

A Black woman with curly hair is breastfeeding her baby in a factory setting. The background shows industrial machinery, including large spools of thread on a textile machine. The woman is wearing a black tank top and is looking down at her baby. The baby is lying on her chest, and she is holding a small white cloth near the baby's face. The overall image is in black and white, with the woman and baby in the foreground and the factory machinery in the background.

# REMOVING BARRIERS TO BREASTFEEDING

A Structural Race  
Analysis of First Food

<b>Acknowledgements</b>	<b>3</b>
<b>Introduction</b>	<b>4</b>
<b>The First Food System: Background &amp; Context</b>	<b>6</b>
What is a structural race analysis	6
Why breast milk and breastfeeding?	7
Meet our mothers	7
<b>The Breastfeeding Journey</b>	<b>8</b>
Before the baby comes	8
At the hospital	9
With the baby at home	11
<b>What We Can Do: Recommendations For Policy &amp; Practice</b>	<b>14</b>
Medical infrastructure	14
Workplace policies	15
Community support	17
<b>Conclusion</b>	<b>18</b>

This report was made possible by the generous support of the [W.K. Kellogg Foundation](#). We are indebted to the brilliant work, insights, lessons, research, and guidance from our partners and community-based leaders, organizers, and national and local policy advocates who have laid the foundation for this report. This report was also made possible, in part, by funds granted by the [Charles H. Revson Foundation](#). The statements made and views expressed, however, are solely the responsibility of CSI.

We especially thank representatives from the following organizations that provided insight through interviews and informal conversations: Academy of Breastfeeding Medicine, Association of Maternal Child Health Programs, BabyFriendly USA, Birthing Project USA, Black Mothers Breastfeeding Association, Boston Medical Center, California Breastfeeding Coalition, Carolina Global Breastfeeding Institute, Charles B. Wang Community Health Center, Ecology Center, Healthy Hearts Plus, Health Connect One, Moms Rising, Mothering Justice, New York City Department of Health and Mental Hygiene, Reaching Our Sisters Everywhere (ROSE), United States Breastfeeding Committee, Uzazi Village, and others. We would also like to thank [Kimberly Seales-Allers](#) for her work on First Food deserts.

We are also grateful to the deep research and writing support provided by [Julia Beatty](#), [Ashley Hollingshead](#), [Simran Noor](#), and [Meredith Reitman](#). With a warm thank you to United States Breastfeeding Committee and Health Connect One for offering feedback and suggestions during the editing process.

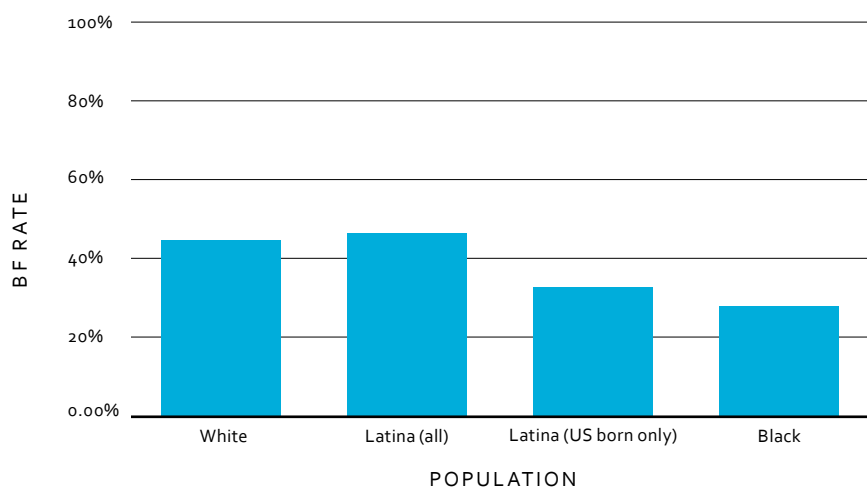
We all want the children in our lives—daughters, sons, nieces, nephews and grandchildren—to have the best possible chance to be strong, healthy, and happy, now and long into the future. One of the earliest and best building blocks to ensure such a future is breast milk. Breast milk, sometimes affectionately called “liquid gold,” provides nutrients and protection from disease unlike anything else, and when delivered through the practice of breastfeeding, creates a bond between mother and child that leads to psychological benefits for both.

But despite the benefits, breastfeeding can be a difficult path to choose. The process of breastfeeding can be frustrating, painful, and anxiety producing. Babies do not always “latch” to the breast right away, and nipples can become raw or even infected with the frequent on-demand nursing required during early months. Intense exertion and concern over whether the baby is getting enough milk add to the physical and emotional strain.

To succeed, mothers must overcome these immediate physical and emotional challenges within the context of a “First Food system,”<sup>1</sup> which imposes structural barriers that leave certain groups, particularly women of color, with less support to truly make this choice. As we will discuss below, overlapping structural inequities in housing, healthcare, and employment lead to differing outcomes for women of color. Healthy People 2020, a national initiative to improve health in the United States through evidence-based interventions, sets a target of 60.6% of infants breastfeeding at six months.<sup>2</sup> White and Latino/a infants, at 44.7% and 46% respectively, are more likely to be breastfeeding at six months than Black infants, who breastfeed at six months at a rate of 27.5%.<sup>3</sup> When looking at infants of only those Latina mothers born in the U.S., their six-month breastfeeding rate drops as well, to 32.3%.<sup>4</sup> In fact, researchers at both Duke and Columbia University found that every additional year of parental residence in the U.S. for immigrants brings a four percent decrease in the rate of breastfeeding.<sup>5</sup>

FIGURE 1:

#### Six-Month Breastfeeding Rate by Population



Many mothers want to choose to breastfeed because of the significant, inarguable benefits it offers both the mother and child, but without the right supports, the choice is made for them. What structural barriers make it more difficult for Black and Latina mothers to engage in a practice that has significantly positive health consequences? What can be done to remove these barriers and to provide support so that women of color have the same options for their children as White women?

<sup>1</sup> Kimberly Allers. “Place Matters: What is a First Food Desert?” YouTube video, 2:14. An animated infographic explaining how where you live impacts infant health. October 10, 2013. [www.youtube.com/watch?v=wqSXdmIXfzM](https://www.youtube.com/watch?v=wqSXdmIXfzM).

<sup>2</sup> Office of Disease Prevention and Health Promotion. “Maternal, Infant, and Child Health | Healthy People 2020.” Last modified August 15, 2015. [www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives](https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives).

<sup>3</sup> U.S. Department of Health and Human Services. The Surgeon General’s Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

<sup>4</sup> Singh, Gopal K, Michael D. Kogan and Deborah L. Dee. “Nativity/Immigrant Status, Race/Ethnicity, and Socioeconomic Determinants of Breastfeeding Initiation and Duration in the United States, 2003.” *Pediatrics* 119 No. Supplement 1 (2007): S38-S46.

<sup>5</sup> Gibson-Davis, Christina M., and Jeanne Brooks-Gunn. “Couples’ Immigration Status and Ethnicity as Determinants of Breastfeeding.” *American Journal of Public Health* 96.4 (2006): 641–646.

In this report, we use a structural race analysis to explore hypothetical stories of three women—Sarah, Nicole and Lara—traveling the journey from prenatal care through childbirth to postnatal care. These illustrative case studies, deeply informed by our archival research and interviews with mothers, help connect the individual to the structures and the person to the policy, in a way that offers the compassion all mothers deserve. At each stage, these women face conditions that influence their ability to achieve six months of exclusive breastfeeding, the universal medical recommendation.<sup>6</sup> By examining obstacles along the way, we suggest policy interventions to support all mothers who choose to breastfeed.

<sup>6</sup> American Academy of Family Physicians. "Breastfeeding (policy statement)." [www.aafp.org/about/policies/all/breastfeeding.html](http://www.aafp.org/about/policies/all/breastfeeding.html). Published 1989. Updated 2012. American Academy of Pediatrics Section on Breastfeeding. "Breastfeeding and the use of human milk (policy statement)." Pediatrics; originally published online February 27, 2012; DOI: 10.1542/peds.2011-3552. American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women and Committee on Obstetric Practice. "Breastfeeding: maternal and infant aspects (committee opinion)." [www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Breastfeeding-Maternal-and-Infant-Aspects](http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Breastfeeding-Maternal-and-Infant-Aspects). Published 2007. Reaffirmed 2013. American Dietetic Association. "Promoting and supporting breastfeeding." J Am Diet Assoc. 2015;115(3):444-449. U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011. World Health Organization/ UNICEF. Global Strategy for Infant and Young Child Feeding. Geneva, Switzerland: World Health Organization; 2003.

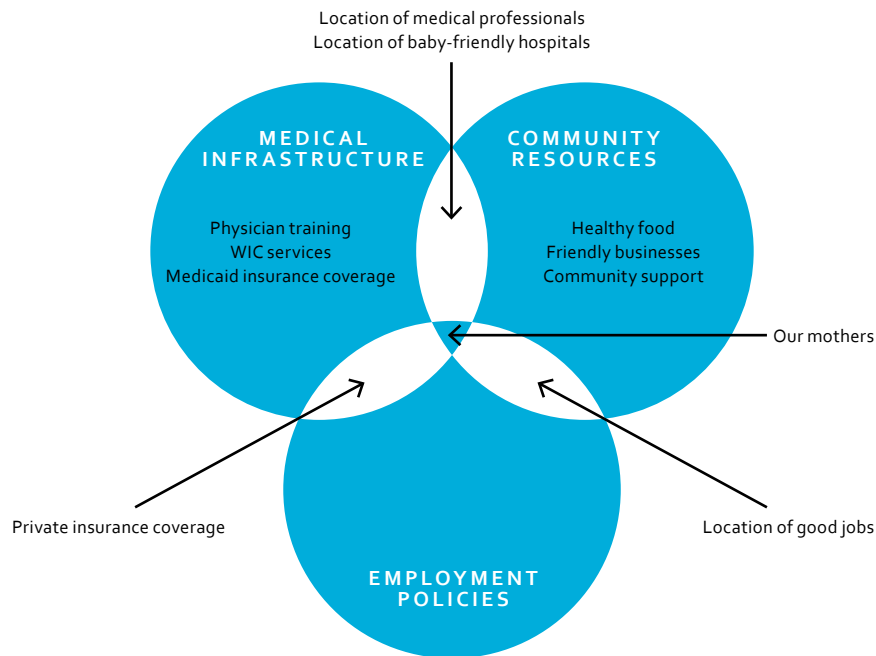
## THE FIRST FOOD SYSTEM: BACKGROUND & CONTEXT

### WHAT IS A STRUCTURAL RACE ANALYSIS?

Often, when we think about racism, we focus on individual attitudes or behaviors, which is important. Sometimes, we look at how particular institutions treat people of different races differently, which is also important. But to truly understand the root causes of racial inequity and thereby produce solutions that work for everyone, we need to take a structural race approach. That means looking at the First Food system through the lens of policies, institutions, and people—together.

Figure 1 shows how institutions and structures shape the communities we live in. Hospital infrastructure, maternal and child health policy, and community conditions all overlap to create a “First Food” system with disparate outcomes by race.

FIGURE 2:



Policies drive how these institutions and structures intersect to create economic and social opportunities, even on a local level, in communities. People of color have historically lived, and tend to still live, in the most under-resourced neighborhoods. This is called structural racial inequity. Structural racial inequity is the way our policies and institutions interact, often invisibly, to produce barriers to opportunity, leading to systemic racial disparities. While interpersonal racial discrimination is often intentional, with structural racial inequity, intent to discriminate is not required.

Structural racial inequity is more often a cumulative result of how multiple institutions and policies intersect, rather than the result of an individual or organization’s action. And because of historic and present day policy decisions, people of color are, more often than not, positioned poorly in terms of institutions and policies, resulting in the deep racial disparities we see in every aspect of our society today.

## WHY BREAST MILK AND BREASTFEEDING?

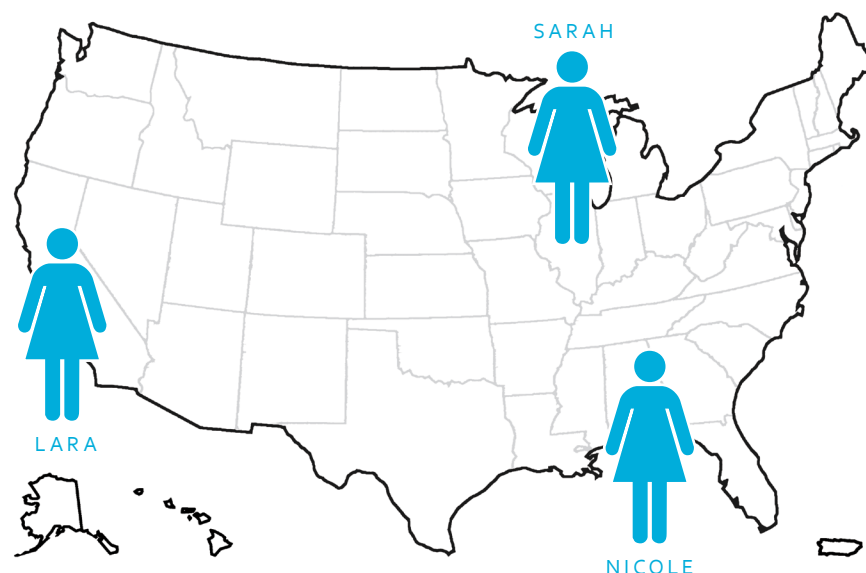
According to the United States Breastfeeding Committee, one of the leading experts on the current state of breastfeeding in the U.S., breastfeeding is the “most effective global public health intervention for child survival.”<sup>7</sup> Breast milk provides critical nutrients to babies when they need them the most, supporting a variety of early developments in the body, including brain development. It also transfers necessary antibodies from mother to child that protect against disease<sup>8</sup>, and wards off other early childhood dangers such as SIDS<sup>9</sup> and asthma.<sup>10</sup>

Breastfeeding also provides key psychological benefits derived from the physical connection between a mother and her child. Studies have shown this not only benefits the child’s health, but may lead to other maternal health benefits such as a decreased likelihood of postpartum depression.<sup>11</sup> And finally, the benefits of breastfeeding do not end with child or maternal health; breastfeeding also has both economic and environmental benefits. Breast milk is far less expensive than formula, and produces far less waste.<sup>12</sup> A healthier infant population also leads to healthier economies overall, as less money is spent on insurance claims, medical services, and funeral services, and fewer employees need to take time off to care for their sick children.<sup>13</sup>

Even given these benefits, breastfeeding can be difficult for all mothers. All mothers need culturally appropriate support and policies and practices that enable a healthy pregnancy, birth, and post-delivery experience. So what allows some mothers to choose this option despite its challenges and others not? We now turn to the stories of our three mothers to find out.

## MEET OUR MOTHERS

Sarah is White and lives in a suburb of Detroit. Her husband is a doctor at the nearby hospital, and she volunteers full-time for a local nonprofit. Nicole is Black and lives in a small town in Alabama. She is a teacher at the middle school and her husband is earning his MSW through online classes at the University of Alabama. Lara is Latina and lives in Los Angeles with her husband and mother. She and her husband both work for (and met through) the city’s transit agency; her mother runs the home and receives Social Security.



<sup>7</sup> Labbok M, Taylor E. Achieving Exclusive Breastfeeding in the United States: Findings and Recommendations. Washington, DC: United States Breastfeeding Committee; 2008.

<sup>8</sup> Duijts, Liesbeth, Vincent W. V. Jaddoe, Albert Hofman, Henriette A. Moll. “Prolonged and Exclusive Breastfeeding Reduces the Risk of Infectious Diseases in Infancy.” *Pediatrics* 126 No. 1 (2010): e18-e25

<sup>9</sup> Vennemann MM1, Bajanowski T, Brinkmann B, Jorch G, Yücesan K, Sauerland C, Mitchell EA; GeSID Study Group. “Does breastfeeding reduce the risk of sudden infant death syndrome?” *Pediatrics*. 123 No. 3 (2009): e406-e410.

<sup>10</sup> Kull, Inger et al. “Breast-feeding in relation to asthma, lung function, and sensitization in young schoolchildren.” *Journal of Allergy and Clinical Immunology*. 125 No. 5 (2010) 1013 - 1019.

<sup>11</sup> Mancini, F et al. “Use of the Postpartum Depression Screening Scale in a collaborative obstetric practice.” *J Midwifery Womens Health*. 52 No. 5 (2007):429-34.

<sup>12</sup> U.S. Department of Health and Human Services. The Surgeon General’s Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

<sup>13</sup> Ma, P et al. “A case study on the economic impact of optimal breastfeeding.” *Matern Child Health J*. 17 No. 1 (2013):9-13.

## BEFORE THE BABY COMES

Before the baby comes, the mother's neighborhood and health care play critical roles in her decision-making. Because the ways our neighborhoods are structured and where women of color tend to live, this decision-making varies not only among our mothers, but among all breastfeeding moms. Let's take a deeper look at how this plays out among our three women, all expecting their first babies.

Sarah's obstetrician, who works with her husband at the hospital, has been very involved in her pregnancy from the start. She is an advocate for breastfeeding and provides Sarah with multiple resources for learning about the practice, including referrals to lactation classes, offered through the nearby baby store and led by a trained lactation consultant. The obstetrician also offers her nutritional guidance, including the services of an on-staff nutritionist to monitor her intake. Sarah is able to follow up on this guidance by driving to her local grocery store for fresh food and cooking it at home for herself and her husband.

Nicole has been seeing the obstetrician in the next town over, covered by the insurance her school offers, though it is difficult to get to his office as often as she would like with her teaching schedule. Her obstetrician, though caring, is one of the few in the county and therefore has less time to listen to Nicole's questions about breastfeeding. Instead, he tells her that formula is just as healthy an option for her, and recommends some brands for her to look into. Nicole and her husband research the brands online and find their documentation supports the doctor's argument. While researching, Nicole sees there are lactation classes offered at a hospital on weekdays, but it is a three-hour drive away.

Lara is also constrained in her choice of obstetrician by the insurance her employer offers. Lara is not familiar enough with breastfeeding to even bring it up with the obstetrician, who in turn sees her job as only monitoring the progress of the pregnancy and does not offer any additional information or resources. Toward the end of her pregnancy, however, Lara's mother starts talking to her about her own experiences breastfeeding and now Lara is curious to learn more. She knows from her local WIC agency that it is critical for her to stay healthy, so she starts using her work breaks to hunt for places offering fresh fruits and vegetables, only to come up short.

### WHAT ARE OUR MOTHERS FACING?

Based on our field research, most obstetrician-gynecologists (OBGYN) are not trained in breastfeeding practice. OBGYNs are also few and far between in rural areas, not satisfying the demand. In 2008, only a little over six percent of OBGYNs were located in rural areas, and in 2010 about half of the counties in the United States lacked even one practicing OBGYN.<sup>14</sup>

Outside of contact with obstetricians, lactation classes can provide critical training and support. But as discussed in the next two sections, those who offer these classes, Baby-Friendly hospitals and certified lactation consultants, are often lacking in neighborhoods of color. Adding to the problem, many mothers may not even know to seek out breastfeeding as an option. Expecting mothers of color have indicated in our interviews that organizations that would promote breastfeeding outside of the medical establishment, such as standalone centers or baby supply stores, tend not to locate themselves in their neighborhoods or to offer affordable, language-appropriate options. Instead, women are faced with relentless formula marketing at their small neighborhood grocery stores or bodegas.

It is these same stores that failed to provide Lara with fresh, healthy food. According to a report published by PolicyLink and the Food Trust, zip codes predominantly

<sup>14</sup> American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women. "Health Disparities in Rural Women (committee opinion)." [www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women](http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women). Published 2014.



home to Latinos have only a third as many chain supermarkets compared to zip codes predominantly home to Whites.<sup>15</sup> So while Sarah may have a relatively easy time fulfilling the evidence-based nutritional guidelines of her hospital's on-staff nutritionist by visiting her local grocery stores, Lara may have a hard time finding just the basics of a healthy diet (see sidebar on food deserts). And the guidance she is receiving from her local WIC agency may vary as well. WIC's peer-counseling services, which help increase breastfeeding rates by providing mother-to-mother support from pregnancy onward, differ by location and resources provided for each local agency. According to 2010 data, only one in four local WIC agencies are funded to provide Loving Support peer counseling services, with larger local agencies more likely to be funded than smaller ones.<sup>16</sup>

And finally, even if there are resources available, many mothers of color may not have the time and flexibility to take advantage of them. First of all, Nicole and Lara both work full time. And they work in service industries—education and transportation—with long hours and/or very little flexibility. Women of color are more likely to work in these types of industries than White women: 32% of Latinas and 28% of Black women work in service compared with only 20% of White women, who are more likely to be found in managerial and professional jobs. This lack of flexibility will hinder their ability to take full advantage of both medical services and dietary recommendations.

## USDA: HOW ARE FOOD DESERTS IDENTIFIED?<sup>18</sup>

The census tract must be both:

### LOW INCOME

- a poverty rate of 20% or greater, OR
- a median family income at or below 80% of the area median family income

### LOW ACCESS

- at least 500 persons and/or at least 33% of the census tract's population live more than one mile from a supermarket or large grocery store

As part of the First Lady's Let's Move initiative, communities can discover whether they qualify as a food desert by going to the Food Desert Locator<sup>19</sup>, and then apply for funding to develop healthy food retail outlets from the Department of the Treasury, Department of Health and Human Services, and the USDA<sup>20</sup>.

## AT THE HOSPITAL

The hospital is a critical juncture in the journey, with a great amount of influence over the future of mother and child. And again, because our system of health care is structured to afford some more support than others, we see health inequities among our mothers.

When it comes time to give birth, Sarah arrives at her obstetrician's hospital, which has been designated as "Baby Friendly" by Baby-Friendly USA, an initiative of the World Health Organization and UNICEF to "encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding."<sup>21</sup> The hospital has a written policy on breastfeeding that has been communicated to all staff, including Sarah's obstetrician. This includes providing breastfeeding education starting during the first trimester and continuing postpartum at affiliated clinics. It also means hospital staff with lactation training, including nurses, help Sarah initiate

<sup>15</sup> Treuhaft, Sarah and Allison Karpyn. *The Grocery Gap: Who Has Access to Healthy Food and Why it Matters*. Oakland, CA and Philadelphia, PA: PolicyLink and The Food Trust, 2010.

<sup>16</sup> U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis. *WIC Breastfeeding Peer Counseling Study, Final Implementation Report, WIC-10-BPC*. By Ann Collins, Catherine Dun Rappaport, and Nancy Burstein. Project Officer: Tracy K. Palmer, MPH. Alexandria, VA: June 2010.

<sup>17</sup> U.S. Department of Labor, Women's Bureau. "The Economic Status of Women of Color: A Snapshot." [www.dol.gov/wb/media/reports/WB\\_WomenColorFactSheet.pdf](http://www.dol.gov/wb/media/reports/WB_WomenColorFactSheet.pdf).

<sup>18</sup> U.S. Department of Agriculture, Agricultural Marketing Service. "Creating Access to Health Affordable Food | Food Deserts." [www.apps.ams.usda.gov/fooddeserts/fooddeserts.aspx](http://www.apps.ams.usda.gov/fooddeserts/fooddeserts.aspx).

<sup>19</sup> U.S. Department of Agriculture, Economic Research Service. "Food Access Research Atlas." Last modified March 11, 2015. [www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx](http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx).

<sup>20</sup> U.S. Department of Agriculture, Agricultural Marketing Service. "Creating Access to Health Affordable Food | Grant Opportunities." [www.apps.ams.usda.gov/fooddeserts/grantOpportunities.aspx](http://www.apps.ams.usda.gov/fooddeserts/grantOpportunities.aspx).

<sup>21</sup> Baby-Friendly USA. "Baby-Friendly Hospital Initiative." [www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative](http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative).

breastfeeding within one hour of her son's birth and allow mother and son to remain together all day and all night. Sarah is sent home with a list of breastfeeding support groups in and around her neighborhood.

The nearest "Baby Friendly" hospital to Nicole, the one that offered lactation classes, is still three hours away. It is also unclear whether her school insurance would cover services at that hospital, so she delivers at the local hospital under the care of her busy obstetrician. Nursing staff at the hospital are not trained in breastfeeding, and when Nicole's little girl has trouble taking her breast, they offer Nicole a bottle of formula. Nicole is determined to try and breastfeed, so declines the formula, but struggles on her own to get things going. Nursing staff eventually take her baby to another room to bottle feed her, while Nicole tries to get some rest. This cycle continues, until Nicole and her family leave the hospital, gift bag full of formula in tow.

There is a Baby-Friendly hospital in Los Angeles for Lara, but her obstetrician recommends a different hospital, where she is affiliated. Lara's baby boy's birth is difficult and she ends up having a Cesarean Section. She worries that the painkillers and antibiotics she has been given will flow into her breast milk, harming her newborn boy. She also worries that the lack of fresh food in her diet has affected her milk supply. Without proper staff training or a culturally attuned lactation consultant, particularly one covered by insurance, she has no assurance of the safety of the medicines or her milk supply, and no one to help her hold the baby for her first latch-on. Lara regretfully turns to formula. She still hopes she can alternate breastfeeding and formula once she heals. She, like Nicole, is supplied with a gift bag full of formula upon leaving the hospital with her family.

#### WHAT ARE OUR MOTHERS FACING?

Baby-Friendly hospitals, those that implement the breastfeeding policies, described in Sarah's story, support women's choice to breastfeed. Studies show that by implementing at least six of the Ten Steps to Successful Breastfeeding (see sidebar), these hospitals lead to mothers being 13 times more likely to continue breastfeeding at six weeks postpartum.<sup>22</sup> But not everyone has access to these special hospitals.

#### BABY-FRIENDLY USA'S TEN STEPS TO SUCCESSFUL BREASTFEEDING<sup>23</sup>

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

<sup>22</sup> DiGirolamo, AM et al. "Effect of maternity-care practices on breastfeeding." *Pediatrics* 122 No. Supplement 2 (2008): 543-549.

<sup>23</sup> Baby-Friendly USA. "The Ten Steps to Successful Breastfeeding." [www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps](http://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative/the-ten-steps).

As of May 2015, only 263 hospitals and birthing centers in 46 states hold the Baby-Friendly designation, and just under 13% of all babies are born in Baby-Friendly hospitals.<sup>24</sup> The numbers for people of color are more disturbing:

- Forty-five percent of hospitals designated as Baby-Friendly are located in communities where the Black population is three percent or less.<sup>25</sup>
- Almost one-fifth of Black people live in states without a single Baby-Friendly hospital.<sup>26</sup>

There was no Baby-Friendly hospital anywhere near Nicole. In fact, there are currently only two in the state of Alabama, the closest of which is a three hour drive away from her home. This meant that she received very little support in her attempt to breastfeed, as staff did not give her the appropriate training, advice, or encouragement during those challenging first days. It also meant she was separated from her baby, rather than allowed to remain in close contact to begin the highly beneficial mother/child bonding. Lara's experience at a similar hospital meant no one made sure she was physically able to breastfeed after her surgery, helping to prop her son up off her stomach or show her alternative positions. And at neither hospital were our mothers given resources for how to find support after leaving the hospital, and were instead encouraged to use formula by providing them with free samples in a gift bag.

## WITH THE BABY AT HOME

Once home, mothers need a great deal of support to continue breastfeeding—from trained and peer support professionals, their employers, and communities. Once again, interlocking structures of neighborhood, healthcare, and employment lead mothers to have very different challenges in front of them.

Upon arrival at home, Sarah takes some time off from volunteering. She continues to meet with her obstetrician, and every Wednesday over lunch, she meets with a group of breastfeeding mothers to talk about the challenges they are facing and share tips for how to solve them. She has also hired a lactation consultant who shares her background. The consultant visits her at home twice a week to ensure the process is going smoothly, reassure Sarah that the baby is the proper weight, and answer any questions she might have. She bought a top-of-the-line breastfeeding pump, skin balms, and nursing covers so she can breastfeed or pump comfortably whether at home or out with friends at her local breastfeeding-friendly coffee shop.

Nicole is still determined to breastfeed, despite the difficulty she is having with her baby's latch. Thankfully, unlike for many colleagues in other districts, the school where she works allowed her some immediate leave and then transitioned her to part time. Her employer also provides health insurance coverage, so Nicole is optimistic that the help she needs is a phone call away. When she calls the insurer, they acknowledge that lactation counseling is a federally mandated benefit, and refer her back to her hospital. Unfortunately, her hospital does not have an outpatient lactation consultant, so they refer her to an independent lactation consultant. Nicole considers paying out-of-pocket, but the cost is too much. So she calls the insurer back and this time they refer her to a provider located in the hospital three hours from her home. The logistics of getting to that appointment feel overwhelming, so she gives up on getting the clinical help she needs. She also worries her little girl is underweight and perhaps not getting enough milk, but she does not know any nursing moms to ask for advice and there are no community support services in her single-stop-light town. Lacking the reassurance and help she needs, Nicole develops mastitis and goes on antibiotics. Her doctor and

<sup>24</sup> Baby-Friendly USA. "Find Facilities." [www.babyfriendlyusa.org/find-facilities](http://www.babyfriendlyusa.org/find-facilities).

<sup>25</sup> Rita Henley Jensen. "'Baby-Friendly' Hospitals Bypass Black Communities." *Womens eNews*. August 28, 2013. <http://womensenews.org/story/reproductive-health/130828/baby-friendly-hospitals-bypass-black-communities#.VdDR3rc7oks>.

<sup>26</sup> Ibid.

pharmacist erroneously tell her she has to “pump and dump” while the antibiotics are in her system, further compounding her fears that her baby is hungry and not getting enough to eat. Coupled with the pain of the infection and a fast-approaching return to work, she switches to formula.

Upon arriving home, Lara is trying to mostly breastfeed and only supplement with formula when absolutely necessary. This works for the short time she has off work, but when she goes back, she faces a problem. She cannot see a safe or easy way for her mother to bring her son to work at the transit agency for her to nurse throughout the day, so to maintain her milk supply and provide her mother with breast milk to feed her son, she needs regular breaks at work to express her breastmilk. Lara has been told at WIC that under federal law she is entitled to flexible break time and clean private space, but she does not know anyone in her workplace who has taken advantage of those accommodations and is too scared for her job security to ask her employer for what she needs. On her days off, she also feels uncomfortable breastfeeding in public, as it is not a widely-practiced behavior in her neighborhood. Her mother continues to encourage her, but without any way of overcoming these challenges, she lets her milk dry up and transitions her son to formula full time.

## WHAT ARE OUR MOTHERS FACING?

Our interviews and archival research strongly suggest that service industries, home to a higher percentage of women of color than White women, are less likely to provide the time and space for mothers to pump and breastfeed (see, for example, reports in [Huffington Post](#)<sup>27</sup>, [Spokesman-Review](#)<sup>28</sup>, and [Brooklyn Reader](#)<sup>29</sup>). Though the Affordable Care Act requires employers to provide hourly workers with reasonable break time to express milk and a place other than the bathroom for this purpose, break times do not have to be paid and there is no method for implementation or enforcement included in the regulation.<sup>30</sup> Mothers may not feel they have the right to request accommodation, particularly if they feel vulnerable due to their own immigration status or a hostile workplace culture. In addition, though in our narratives Lara and Nicole both have a short period of paid leave, this option varies greatly by race. About half of White women, compared to 43% of Black women and only 25% of Latinas, have paid parental leave.<sup>31</sup>

International Board Certified Lactation Consultants, or IBCLCs, and peer support professionals can provide critical postpartum care for mothers, including home visits. But the simple facts are that there are not enough of these professionals, especially IBCLCs, particularly in states with high populations of people of color, and not enough who share the background of women of color. There are only 13,848 IBCLCs in the US overall, and only 1.8 IBCLCs per 1000 births in states with high population of color, far below the recommended proportion of 8.6 per 1000 births.<sup>32</sup> Our interviews and archival research suggest that fulfilling the educational criteria for IBCLC candidacy is easier for those already in the health profession, particularly registered nurses, and those able to afford the rather costly application fee, both subpopulations that skew White.<sup>33</sup>

Even if IBCLCs are available in the neighborhood, financial and insurance restrictions may inhibit a mother’s ability to take advantage of them. Under the Affordable Care Act, only IBCLCs within network are covered and any IBCLCs out-of-network are liable to be denied reimbursement. Expensive breastfeeding tools such as electric breast pumps, which can run from \$60 to over \$300, might also not be covered by insurance. While the ACA requires most private insurance providers to cover breast pumps, it does not regulate the type of pump allowed.

<sup>27</sup> Dave Jamieson.

“Dirty Bathrooms, No Privacy: The Horrifying Struggles Of Breastfeeding Moms Who Need To Pump At Work.” *Huffington Post*. July 24, 2014. [www.huffingtonpost.com/2014/07/24/breastfeeding-pumping-at-work\\_n\\_5610554.html](http://www.huffingtonpost.com/2014/07/24/breastfeeding-pumping-at-work_n_5610554.html).

<sup>28</sup> Adrian Rogers. “Breastfeeding While on the Job Challenging.” *The Spokesman-Review*. October 6, 2013. [www.spokesman.com/stories/2013/oct/06/nursing-dilemma/](http://www.spokesman.com/stories/2013/oct/06/nursing-dilemma/).

<sup>29</sup> Khushbu Srivastava, “The Laments of a Working Breastfeeding Mother.” *Brooklyn Reader*. April 27, 2015. [www.bkreader.com/2015/04/the-laments-of-a-working-breastfeeding-mother/](http://www.bkreader.com/2015/04/the-laments-of-a-working-breastfeeding-mother/).

<sup>30</sup> U.S. Department of Labor, Wage and Hour Division (WHD). “Break Time for Nursing Mothers.” [www.dol.gov/whd/nursingmothers/](http://www.dol.gov/whd/nursingmothers/).

<sup>31</sup> Sarah Jane Glynn and Jane Farrell. “Latinos Least Likely to Have Paid Leave or Workplace Flexibility.” *Center for American Progress*. November 20, 2012. [www.americanprogress.org/issues/labor/report/2012/11/20/45394/latinos-least-likely-to-have-paid-leave-or-workplace-flexibility/](http://www.americanprogress.org/issues/labor/report/2012/11/20/45394/latinos-least-likely-to-have-paid-leave-or-workplace-flexibility/).

<sup>32</sup> U.S. CDC, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity and Obesity. *Breastfeeding Report Card, United States, 2014*. [www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf](http://www.cdc.gov/breastfeeding/pdf/2014breastfeedingreportcard.pdf).

<sup>33</sup> Kathleen A Kendall-Tackett. “Infant Mortality: Narrowing the Gap.” *American Psychological Association*. January 2015. [www.apa.org/pi/ses/resources/indicator/2015/01/infant-mortality.aspx](http://www.apa.org/pi/ses/resources/indicator/2015/01/infant-mortality.aspx).

Medicaid is even more spotty in its coverage, because states can decide whether or not to cover breastfeeding equipment.<sup>34</sup> Medicaid expansion states can appeal for Medicaid waivers to reimburse non-licensed providers, including lactation support providers. The few that have done so are only covering IBCLCs; none have provided a model that encompasses the range of possible support, from community-based to clinical care. Medicaid non-expansion states are not in this process at all, leaving about half the nation's low-income women without access to services recommended Women's Preventive Services.

Finally, communities vary by how accepting they are of breastfeeding in public. In areas called "First Food deserts," which lack critical breastfeeding supports, at least 50% of community members would not feel comfortable seeing a mother breastfeed in public.<sup>35</sup> Sarah's experience at her local breastfeeding-friendly coffee shop, which pledged to treat a breastfeeding mother the same as any other patron, is very different from Lara's neighborhood restaurant that asks her to breastfeed in the restroom or not at all. According to our field research, breastfeeding-friendly businesses are more likely to be in neighborhoods with higher concentrations of White people than in those with higher concentrations of people of color.

All of these factors in Sarah's, Nicole's, and Lara's lives compound to make it much more difficult for Nicole and Lara to choose breastfeeding at each stage in the journey than for Sarah to do so. So what can we do to remove these obstacles and provide support for women of color who choose to breastfeed?

<sup>34</sup> U.S. Health and Human Services. "Breast Pumps and Insurance Coverage: What You Need to Know." Last modified September 30, 2014. [www.hhs.gov/healthcare/prevention/breast-pumps/](http://www.hhs.gov/healthcare/prevention/breast-pumps/).

<sup>35</sup> Kimberly Allers. "Place Matters: What is a First Food Desert?" YouTube video, 2:14. An animated infographic explaining how where you live impacts infant health. October 10, 2013. [www.youtube.com/watch?v=wqSXdmIXfzM](http://www.youtube.com/watch?v=wqSXdmIXfzM).

## WHAT CAN WE DO: RECOMMENDATIONS FOR POLICY & PRACTICE

At each stage, smart policy interventions with robust implementation can make it easier for all women to choose to breastfeed if they want to.

We seek policy interventions that truly address the root causes that are linked to breastfeeding outcomes, especially lower rates for women of color. We know that no single policy alone can dismantle structural inequity. This takes reform, including diversification of the medical sector and those providing services, as well as changes to and better implementation and promotion of existing policies like the ACA breastfeeding provisions. But it also takes transformation, including directing funding streams to challenge all barriers at the neighborhood level. We therefore need a variety of policy and practice interventions that support women and communities of color to truly achieve higher breastfeeding rates for all mothers.

### MEDICAL INFRASTRUCTURE

We can implement policy to increase the number of Baby-Friendly hospitals in the U.S. We can incentivize the Baby-Friendly designation process for smaller hospitals in communities of color and connect these hospitals more deeply with their communities. California SB 402 set a target that all maternity care units must have the Baby-Friendly designation by 2025, and to date about one third of the Baby-Friendly hospitals in the U.S. are located in California.<sup>36</sup> In these hospitals, the breastfeeding rates are much closer to balance: 71% of White mothers, 66% of Latina mothers, and 62% of Black mothers provide only breast milk to their infants.<sup>37</sup>

We can increase the number and diversity of IBCLCs, and value the work of CLCs (Certified Lactation Counselors) and doulas as viable alternatives. One community model, the Uzazi Village Lactation Consultant Mentorship Program in Kansas City, Missouri eases the passage of lactation candidates from a wider, more diverse and culturally appropriate applicant pool through the certification process. They allow interns to work at the Uzazi clinic to complete their required hours and are in the process of connecting interns to placements in hospitals and developing a one-stop curriculum for interns at a local community college. Another model, HealthConnect One's federally funded Community-Based Doula Leadership Institute, supports peer-to-peer programs across the country that assist mothers from the beginning of pregnancy through the postpartum period. By receiving training, technical assistance and evaluation, these community-based doula programs are able to create and support a trusted group of expert advisors to assist mothers every step of the way.

We can improve health care professional training and insurance coverage to make sure women of color have access to the competent, culturally sensitive health care providers. Pediatricians, obstetricians, and IBCLCs can be trained on both breastfeeding and cultural competency. The American College of Obstetricians and Gynecologists, along with the American Academy of Pediatrics, has produced comprehensive training resources—including handbooks, videos, and slides—on both breastfeeding and cultural awareness for physicians to incorporate into their practice.<sup>38</sup>

WIC breastfeeding policies can also be standardized. In late 2009, California WIC began implementing revised USDA guidelines that encouraged agencies to avoid giving formula to breastfeeding mothers in the first 30 days. When this policy was implemented

<sup>36</sup> Christine Staricka, "What Does California's SB 402 Mean to You?". Posted October 10, 2013. California Breastfeeding Coalition. <http://californiabreastfeeding.org/what-does-californias-sb-402-mean-to-you/>.

<sup>37</sup> Health Connect One. Illinois Breastfeeding Blueprint: A Plan for Change. [www.healthconnectone.org/pages/illinois\\_breastfeeding\\_blueprint/313.php](http://www.healthconnectone.org/pages/illinois_breastfeeding_blueprint/313.php).

<sup>38</sup> American Congress of Obstetricians and Gynecologists. "ACOG, AAP Develop First Collaborative Physician-Focused Breastfeeding Handbook". January 25, 2006. [www.acog.org/About-ACOG/News-Room/News-Releases/2006/ACOG-AAP-Develop-First-Collaborative-Physician-Focused-Breastfeeding-Handbook](http://www.acog.org/About-ACOG/News-Room/News-Releases/2006/ACOG-AAP-Develop-First-Collaborative-Physician-Focused-Breastfeeding-Handbook). American Congress of Obstetricians and Gynecologists. "Cultural Awareness and Sensitivity in Women's Health Care." [www.acog.org/About-ACOG/ACOG-Departments/Health-Care-for-Underserved-Women/Cultural-Awareness-and-Sensitivity-in-Womens-Health-Care](http://www.acog.org/About-ACOG/ACOG-Departments/Health-Care-for-Underserved-Women/Cultural-Awareness-and-Sensitivity-in-Womens-Health-Care).

along with several other related changes, the largest WIC agency in California saw a noticeable rise in exclusive breastfeeding rates.<sup>39</sup> We can improve health care coverage to address the need for IBCLCs or other types of lactation support, including CLC's or doulas. For example, Medicaid Maternity Packages can include doula care. In one community model, Healthy Start Brooklyn, the program reaches out to women and their families through a variety of neighborhood settings, such as health care clinics and hair salons, connecting them to important health and social services. One of their services, the By My Side Birth Support Program ensures free doula care for women in five ZIP codes in Brooklyn whose income qualifies them for government nutrition programs. Another example hails from Oregon, where the Medicaid waiver process was available earlier than other states. The Oregon Office of Equity and Inclusion convened a committee to advocate for provision and reimbursement of culturally relevant doulas at all Medicaid births where the mother would otherwise be birthing alone.

On a national scale, clarification is needed to better define the provisions of the Affordable Care Act related to breastfeeding. This includes guidance for private insurers on which types of providers address which lactation care services. It also needs to close the gap on types of pumps that are required. The most common issues that arise with implementation include limits to mothers' number of visits, and limits in how much time they have to get a pump. Though the state Medicaid waiver process allows for reimbursement of non-licensed providers, advocacy to Medicaid Officers has to follow diplomacy efforts between and among lactation support providers, so that messaging is clear and consistent, and inclusive of reimbursement for all, according to their scope of practice.

There is a robust body of evidence on the importance of exclusive human milk for medically fragile newborns. In the cases that a mother's own milk is not available, banked donor milk helps protect from the risks associated with not breastfeeding, particularly necrotizing enterocolitis (NEC), a costly disease with lifelong impacts. A national strategy is needed to efficiently and effectively provide banked donor milk to vulnerable infant populations. Funding for research, development of guidelines for use of donor milk with medically fragile infants, and exploration of federal regulation to guide and support nonprofit milk banks through an equity lens are all critical interventions worth U.S. investment.

## WORKPLACE POLICIES

As of 2012, the Society for Human Resource Management reports that only 30% of surveyed employers have an on-site lactation or mother's room, and no employers have plans to implement such a room in the next year.<sup>40</sup> The breastfeeding planks of the Affordable Care Act (ACA) need to have clear implementation and enforcement guidelines. The ACA, though the Break Time for Nursing Mothers amendment, requires employers to provide a reasonable amount of break time, as often as needed, for new mothers to express their milk. They also need to provide a space other than a bathroom that is "shielded from view" and "free from intrusion" for mothers to express milk. This space does not need to be permanent, but available when any employee needs it.<sup>41</sup> The Office on Women's Health has launched a comprehensive Employer Solutions resource to promote the law and demonstrate practical solutions for accommodations in every industry. The database is searchable by location, industry, size of business, and challenges, including scheduling and workplace culture.

Perhaps due to the fact that this act is relatively new, there is little data on how employers are responding to it, how employees are being treated in return, and how this varies across race, occupation and geography.

<sup>39</sup> California WIC Association. "WIC Works: Policy Changes Raise Breastfeeding Rates." September 2011. [www.calwic.org/storage/WIC\\_WORKS\\_Policy\\_Changes\\_Raise\\_Breastfeeding\\_Rates.pdf](http://www.calwic.org/storage/WIC_WORKS_Policy_Changes_Raise_Breastfeeding_Rates.pdf).

<sup>40</sup> Society for Human Resource Management. 2012 Employee Benefits: The Employee Benefits Landscape in a Recovering Economy. 2012. [www.shrm.org/Research/SurveyFindings/Articles/Documents/2012\\_EmpBenefits\\_Report.pdf](http://www.shrm.org/Research/SurveyFindings/Articles/Documents/2012_EmpBenefits_Report.pdf).



One of the 2011 Surgeon General's Calls to Action is to "work towards establishing paid maternity leave for all employed mothers." They argue that "paid leave is necessary to reduce the differential effect of employment on breastfeeding among disadvantaged racial, ethnic, and economic groups, which in turn would allow disadvantaged populations to benefit from the health effects of breastfeeding." Their suggested implementation strategy includes both creating a model for maternity leave for federal workers and working within states to establish funding mechanisms for paid maternity leave.<sup>42</sup> Our interviews suggest there is great deal of momentum on this issue occurring at both the federal and state levels.

Anecdotal evidence among advocacy groups, however, points to a gap between the letter and spirit of the law, and the lived experience, particularly among the low-income, hourly wage workers the law was intended to protect. Advocates across the country are working locally to support mothers to find solutions for accommodations with their employers and to encourage them to file complaints with the Department of Labor in the event these needs are not met. In many instances, however, women fear retaliation for making these requests or for documenting complaints. The national policy solution, therefore, is to change the law in three critical ways: 1) amend the law to cover all women, regardless of whether they are paid as hourly or salaried workers, 2) while keeping the standard that all employers must provide accommodations regardless of size, lower the threshold for undue hardship exemption from 50 to 15, to be in alignment with the Pregnancy Discrimination Act and the Americans with Disabilities Act, and 3) add a penalty provision so that women can pursue a private right of action in the event that they have lost wages or work due to an employer failing to accommodate their breastfeeding needs.

With the majority of women of childbearing age in the labor force, the United States needs to provide paid maternity leave, like industrialized countries throughout the world. The United Nations recommends 18 weeks paid leave, funded through a combination of employer and public funds. Though the U.S. has had the Family and Medical Leave Act since 1993, it provides only 12 weeks of unpaid leave, and only to those with an employer size over 50 who have been employed at least one year. These factors all contribute to the multiple barriers for the majority of women being able to access time to care for their families, even in the special days after the birth of a child. Studies have demonstrated that provision of paid maternity leave increases breastfeeding initiation, exclusivity, and duration. Lack of paid leave disproportionately impacts low-income women and women of color. Per the implementation strategies of the Surgeon General's Call to Action to Support Breastfeeding, many states are developing and implementing paid leave programs, structured in various ways. As momentum and political will for these policies builds, it will be critical for the best state-level strategies to inform a national approach that gives all families the time to care for family and bond with newborns.

Upon return to work and school, infants are placed in a variety of childcare settings; therefore, childcare providers have a critical role in supporting breastfeeding. While federal guidelines exist that describe breastfeeding support in childcare, few states either mandate that childcare centers implement practices supportive of breastfeeding, or integrate safe breast milk handling into food regulations. This is starting to change, as some states are offering educational materials, training, and incentives to childcare providers. Recruiting and training childcare providers to support working mothers in their breastfeeding goals is a critical mechanism of community support for every mother. Advocates can encourage state health departments and other state agencies that license or oversee childcare, to integrate breastfeeding into their processes and programs.

<sup>42</sup> U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Support Breastfeeding. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.



Around the country, communities are taking employees' rights into their own hands. The New York City Pregnant Workers Fairness Act, part of the New York City Human Rights Law, went into effect just last January. This law requires employers to make reasonable accommodations for employees, so long as they do not cause undue hardship for the employer.<sup>43</sup> An early application of the law challenged the forcing out of a pregnant woman, Floralba Fernandez Espinal, who could not continue to do heavy lifting at the thrift store where she worked. As a result of the law, the store agreed to reinstate the employee in a light-duty capacity and to provide her back pay, which was critical to her being able cover rent and utilities.<sup>44</sup>

## COMMUNITY SUPPORT

Communities vary in their acceptance of breastfeeding as a natural practice in public. In King County, Washington, for example, breastfeeding is now considered a civil right; expanding a mother's ability to comfortably breastfeed in public.<sup>45</sup> Other models use a structural analysis to ensure supportive breastfeeding policy and practice across multiple institutions. For example, the Brooklyn Breastfeeding Empowerment Zone, partially funded by the WK Kellogg foundation, supports mothers in the predominantly Black neighborhoods of Bedford Stuyvesant and Brownsville who plan to or are breastfeeding. The health department plans to work with local community centers and faith-based organizations to establish places where women can breastfeed. There is already a community lactation station in Restoration Plaza. The program will also offer two home visiting programs, as well as a text messaging program called Mobile Milk.

*The International Code of Marketing of Breast-Milk Substitutes* (the Code) establishes rules to protect mothers from unethical marketing practices. Unfortunately, the Code has not been adopted as legally binding in the United States. In the meanwhile, there are several strategies that could shield families from predatory marketing. Provision of free samples to the public, such as our mothers Nicole and Lara received in the stories above, are a clear violation of the Code's rule prohibiting direct advertising. U.S. manufacturers voluntarily honored that until 1990, and should be encouraged to do so again. Funding is needed for research of health claims made by formula manufacturers, and for how those claims influence consumers. Critically, health care providers should not be used as advertisers of infant formula, as their brand endorsement is implied when they distribute free samples.

<sup>43</sup> New York City Commission on Human Rights. "Pregnancy and Employment Rights Posters." [www.nyc.gov/html/cchr/html/publications/pregnancy-employment-poster.shtml](http://www.nyc.gov/html/cchr/html/publications/pregnancy-employment-poster.shtml).

<sup>44</sup> Rachel L. Swarns. "A Pregnant Worker, Forced to Go on Unpaid Leave, Is Back on the Job." New York Times. February 26, 2014. [http://cityroom.blogs.nytimes.com/2014/02/26/a-pregnant-worker-forced-to-go-on-unpaid-leave-is-back-on-the-job/?\\_r=0](http://cityroom.blogs.nytimes.com/2014/02/26/a-pregnant-worker-forced-to-go-on-unpaid-leave-is-back-on-the-job/?_r=0).

<sup>45</sup> Phuong Le. "Breastfeeding As Civil Right: Seattle Council Protects Public Nursing" Huffington Post. April 9, 2012. [www.huffingtonpost.com/2012/04/09/breastfeeding-as-civil-ri\\_n\\_1413508.html](http://www.huffingtonpost.com/2012/04/09/breastfeeding-as-civil-ri_n_1413508.html).

Though the women whose lives we traced in this report all had a desire to breastfeed, only Sarah was able to maintain this practice. Structural differences in community resources, medical care and coverage, and patterns and policies relating to employment gave Nicole and Lara little choice but to turn to formula.

In this report we have established a baseline for discussion and offered a set of policy entry points to pursue to close gaps. We recognize that deeper research could and should be done to further understand the challenges and opportunities within the field, particularly in connecting discussions around implicit bias within the healthcare industry and health outcomes for people of color. This report shows that challenges to breastfeeding are not impossible to overcome. Rather, working together and across the many systems that impact a mother's ability to breastfeed, we can increase rates of breastfeeding for all mothers.

By working to implement the interventions described above, we believe that all mothers and their children will be able to choose breastfeeding and benefit from its physical and psychological advantages, leading to better health outcomes for everyone.

Center for Social Inclusion catalyzes grassroots communities, government, and other institutions to dismantle structural racial inequity. We craft strategies and tools to transform our nation's policies and practices that harm communities of color, in order to ensure better outcomes for all.

Copyright © 2015 by the Center for Social Inclusion

All rights reserved. No part of this report may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or by any information storage and retrieval systems, without the permission of Center for Social Inclusion.

For any commercial reproduction, please obtain permission from Center for Social Inclusion.

**CONTACT US:**

Center for Social Inclusion  
150 Broadway, Suite 303  
New York, NY 10038  
(212) 248-2785  
info@thecsi.org

**FIND US ONLINE:**

[www.centerforsocialinclusion.org](http://www.centerforsocialinclusion.org)  
[www.facebook.com/centerforsocialinclusion.org](https://www.facebook.com/centerforsocialinclusion.org)  
[www.twitter.com/theCSI](https://www.twitter.com/theCSI)

© 2015 Center for Social Inclusion. Creative: Tronvig Group.