be tied to breastfeeding. Mothers who do not breastfeed can still bond with their children and be good mothers. But whereas not all mothers should be expected to breastfeed, neither should any mother be assumed to be incapable or unworthy of breastfeeding and denied access to breastfeeding services because of such perception. Social workers practice each day with nonideal family situations, but breastfeeding may be helpful even in those situations. For example, if a mother who has struggled with addiction can stop using, breastfeeding may still be an option for her child. Infants born with neonatal abstinence syndrome are able to breastfeed, and the receipt of breastmilk results in a reduction of their withdrawal symptoms (Pritham, 2013). A mother's breastfeeding may augment her own recovery, subvert the stigma of having exposed the baby to drug use, and help her bond with the baby (Mallory & Watson, 2016).

Competence

Social workers are expected to practice competently within their areas of expertise and to continue to develop and enhance their professional knowledge for effective practice (NASW, 2017). Generalist social work practice competence for breastfeeding includes knowing breastfeeding recommendations and common concerns of breastfeeding mothers, and a willingness to collaborate with lactation specialists and others to prioritize and preserve breastfeeding. Experts recommend exclusive breastfeeding for the first six months (AAP, 2012; WHO, 2017). The two most common problems experienced by novice breastfeeding mothers in the early weeks postpartum are nipple or breast pain and concern over a low milk supply (Amir, 2014). Report of these concerns from a mother means that she should be connected with a knowledgeable breastfeeding mother, lactation consultant, or breastfeeding support group as soon as possible to preserve breastfeeding. Breast pain indicates a poor latch, physical problems such as infant tongue-tie, or maternal breast infections. Many mothers doubt their milk supply when they cannot see the amount that the baby is getting; actual low milk supply can be reversed by allowing the infant to continue to suckle to stimulate the body to produce more milk.

GRAND CHALLENGES ADDRESSED BY BREASTFEEDING

AASWSW has identified 12 Grand Challenges for Social Work, aiming to focus social work intention and direct targeted efforts to address and remedy disparities and injustices (Uehara et al., 2013). The grand challenges provide a mechanism through which the field can organize, galvanize, and collectively advance the profession (Bent-Goodley, 2016). The grand challenges are categorized into three overarching areas: (1) the promotion of individual

and family well-being, (2) strengthening of the social fabric, and (3) the creation of a just society. Investing in the pursuit of breastfeeding equity has the potential to both promote individual and family well-being and create a more just society. Within the 12 challenges, breastfeeding is directly related to the initiative to close the health gap and the achievement of equal opportunity and justice.

Closing the Health Gap

Breastfeeding is associated with a reduction of risk in many arenas that constitute the health gap between white people and people of color. It is associated with both short- and long-term psychological and physiological benefits for the mother–infant dyad and can serve as an upstream intervention, because the health benefits extend across both of their lifetimes. Although it alone cannot address the multiple social determinants of health that affect health inequity, breastfeeding may serve as a mediating factor, decreasing poor health outcomes that are pervasive in low-income communities of color. For example, in the immediate postpartum period, breastfeeding reduces an infant's risk of dying in the first year of life (Khan et al., 2015). This is particularly noteworthy as the infant mortality rate for African Americans is more than twice the rate for white Americans (Kochanek, Murphy, Xu, & Tejada-Vera, 2016). In short, breastfeeding is a critical mechanism through which social work can pursue health equity for both infants and their mothers (White, 2014).

Achieving Equal Opportunity and Justice

Social work is a discipline that prioritizes the identification and remediation of social injustices, and breastfeeding is one component of maternal and child health inequity. Like other health disparities, breastfeeding is directly and indirectly affected by interpersonal and structural discrimination. For example, Gee, Zerbib, and Luckett (2012) found that African American women receive less in-hospital lactation support than their white counterparts following birth. The availability of community support at hospital discharge may differ by the mother's race as well. Evans, Labbok, and Abrahams (2011) demonstrated that WIC clinics serving higher proportions of African American women had more limited and less intensive breastfeeding services than clinics predominantly serving white and Hispanic women. Even when services are available, they may not be culturally responsive, failing to recognize the unique barriers that women of color may face in breastfeeding (Reeves & Woods-Giscombe, 2015).

Suppressed breastfeeding rates among African American women in particular are part of this nation's historical and present-day legacy of racism, structural violence, and oppression (Freeman, 2015). As such, we have a moral and ethical obligation to acknowledge this history, uncover ways that injustice is still being perpetrated, and work systematically to dismantle our oppressive reproductive practices. Given the professional values of social work, and the unique, person-centered disciplinary lens, mobilizing and engaging social work professionals around the issue of breastfeeding could make great strides in achieving equal opportunity and justice.

Role of Social Work in Research: Interdisciplinary Breastfeeding Collaborations

The Grand Challenges for Social Work encourage innovative, collaborative work (Uehara et al., 2013). Breastfeeding represents an arena where social work must join forces with other disciplines. The unique perspective that social work brings to the interdisciplinary table, or our scholarly capital (Barth, Gilmore, Flynn, Fraser, & Brekke, 2014), includes the person-in-environment framework, the strengths-based lens, and ready recognition of multiple social–ecological factors. Using the strengths-based approach in breastfeeding scholarship can move beyond the identification of breastfeeding barriers toward understanding the factors that support resilience in achieving breastfeeding goals. Until the circumstances within which women are breastfeeding are considered, research and interventions will inherently be insufficient. Breastfeeding decision making is made within a woman's social support network and work environment, while weighing child care availability and other contextual factors. This understanding of breastfeeding as a health behavior that is nested within varying social–ecological levels allows for a more comprehensive understanding of a mother's breastfeeding support needs. Using a strengths-based lens is critical. Breastfeeding research has long been framed as trying to understand why deficient women make poor health choices in the face of all evidence to the contrary. A social work approach to breastfeeding is unique in that it explicitly calls for identifying sources of strength and recognizing resilience in breastfeeding women.

Role of Social Work in Practice

Hull House and Children's Bureau practitioners pioneered the social work role in maternal and child health (Combs-Orme, 1990). Their policy, research, and practice efforts to address infant mortality contributed to a 92 percent reduction in infant deaths in the 20th century (Combs-Orme, 1988), representing a stunning accomplishment of the social work profession (Uehara et al. 2015). Given the 21st century's research demonstrating the impact of social determinants of health on health outcomes, our discipline would be remiss in not preparing social work practitioners to reengage that maternal–child health work. Social work practitioners can support breastfeeding at a number of junctures. Social workers can advocate on behalf of breastfeeding women for more inclusive breastfeeding-friendly spaces and maternal leave policies that support women's efforts to breastfeed in the critical postpartum period. Social workers can directly engage pregnant and parenting women throughout the perinatal period through programs such as WIC, early intervention home visiting programs, in hospitals, and in medical offices working as behavioral health specialists. During these interactions social workers can support breastfeeding mothers and work collaboratively within families to address barriers to breastfeeding.

Understanding the context within which women are breastfeeding is critical to determine how best to provide support. This includes recognition of micro, mezzo, and macro factors affecting breastfeeding and intentional efforts to improve the chances that a mother can successfully maintain breastfeeding. It is easy to imagine that sustaining breastfeeding is difficult, if not impossible, when a young mother, with few family supports and little money, is sent home from hospital in a taxi alone with her newborn, to return to a precarious home base. Should breastfeeding problems arise, this mother may not have a support network knowledgeable of breastfeeding, and she may not have access to or be aware of professional breastfeeding resources. If she has not seen breastfeeding modeled in public, she may feel alone and uncertain about venturing out of the house, doubting that others welcome the sight of her breastfeeding. She may need to return to work earlier than her more affluent counterparts, without an efficient breast pump, which is necessary to maintain milk supply. Social workers can be part of the solution for such mothers. Support groups and early intervention community-centered programs counter isolation (Pérez-Escamilla, 2015). Peer counseling can provide mother-to-mother phone and home visit support. When programs are responsive to the conditions within which women live, and positive relationships and supportive networks are nurtured to celebrate motherhood and assist breastfeeding, breastfeeding itself can become part of reknitting the fabric of sisterhood, family, and community.

CONCLUSION

The Grand Challenges for Social Work compel us to tackle some of society's toughest problems (Uehara et al., 2015); committing to breastfeeding will help affect entrenched health equity issues. Building on the core values of our discipline, social workers can empower women to achieve their breastfeeding goals, contribute to breastfeeding research, and help reduce health inequities across the life course for at-risk populations. If we do this, we will bring energy to achieving health equity and create a more inclusive and just society through attention to the health and well-being of mothers and children. SW

REFERENCES

Abedi, P., Jahanfar, S., Namvar, F., & Lee, J. (2016). Breastfeeding or nipple stimulation for reducing postpartum haemorrhage in the third stage of labour. *Cochrane Database of Systematic Reviews, 2016*(1), 1–38. doi:10.1002/14651858.CD010845.pub2

Allen, J. A., Li, R., Scanlon, K. S., Perrine, C. G., Chen, J., Odom, E., & Black, C. (2013). Progress in increasing breastfeeding and reducing racial/ethnic differences—United States, 2000-2008 births. *Morbidity and Mortality Weekly Report, 62*(5), 77–80.

Alzate, M. M. (2009). The role of sexual and reproductive rights in social work practice. *Affilia, 24*, 108–119. doi:10.1177/0886109909331695

American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk [Policy statement]. *Pediatrics, 129*(3), e827–e841. doi:10.1542/peds.2011-3552

Amir, L. H. (2014). Managing common breastfeeding problems in the community. *British Medical Journal, 348*, g2954. doi:10.1136/bmj.g2954

Andreas, N. J., Kampmann, B., & Le-Doare, K. M. (2015). Human breast milk: A review on its composition and bioactivity. *Early Human Development, 91*, 629–635.

Barth, R. P., Gilmore, G. C., Flynn, M. S., Fraser, M. W., & Brekke, J. S. (2014). The American Academy of Social Work and Social Welfare. *Research on Social Work Practice, 24*, 495–500. doi:10.1177/1049731514527801

Bent-Goodley, T. B. (2016). Social work's grand challenges: Mobilizing the profession [Editorial]. *Social Work, 61*, 197–198. doi:10.1093/sw/sww035

Binns, C., Lee, M., & Low, W. L. (2016). The long-term public health benefits of breastfeeding. *Asia Pacific Journal of Public Health, 28*(1), 7–14.

Bruk-Lee, V., Albert, D., & Stone, K. L. (2016). Lactation and the working woman: Understanding the role of organizational factors, lactation support, and legal policy in promoting breastfeeding success. In C. Spitzmueller & R. A. Matthews (Eds.), *Research perspectives on work and the transition to motherhood* (pp. 217–239). Cham, Switzerland: Springer International.

Combs-Orme, T. (1988). Infant mortality and social work: Legacy of success. *Social Science Review, 62*(1), 83–102.

Combs-Orme, T. (1990). *Social work practice in maternal and child health*. New York: Springer.

Drago, R., Hayes, J., & Yi, Y. (2011). *Better health for mothers and children: Breastfeeding accommodations under the ACA*. Washington, DC: Institute for Women's Policy Research.

Elfgen, C., Hagenbuch, N., Gorres, G., Block, E., & Leeners, B. (2017). Breastfeeding in women having experienced childhood sexual abuse. *Journal of Human Lactation, 33*(1), 119–127.

Evans, K., Labbok, M., & Abrahams, S. W. (2011). WIC and breastfeeding support services: Does the mix of services offered vary with race? *Breastfeeding Medicine, 6*, 401–406.

Freeman, A. (2015). "First food" justice: Racial disparities in infant feeding as food oppression. *Fordham Law Review, 83*, 3053–3087.

Gee, R. E., Zerbib, L. D., & Luckett, B. G. (2012). Breastfeeding support for African-American women in Louisiana hospitals. *Breastfeeding Medicine, 7*, 431–435.

Geronimus, A. T., Hicken, M., Keene, D., & Bound, J. (2006). "Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. *American Journal of Public Health, 96*, 826–833.

Golden, J. (1996). *A social history of wet nursing in America: From breast to bottle*. Cambridge, UK: Cambridge University Press.

Goode, K., & Katz Rothman, B. (2017). African-American midwifery, a history and a lament. *American Journal of Economics and Sociology, 76*(1), 65–94.

Harrison, D., Reszel, J., Bueno, M., Sampson, M., Shah, V. S., Taddio, A., et al. (2014). Breastfeeding for procedural pain in infants beyond the neonatal period. *Cochrane Database of Systematic Reviews, 2014*(8), 1–9. doi:10.1002/14651858.CD011248.pub2

Hawkins, S. S., Noble, A., & Baum, C. (2017). Effect of the Affordable Care Act on disparities in breastfeeding: The case of Maine. *American Journal of Public Health, 107*, 1119–1121.

Heinrichs, M., Neumann, I., & Ehlert, U. (2002). Lactation and stress: Protective effects of breastfeeding in humans. *Stress, 5*, 195–203.

Hurst, C. G. (2012). Sexual or maternal breasts? A feminist view on the contested right to breastfeed in public. In P. Hall Smith, B. L. Hausman, & M. Labbok (Eds.), *Beyond health, beyond choice* (pp. 333–347). Rutgers, NJ: Rutgers University Press.

Jensen, E., & Labbok, M. (2011). Unintended consequences of the WIC formula rebate program on infant feeding outcomes: Will the new food packages be enough? *Breastfeeding Medicine, 6*, 145–149.

Khan, J., Vesel, L., Bahl, R., & Martines, J. C. (2015). Timing of breastfeeding initiation and exclusivity of breastfeeding during the first month of life: Effects on neonatal mortality and morbidity—A systematic review and meta-analysis. *Maternal and Child Health Journal, 19*, 468–479. doi:10.1007/s10995-014-1526-8

Klaus, M. (1998). Mother and infant: Early emotional ties. *Pediatrics, 102*(Suppl. E1), 1244–1246.

Kochanek, K. D., Murphy, S. L., Xu, J. Q., & Tejada-Vera, B. (2016). *Final data for 2014*. Hyattsville, MD: National Center for Health Statistics.

Lee, H. J., Rubio, M. R., Elo, I. T., McCollum, K. F., Chung, E. K., & Culhane, J. F. (2005). Factors associated with intention to breastfeed among low-income, inner-city pregnant women. *Maternal and Child Health Journal, 9*, 253–261.

Mallory, A., & Watson, C. (2016, November). *The NAS epidemic: Preserving the dignity and worth of mother and baby*. Workshop conducted at 62nd Annual Program Meeting of Council on Social Work Education, Atlanta.

Mass, S. (2015). Educating the obstetrician about breastfeeding. *Clinical Obstetrics and Gynecology, 58*, 936–943.

May, L., Borger, C., McNutt, S., Harrison, G., Weingield, N., Macallum, C., & Montaquila, J. (2015). *WIC ITFPS-2 infant report: Intention to breastfeed*. Rockville, MD: Westat.

McCann, M., Baydar, N., & Williams, R. (2007). Breastfeeding attitudes and reported problems in a national sample of WIC participants. *Journal of Human Lactation, 23*, 314–324.

McDowell, M. M., Wang, C. Y., & Kennedy-Stephenson, J. (2008). Breastfeeding in the U.S.: National health and nutrition examination surveys, 1999-2006. *NCHS Data Brief, 5*, 1–8.

Mezzacappa, E. S. (2004). Breastfeeding and maternal stress response and health. *Nutrition Reviews, 62*(7), 261–268.

Moss, B. G., & Yeaton, W. H. (2014). Early childhood healthy and obese weight status: Potentially protective benefits of breastfeeding. *Maternal and Child Health Journal, 18*, 1224–1232.

National Association of Social Workers. (2017). *Code of ethics of the National Association of Social Workers*. Retrieved from http://www.socialworkers.org/pubs/code/code.asp

Neelon, S.E.B., Stroo, M., Mayhew, M., Maselko, J., & Hoyo, C. (2015). Correlation between maternal and infant cortisol varies by breastfeeding status. *Infant Behavior and Development, 40*, 252–258.

Newman, J., & Goldfarb, L. (2015). *Newman-Goldfarb protocols for induced lactation*. Retrieved from http://www.asklenore.info/breastfeeding/induced_lactation/protocols4print.shtml

Núñez, A. E. (2016). *Good intention is not enough*: Intentional action to address health disparities. *Breastfeeding Medicine, 11*, 398–405. doi:10.1089/bfm.2016.0138

Ogbuanu, C., Glover, S., Probst, J., Liu, J., & Hussey, J. (2011). The effect of maternity leave length and time of return to work on breastfeeding. *American Academy of Pediatrics, 127*, e1414–e1427.

Panzera, A. D., Castellanos-Brown, K., Paolicelli, C., Morgan, R., Potter, A., & Berman, D. (2017). The impact of federal policy changes and initiatives on breastfeeding initiation rates and attitudes toward breastfeeding among WIC participants. *Journal of Nutrition Education and Behavior, 49*(7, Suppl. 2), 207–211.

Pérez-Escamilla, R. (2015). Equity in breastfeeding: Where do we go from here? *Journal of Human Lactation, 31*(1), 12–14.

Pritham, U. A. (2013). Breastfeeding promotion for management of neonatal abstinence syndrome. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 42*, 517–526.

Randall, V. R. (1995). Slavery, segregation and racism: Trusting the health care system ain't always easy: An African American perspective on bioethics. *Saint Louis University Public Law Review, 15*, 191–235.

Reeves, E. A., & Woods-Giscombe, C. L. (2015). Infant-feeding practices among African American women: Social-ecological analysis and implications for practice. *Journal of Transcultural Nursing, 26*, 219–226.

Roberts, D. E. (2016). *Killing the black body: Race, reproduction, and the meaning of liberty* (2nd ed.). New York: Vintage Books.
Rojjanasrirat, W., & Sousa, V. D. (2010). Perceptions of breastfeeding and return to work or school among low-income pregnant women. *Journal of Clinical Nursing, 19*, 2014–2022.
Russell, C. A. (2016). Questions of race in bioethics: Deceit, disregard, disparity, and the work of decentering. *Philosophy Compass, 11*(1), 43–55.
Silfverdal, S. A., Ekholm, L., & Bodin, L. (2007). Breastfeeding enhances the antibody response to Hib and Pneumococcal serotype 6B and 14 after vaccination with conjugate vaccines. *Vaccine, 25*, 1497–1502.
Skloot, R. (2011). *The immortal life of Henrietta Lacks*. New York: Broadway Books.
Sorensen, J., & Sealander, J. (Eds.). *The Grace Abbott reader*. Lincoln: University of Nebraska Press.
Szucs, K. A., Miracle, D. J., & Rosenman, M. B. (2009). Breastfeeding knowledge, attitudes, and practices among providers in a medical home. *Breastfeeding Medicine, 4*(1), 31–42.
Turin, C. G., & Ochoa, T. J. (2014). The role of maternal breast milk in preventing infantile diarrhea in the developing world. *Current Tropical Medicine Reports, 1*(2), 97–105.
Uehara, E., Barth, R. P., Catalano, R. F., Hawkins, J. D., Kemp, S. P., Nurius, P. S., et al. (2015). *Identifying and tackling Grand Challenges for Social Work* (Working paper No. 3). Columbia, SC: American Academy of Social Work and Social Welfare.
Uehara, E., Flynn, M., Fong, R., Brekke, J., Barth, R. P., Coulton, C., & Walters, K. (2013). Grand Challenges for Social Work. *Journal of the Society for Social Work Research, 4*(3), 165–170.
Victora, C. G., Bahl, R., Barros, A. J., França, G. V., Horton, S., Krasevec, J., et al. (2016). Breastfeeding in the 21st century: Epidemiology, mechanisms, and lifelong effect. *Lancet, 387*(10017), 475–490.
White, J. A. (2014). Equity and social justice within African American breastfeeding approaches. *Breastfeeding Medicine*. Online publication. doi:10.1089/bfm.2014.0075
World Health Organization. (2017, August). *Ten facts on breastfeeding*. Retrieved from http://www.who.int/features/factfiles/breastfeeding/en/
Wright, R. L., Bird, M., & Frost, C. J. (2015). Reproductive health in the United States: A review of the recent social work literature. *Social Work, 60*, 295–304.

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