Pandora's Box Is Already Open

Answering the Ongoing Call to Dismantle Institutional Oppression in the Field of Breastfeeding

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The diversity of our world is staggering. Sex, gender, gender identity and expression, sexual orientation, class, language, race, color, culture, ethnicity, nationality, marital status, geography, immigration, generation, religion, ability, size, and age are among the characteristics that make people similar to and different from each other. Systems of oppression and its concomitant, unearned privilege, corrupt these characteristics into fictitious markers of worth that determine the degree of access to power and opportunities afforded to individuals and their communities. Systems of privilege/oppression are a global and local reality.[1] They vary in their exact nature from one place and time to another and are the cause of social inequities of all kinds, including in the field of breastfeeding.

The call to eliminate racial and other social inequities in breastfeeding rates, access to breastfeeding support, and access to the International Board Certified Lactation Consultant (IBCLC) credential is increasingly voiced and heard by individuals and organizations in the field of breastfeeding.[2-8] In the United States, for example, the 2013 "Inequity in Breastfeeding Support Summit" addressed the effect of institutional racism, power, and white privilege as well as heterosexism and cisgenderism on breastfeeding and maternal-infant health. In 2014, the International Board of Lactation Consultant Examiners, International Lactation Consultant Association, and Lactation Education, Accreditation and Approval Review Committee co-hosted the "Lactation Summit" to address a broad range of inequities—including those resulting from racism, classism, heterosexism, cisgenderism, and nationalism—within the lactation consultant profession. Also in 2014, the US Breastfeeding Committee's Fifth National Breastfeeding Coalitions Conference included an emphasis on decreasing racial inequity in access to breastfeeding support. These efforts join the monumental work of many other US-based organizations such as the African American Breastfeeding Network, Black Mothers' Breastfeeding Association, International Center for Traditional Childbearing, Mahogany Moms Breastfeeding Coalition, Native American Breastfeeding

Coalition of Washington, Oregon Inter-Tribal Breastfeeding Coalition, Reaching Our Sisters Everywhere, and Uzazi Village (Note 1).

Eliminating inequity in the field of breastfeeding requires that we understand that racism and all other systems of privilege/oppression exist at various levels: personally mediated, internalized, institutional, and systemic.[9,10] Personally mediated oppression is conscious or unconscious prejudice and discrimination by individuals who hold power because of their membership in a dominant social group. Internalized oppression occurs when members of a stigmatized social group absorb pervasive negative messages about their value and capabilities while growing up and living in an oppressive society; internalized superiority occurs when members of a dominant social group absorb pervasive positive messages. Institutional oppression is inequitable access to products, services, opportunities, and power based on sex, race, class, gender identity or expression, sexual orientation, and other characteristics. It is encoded—intentionally or unintentionally—in institutional policies, procedures, practices, customs, and structures. Systemic oppression is the inescapable web created by past and current institutional oppression occurring across all sectors and within the very structure of a society.

The existence of institutional oppression in the field of breastfeeding is not a matter of conjecture. For example, research at the national level in the United States documents significant racial inequity in breastfeeding initiation and duration rates, in access to the IBCLC credential, and in implementation of in-hospital strategies supportive of breastfeeding. The percentages of non-Hispanic white mothers and black mothers breastfeeding in the United States at birth is 75.2% and 58.9%, at 6 months is 46.6% and 30.1%, and at 12 months is 24.3% and 12.5%, respectively.[11] Chetwynd et al's[12] 2011 national survey of insurance reimbursement revealed the racial/ethnic demographics of US IBCLCs to be 87.1% non-Hispanic white, 1.6% non-Hispanic black, 4.7% Hispanic, 1.4% Asian/Pacific Islander, 0.8% American Indian/Native Alaskan, 0.7% mixed race, and 3.7% other. Racial inequity in access to the IBCLC credential is evident when these data are compared with population demographics from the 2011 US Census: 63.4% non-Hispanic white, 12.3% non-Hispanic black, 14.7% Hispanic, 5% Asian/Pacific Islander, 5% American Indian/Native Alaskan, and 2.3% 2 or more races.[13] In a national study, the implementation rate was significantly less for 5 out of 10 recommended maternity care practices supportive of breastfeeding among US facilities in zip code areas in which the percentage of black residents is greater than 12.2% (the average percentage of black residents in the US during 2007-2011) compared with facilities in zip code areas in which the percentage of black residents is less than or equal to 12.2%: early initiation of breastfeeding (46.0% vs 59.9%), limited use of breastfeeding supplements (13.1% vs 25.8%), rooming-in (27.7% vs 39.4%), limited use of pacifiers (30.5% vs 37.9%), and postdischarge support (23.9% vs 29.9%).[14] Listening to Mothers[SM] III, also a national survey, found that non-Hispanic black mothers who intended to breastfeed were significantly more likely to report being provided formula or water supplements (45%) and formula samples and offers (64%) in US hospitals than Hispanic mothers (38% and 49%, respectively) and non-Hispanic white mothers (32% and 52%, respectively) who intended to breastfeed.[15] Two studies—1 at the national

level—have found that racial inequity in breastfeeding initiation rates significantly decreased or vanished in US hospitals that altered their policies to attain the Baby-Friendly Hospital Initiative designation.[16,17] This important finding demonstrates that because institutional oppression is embedded in policies, procedures, practices, customs, and structures, it can be dismantled by changing them. Together, these studies demonstrate the widespread existence in the United States of institutional racism in the field of breastfeeding.

When we understand oppression as isolated and intentional acts of prejudice by individuals, we may find it difficult to recognize the effect of systems of privilege/oppression on the field of breastfeeding. We may feel the urge to protest *personally*: not *me*, not *my* colleagues, not the dyads *I* serve. But when we understand that all forms of oppression occur at levels beyond the interpersonal, we become equipped to see that social inequities in breastfeeding rates, access to breastfeeding support, and access to the IBCLC credential *are* institutional oppression in the field of breastfeeding. This recognition is understandably painful when it clashes with our beliefs about ourselves, our institutions, and our field (eg, we value diversity, we welcome and serve everyone equally). Such conflicts often initiate unconscious and self-protective thought processes in our unsuspecting minds. A wealth of research shows that cognitive dissonance and ego-defensive cognitive biases frequently result in the unconscious rejection of new information that conflicts with existing beliefs and leaves us feeling bad about ourselves.[18-21] Yet, bearing to recognize the existence of institutional oppression in the field of breastfeeding is a profoundly positive step because it is the gateway to avenues of action that are essential to eliminating inequities in the field of breastfeeding.

The reality of systems of privilege/oppression is veiled in conversations and efforts centered on “embracing diversity,” “celebrating what we all have in common,” or “being colorblind.”[10,22] Such foci maintain cognitive and emotional comfort for those of us with unearned privilege while turning a blind eye to widespread inequities of access to power and opportunities that cause inequities in breastfeeding rates, access to breastfeeding support, and access to the IBCLC credential. They deny the lived experiences of communities targeted by systems of privilege/oppression and at whose expense the unearned privilege of dominant social groups is afforded. Those of us who belong to dominant groups often fear speaking openly of privilege and oppression, as if doing so is akin to opening Pandora’s Box: we may believe that to speak is to create strife that would not exist if only we remained silent (Note 2). In reality, Pandora’s Box has long been open. Stigmatized social groups have long been living with the devastating consequences of oppression while those with unearned privilege have long been taught by their culture not to see the systems into which they have unintentionally been born or the oppressive biases they have unconsciously absorbed in childhood.[20]

Although it is not in our power to erase history, it is in our power to see and engage with the reality of which we are all a part. We can learn to understand and effectively respond to the unconscious cognitive processes and emotions that are so often

triggered in ourselves and in others when we work to help change the status quo. We can learn to monitor our thoughts, feelings, and behaviors and how they relate to the role of "agent" or "target" that we have been assigned within various systems of privilege/oppression.[20,23,24] We can practice becoming comfortable being uncomfortable so that we can learn to effectively listen, speak, and take the actions that are essential to dismantle institutional oppression in our field.

Every organization that is committed to eliminating inequity in the field of breastfeeding must identify, dismantle, and re-create policies, procedures, practices, customs, and structures in which institutional oppression is encoded. Pro-diversity and anti-discrimination proclamations are necessary *and* insufficient for change to occur. Broad action items include, but are not limited to:

1. Collecting baseline data on the state of inequity of outcomes in all areas of institutional functioning, including access to positions of leadership, membership, service design and provision, resources, and service receipt.
2. Providing mandated and ongoing anti-oppression training to *all* those in positions of power as well as to members at all other levels of the organization. Necessary training areas include the nature, effect, and complex intersection of systems of privilege/oppression; stages of individual and institutional development in anti-oppression work; the ethical mandate to dismantle institutional oppression; common biases, cognitive processes, and emotional responses related to privilege/oppression; and caucusing, collaborating, and creating accountability to communities that experience disproportionately low access to membership in, power in, and/or receipt of services from the organization.
3. Engaging in a systemic analysis of institutional privilege/oppression in all existing (and newly proposed) areas of the structure and functioning of the organization, including its mission, vision, policies, procedures, projects, initiatives, and budget decisions.[25] This analysis must seek, justly compensate, and then use input from communities that experience disproportionately low access to membership in, power in, and/or receipt of services from the organization (eg, communities of color, LGBTQ communities, geographically remote communities, communities that speak a nondominant language).
4. Developing a long-term, strategic plan to rebuild the structure and function of the organization in a nonoppressive manner based on the results of that systemic analysis. This planning must also seek, justly compensate, and then use input from communities that experience disproportionately low access to membership in, power in, and/or receipt of services from the organization.
5. Implementing that strategic plan while continually measuring inequity in all outcome areas so as to identify and implement any needed revisions to the plan.

The call to eliminate institutional oppression in the field of breastfeeding will only become more urgent. As of 2011, non-Hispanic white children younger than 1 year were a minority in the United States.[26] As of 2012, 50.1% of children younger than 5 years were non-Hispanic white; if patterns of US population growth evident since 2010 continue, non-Hispanic white children younger than 5 years are expected to become a minority by 2015.[27] And by 2043, non-Hispanic whites are projected to make up less than half of the total US population.[28] Similar demographic shifts are happening in other Western countries (eg, Canada, Norway, Denmark, the United Kingdom, New Zealand, Germany, the Netherlands, Austria).[29] Dismantling institutional oppression in the field of breastfeeding is essential for the elimination of breastfeeding inequities that will otherwise increasingly harm even more people. It is also essential for the survival of breastfeeding-related institutions in an increasingly diverse world. Now is the time for commitment, courage, and stamina. We must develop a critical mass of individuals and institutions working steadfastly together to make the vision of equity in the field of breastfeeding a reality.

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Notes

1. Space limitations preclude a full review of the long history of anti-oppression efforts in and the effect of all systems of privilege/oppression on the field of breastfeeding. I acknowledge the contribution that my restricted commentary makes to the frequent invisibility of the complex experiences and significant accomplishments of many social groups that are targeted by 1 or more systems of privilege/oppression. The brief review of institutional racism in the field of breastfeeding in the United States that is presented here is just a glimpse of the institutional oppression that exists nationally and globally in the field of breastfeeding. It serves as a call for further research, review, analysis, and action.
2. In Greek mythology, the opening of Pandora's Box released a multitude of evils into the world that had not been in existence before.

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