BreastfeedLA

Lactation Justice: Progress, Lessons, and the Road Ahead

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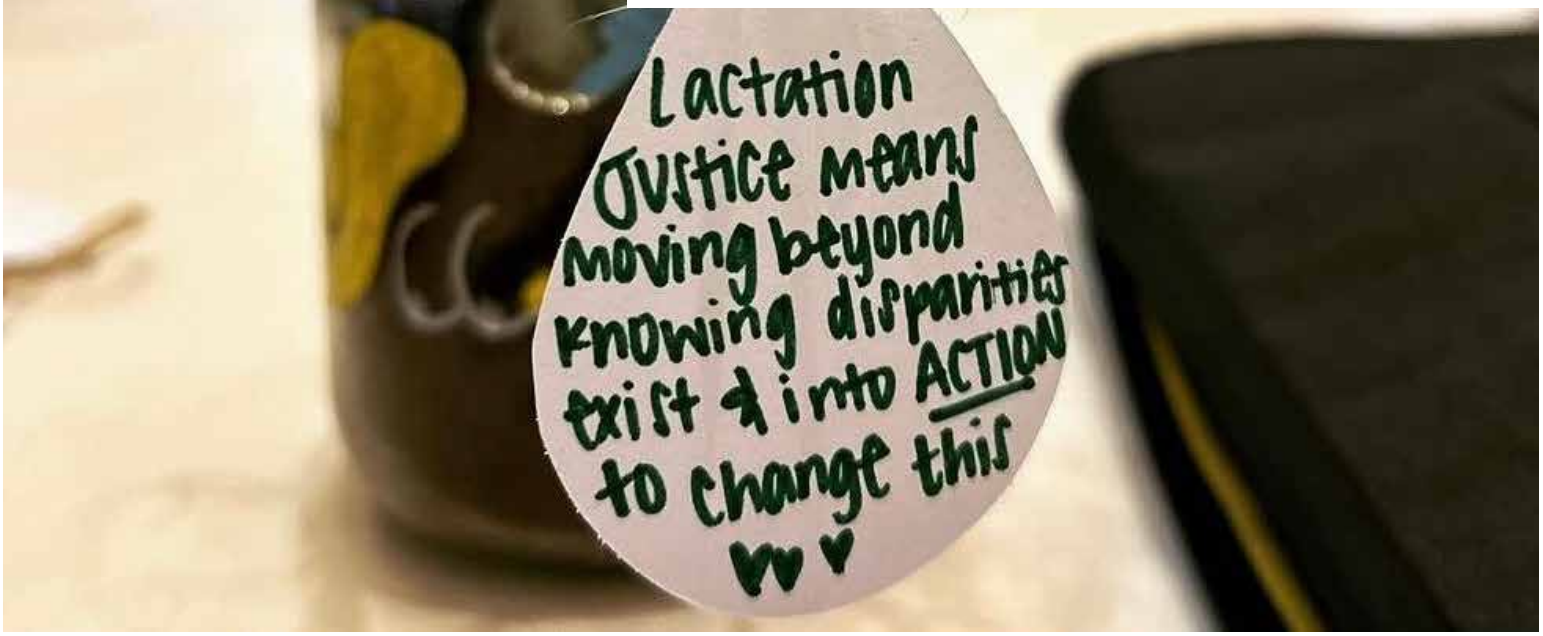


Executive Summary

The *"Lactation Justice: Activating our Community Response"* summit, organized by BreastfeedLA on October 12th and 13th, 2023 aimed to address the barriers faced by marginalized groups, especially people of color, in making informed infant feeding decisions. The summit explored how race and racism affect breast/chestfeeding outcomes, bringing together healthcare providers, parents, and policymakers to discuss diverse experiences and expertise in supporting human milk feeding practices in Los Angeles County and beyond. While this report provides an overview of summit discussions, we acknowledge that it does not cover every aspect. Ongoing efforts to address those not included in this report are needed to reduce disparities in infant feeding.

Using an adapted version of the Socioecological Model (SEM) of breast/chestfeeding developed by Alberta Health Services, this report outlines factors discussed at the summit across five levels: individual, relationship, healthcare system, community, and societal. Although included in the model, we intentionally omitted a section in the report dedicated solely to the individual level to shift our understanding of breast/chestfeeding beyond the individual. Below is a summary of the section topics addressed and recommendations.

Throughout the report we use gender inclusive language to refer to breastfeeding and lactating parents. The term breast/chestfeeding will be used to be inclusive of parents who may not align with the term breastfeeding because of their gender or relationship with their anatomy. Gender-neutral terms like lactating parents or birthing people will also be used in place of women, when possible, as not every person who lactates or gives birth identifies as a woman. It is important to note, however, that in specific instances, these gender-inclusive terms may not be suitable or accurate when describing particular data sets, and as a result, the word women may be used in some circumstances. This caution is to ensure that the language used accurately reflects the characteristics of the population under study. In some cases, precise gender-related terms might be necessary for an accurate portrayal of the data, and using overly broad terms could potentially lead to misleading or incomplete descriptions.

We thank our collaborators, speakers, and attendees for taking this journey with us.

Relationship

The relationship level examines the influence of the birthing parent's close relationships and home environments on breast/chestfeeding. This section emphasizes partner, peer, and familial support, which were themes consistently highlighted in summit discussions.

Recommendations

- Embrace Family Diversity: Expand research and programs to encompass diverse family structures, including LGBTQIA+ and multi-generational families, recognizing their unique dynamics and support needs.
- Educational Empowerment: Implement educational programs targeting partners and families to enhance their understanding of the benefits and challenges of breast/chestfeeding. Emphasize their pivotal role in supporting the birthing parent through this journey.
- Practical Support: Encourage partners to actively engage in practical assistance, such as helping with household chores and childcare, to create a supportive environment for breast/chestfeeding.

Healthcare System

The healthcare system level explores the landscape of healthcare systems including their policies, culture, physical spaces, and quality of care and its impact on breast/chestfeeding. This section of the report emphasizes the influence of quality of care and policies, such as implicit bias training within hospital settings.

Recommendations

- **Maintain Standards:** Implement targeted interventions and strengthen support systems in California hospitals to ensure compliance with California Health and Safety Code Section 123367.
- **Cultural Competence:** Integrate cultural competence into maternal care practices, particularly in delivering the Ten Steps to Successful Breastfeeding, to address racial disparities in in-hospital breast/chestfeeding rates.
- **Address Bias:** Combat unconscious racism and implicit biases in the healthcare system by prioritizing efforts to overcome challenges hindering compliance with the California Dignity in Pregnancy and Childbirth Act.

Community

The community level explores settings where social relationships take place, their impact on breast/chestfeeding, and the availability and accessibility of lactation-related accommodations and support within these settings. This section emphasizes various sources of community-based support such as peer support (i.e., Baby Cafés) and lactation professionals, all themes consistently highlighted in the summit.

Recommendations

- **Peer and Community-Led Support Programs:** Acknowledge the pivotal role of peer and community-led support programs such as WIC and Baby Cafe in promoting breast/chestfeeding among diverse populations, ensuring equitable access to support by providing necessary recognition and backing for these programs and investigate the effectiveness of these models in addressing the unique needs of diverse communities through formal evaluation methods.
- **Diversity in Professionals:** Prioritize diversity and inclusivity within the lactation profession by actively recruiting and training professionals from underrepresented backgrounds to better meet the needs of diverse lactating persons and communities.

Societal

The societal level examines the broad societal factors shaping breast/chestfeeding norms as well as media and formula marketing that help create a climate in which breast/chestfeeding is promoted or discouraged. This section includes the influence of these norms on established lactation related policies and practices within various systems and sectors such as the carceral system, child welfare system, and emergency preparedness. These were all themes consistently highlighted in summit discussions.

Recommendations

- **Regulation Advocacy:** Advocate for stronger regulations of the International Code of Marketing of Breast/chest milk Substitutes to counteract exploitative marketing practices by the infant formula industry.
- **Establish Support Infrastructure & Emergency Preparedness:** Integrate lactation education and support into emergency protocols alongside formula distribution efforts to ensure lactating individuals have access to resources during crises. Advocate for the creation of a full-time dedicated staff member in Los Angeles County to oversee and coordinate breast/chestfeeding support efforts, especially during emergencies, ensuring timely and effective assistance for lactating individuals.
- **Resource Allocation:** Allocate comparable funding for breast/chestfeeding initiatives during crises to match the resources spent on formula distribution, ensuring equitable support for breast/chestfeeding. Maximize the effectiveness and impact of breast/chestfeeding campaigns by increasing their financial backing to match that of the multi-billion-dollar formula industry, ensuring widespread dissemination of accurate information and support for breast/chestfeeding practices.
- **Reform Child Welfare:** Push for reforms in the child welfare system to prioritize keeping families together and provide comprehensive support services addressing underlying issues such as poverty and lack of resources, thereby fostering environments conducive to breast/chestfeeding.
- **Support Incarcerated Parents:** Create policies and programs that support breast/chestfeeding among incarcerated and detained parents, ensuring access to lactation support services and resources to promote bonding and child health.

Introduction

Lactation Justice is Reproductive Justice

Reproductive justice covers all stages of life, from before conception to lactation, involving choices surrounding family planning, contraception, childbirth, and breast/chestfeeding.[1] The connection between reproductive justice and lactation justice, highlighted by keynote speaker Shanti Moore from SisterSong, aims to ensure equitable access to all rights related to reproduction, including lactation support. This framework intersects with the health benefits of breast/chestfeeding, emphasizing informed choices and equitable access to lactation resources and support services.

Pictured: Keynote speaker Shanti Moore

Recent events, such as the reversal of Roe v. Wade, threaten reproductive rights, lactation justice, and healthcare access for birthing people across the nation.[2] Restrictions on abortion will have wide-ranging social, psychological and economic consequences, disproportionately affecting people of color and those with lower incomes.[3,4] Such restrictions could significantly increase pregnancy related deaths, especially among Black women.[5] This regression in legislation not only impacts reproductive autonomy but also hinders access to crucial services throughout the reproductive journey (i.e., prenatal and postnatal care, lactation support, and maternal health services) that could exacerbate existing disparities in lactation outcomes. While abortion rights are protected in California, their removal in other states will likely worsen existing healthcare disparities including those related to lactation support and outcomes.[6]

Why Breast/Chestfeeding Matters

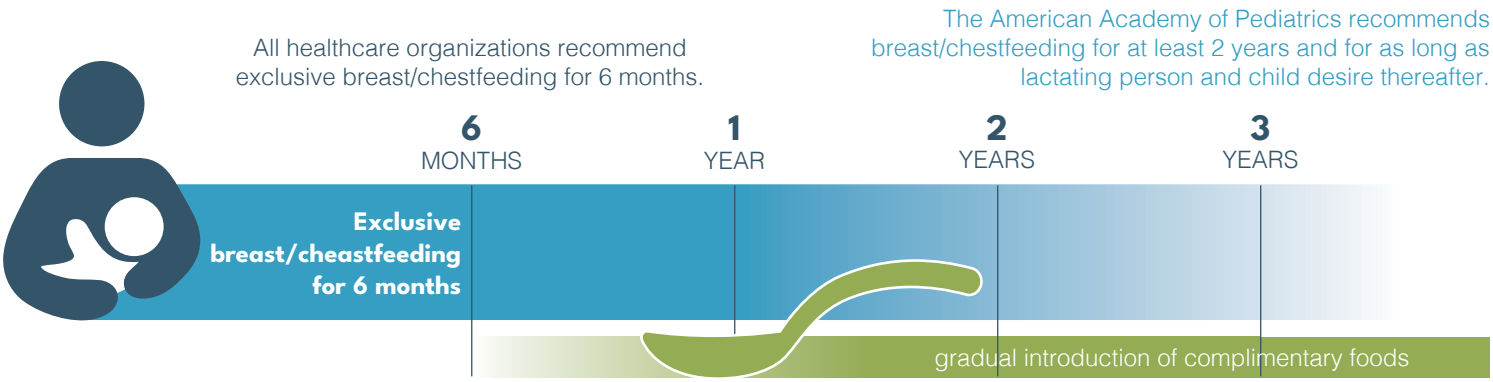
Human milk is considered the gold standard for infant feeding. All major health organizations recommend exclusive breast/chestfeeding for the first six months, followed by continued breast/chestfeeding with complementary foods until at least two years (Graphic 1).[7]

Breast/chestfeeding provides health benefits for both babies and their parents, protecting against diseases like certain cancers, type 2 diabetes, cardiovascular disease, postpartum depression, and sudden infant death syndrome (SIDS).[8,9] Additionally, human milk offers ideal nutrition and immune protection for optimal growth and development of infants.[10] Research has identified a link between breast/chestfeeding and reduced risk of infant mortality across various demographic groups.[11] These benefits hold even greater importance for communities of color as they have the potential to mitigate adverse health outcomes that disproportionately affect underserved communities, such as obesity, diabetes, hypertension, and infant mortality rates.[12–16] Breast/chestfeeding also has economic benefits by reducing premature deaths and future illness expenses.[17] Furthermore, it aids the environment by reducing waste and pollution and food insecurity by offering a reliable food source during uncertain conditions.[18,19]

Recognizing the importance of breast/chestfeeding to health and the economy, the Healthy People 2030 goals aim to increase exclusive breast/chestfeeding to 42.4% at 6 months, and breast/chestfeeding up to 12 months to 54.1%.[20,21] However, despite its benefits, breast/chestfeeding rates in Los Angeles County continue to fall below public health recommendations.

Graphic 1

Healthcare Breast/Chestfeeding Recommendations

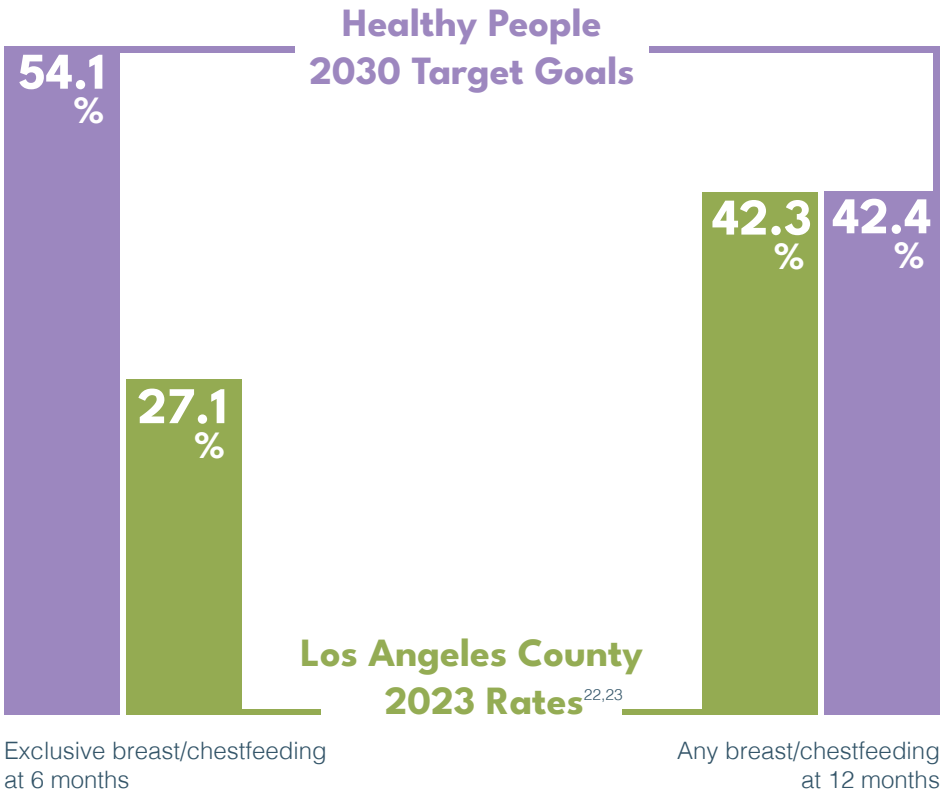


State of Infant Feeding in Los Angeles County

During Day 1 of the Summit, Skye Shodahl, a doctoral student at the University of California, Los Angeles, delivered a presentation on the current state of infant feeding in Los Angeles County. This section shares key data points from her presentation as well as additional data. We begin with an examination of in-hospital breastfeeding initiation and exclusivity rates, followed by an analysis of the duration and maintenance of breast/chestfeeding, focusing on any and exclusivity rates at various time points. The purpose of this section is to provide a comprehensive overview of the current state of infant feeding in Los Angeles County.

Graphic 2

Progress Towards Healthy People 2030 Breast/Chestfeeding Goals



Progress Towards Healthy People 2030 Goals

Regarding the Healthy People 2030 objectives, which aims to increase exclusive breast/chestfeeding to 42.4% at 6 months and breast/chestfeeding up to 12 months to 54.1%, Los Angeles County is making progress (Graphic 2).[20,23] For exclusive breast/chestfeeding at 6 months, Los Angeles county is at 27.1%, notably lower than the target.[23] However, breast/chestfeeding at 12 months is at 42.3%, nearly meeting the goal.[23] While Los Angeles County has made strides in meeting the Healthy People 2030 goals, continued efforts are needed to further enhance exclusive breast/chestfeeding rates at 6 months to align with established targets.

In-Hospital Breast/Chestfeeding Initiation

Graphic 3 includes detailed rates for in-hospital breast/chestfeeding initiation for two indicators: 1) "any breast/chestfeeding," defined as the infant receiving either only human milk or a combination of human milk and formula, and 2) "exclusive breast/chestfeeding," defined as the infant receiving only human milk.[24]

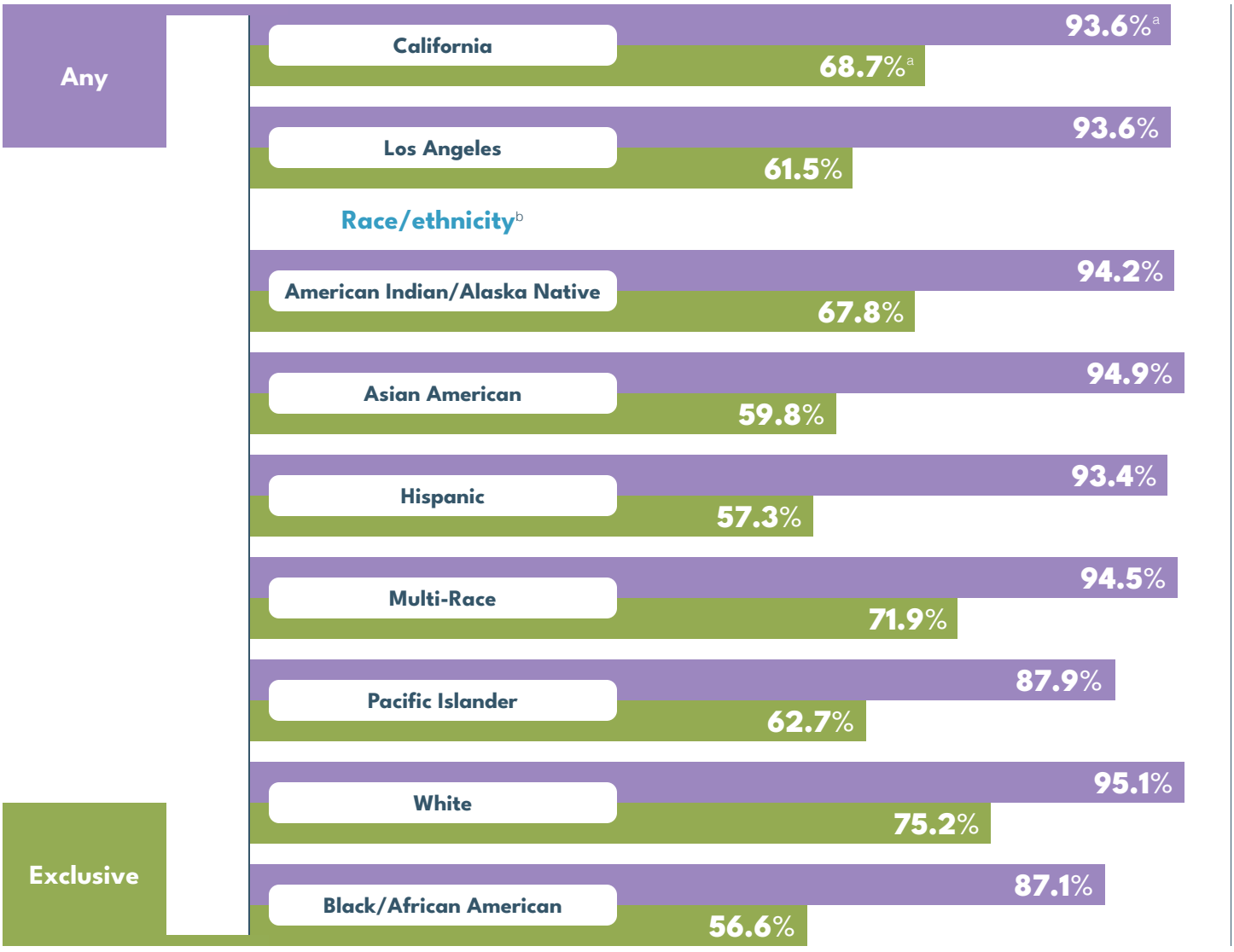
Between 2021-2022, the rate of any in-hospital breast/chestfeeding was 93.6% in Los Angeles County, in line with the state average (93.6%). However, these rates vary significantly across racial/ethnic groups. While some groups, like white (95.1%), multi-racial individuals (94.5%), and Asian Americans (94.9%), surpass state and county averages, others, particularly Black/African Americans (87.1%) and Pacific Islanders (87.9%), fall below these rates.

Despite high in-hospital breast/chestfeeding initiation rates, the rate of exclusive in-hospital breast/chestfeeding was notably lower at 61.5%, below the state average of 68.7%. Similar to in-hospital any breast/chestfeeding rates, exclusive rates vary significantly across racial/ethnic groups. While certain groups, such as white, demonstrate higher rates of exclusive breast/chestfeeding at 75.2%, others, notably Asian Americans (59.8%), Hispanics (57.3%), and Black/African Americans (56.6%), have the lowest rates within the county.

Overall, in-hospital breast/chestfeeding rates demonstrate that while any breast/chestfeeding rates are high, exclusivity remains a significant concern for Los Angeles County. While there is a strong desire to breast/chestfeed, barriers may exist which hinder adequate support to exclusively breast/chestfeed within hospital settings.

Graphic 3

Average In-Hospital Any and Exclusive Breast/Chestfeeding Rates from 2021-2022 for California and Los Angeles County, Stratified by Race/Ethnicity.[24]



a. Overall average derived from individual yearly rates for the years 2021 and 2022.
b. Rates specific to Los Angeles categorized by racial groups.

Any and Exclusive Breast/Chestfeeding

Table 1 includes detailed rates for ever breast/chestfeeding as well as duration, including any and exclusive breast/chestfeeding rates at 1,2, and 3 months.[25] Between 2020-2021, the rate of ever breast/chestfeeding in Los Angeles County was 93.1%, similar to the state average of 94.6%. Additionally, the rate of any breast/chestfeeding was 85.6% at 1 month, 77% at 2 months, and 69.6% at 3 months, nearly the same as the state average (85.6%, 78.9%, and 70.6%, respectively). While rates for ever and any breast/chestfeeding at 1, 2, and 3 months are high, rates for exclusive breast/chestfeeding were substantially lower at 36.5% at 1 month 30.5% at 2 months, and 26.6% at 3 months. These rates also fall below the state averages of 42.1%, 36.1%, 30.8%, respectively.

Within Los Angeles County disparities in initiation and continuation exist across demographic characteristics such as race, income, and education. Across racial/ethnic groups, whites consistently exhibit the highest initiation rates as well as any and exclusive breast/chestfeeding at 1,2, and 3 months with Black/African Americans consistently presenting the lowest rates across all time points. Interestingly, Asian Americans/Pacific Islanders present one of the highest initiation and any breast/chestfeeding rates at 1,2, and 3 months yet consistently display the lowest rates of exclusivity across these timepoints.

Across income levels, categorized by federal poverty guidelines (FPG), initiation rates and any breast/chestfeeding rates at 1, 2, and 3 months display a gradient showcasing higher rates among wealthier categories. On the contrary, rates for exclusive breast/chestfeeding follow a slightly different pattern. While the highest rates are observed among individuals at or above 200% FPG, it is noteworthy that those in the lowest income bracket do not reflect the lowest rates of exclusivity. Interestingly, those within the 0-100% FPG category consistently show rates slightly higher than those within the 101-200% FPG category.

Across education levels, a consistent trend emerges for initiation rates as well as any and exclusive breast/chestfeeding at 1, 2, and 3 months, with individuals with higher educational attainment having higher rates. Surprisingly, those with the lowest education level (i.e., less than high school) do not exhibit the lowest rates across all time periods. Specifically, those with less than a high school education consistently show rates slightly higher than high school graduates.

Overall, these statistics highlight persistent disparities in breast/chestfeeding outcomes across various demographic characteristics, including race/ethnicity, income, and education. Additionally, there is a consistent trend of declining rates for both any and exclusive breast/chestfeeding over time, from 1 month to 3 months. This pattern highlights a gap between current rates and the recommended six-month exclusivity period. These data emphasize the need for targeted support and interventions to ensure equitable breast/chestfeeding practices across diverse communities in Los Angeles County.

In the subsequent sections of this report, we will explore potential underlying factors contributing to these disparities. It is important to note that a major limitation is the lack of disaggregated data, which does not allow for the identification of specific trends across ethnic subgroups, potentially masking existing disparities within racial groups. To gain a more comprehensive understanding of the landscape of breast/chestfeeding in Los Angeles, more granular level data for breast/chestfeeding research is needed.

Table 1

Any and exclusive breast/chestfeeding rates from 2020-2021 for California and Los Angeles County, stratified by race/ethnicity, federal poverty guidelines (FPG), and education level.[25]

	Ever	Any			Exclusive		
		1 month	2 months	3 months	1 month	2 months	3 months
California	94.6	85.6	78.9	70.7	42.1	36.1	30.8
Los Angeles	93.1	85.5	77.0	69.6	36.5	30.5	26.6
Race/ethnicity[a]							
Black/African American	87.2	78.5	67.9	57.8	44.8	34.8	27.2
Asian/Pacific Islander	93.3	86.7	82.6	74.3	26.1	23.9	21.8
Hispanic	93.8	82.3	71.9	65.6	32.3	24.9	21.6
White	96.0	93.5	88.1	83.2	49.2	46.9	46.0
Federal Poverty Level[b]							
0-100% FPG	92.1	79.2	68.4	59.6	35.8	27.9	23.9
101-200% FPG	90.7	81.3	73.1	68.5	28.9	21.7	20.3
> 200% FPG	97.1	93.2	86.9	80.8	41.0	37.2	32.4
Education Level[c]							
Less than High School	91.3	82.8	69.4	64.3	34.3	21.9	19.0
High School or GED	90.3	75.2	63.1	54.7	26.9	20.1	16.6
Some College	93.2	83.5	74.8	67.5	36.7	31.2	30.7
College Graduate	96.7	92.5	87.2	81.2	41.0	36.9	31.9

a. Rates specific to Los Angeles categorized by racial groups
b. Rates specific to Los Angeles categorized by federal poverty guidelines
c. Rates specific to Los Angeles categorized by education level

Our Conceptual Framework

To help synthesize the discussions and topics that were highlighted throughout the summit, this report is organized using the framework outlined in Graphic 4. This graphic is an adapted version of the Socioecological Model (SEM) of breast/chestfeeding developed by Alberta Health Services. In line with the Summit's emphasis on equity, our modified framework integrates an equity lens, grounded in Critical Race Theory (CRT). By doing so, we account for how factors that impact breast/chestfeeding are influenced by systemic inequalities, particularly systemic racism, to create disparities in outcomes.

To provide an even more comprehensive understanding of breast/chestfeeding, the current framework further expands upon the original by including factors discussed at the Summit, denoted by a star in Graphic 4. The highlighted factors within the model are explicitly addressed in this report. Those not highlighted are included in the framework to acknowledge the breadth of factors that impact breast/chestfeeding, although they are not addressed in this report. The following paragraphs will provide an overview of the SEM and CRT, the two foundational frameworks that influenced the current model's development (i.e., structure and key components).

Socioecological Model (SEM)

The SEM, developed by Urie Broffenbrenner, considers the complex interaction between individual, relationship, community, and societal factors to understand both the development of health problems and efforts to address these problems.[27] The SEM proposes that the different levels are interconnected, which is useful for understanding the impact that each level of the SEM has on one another.[27] In this report, the SEM is especially useful as it provides a comprehensive way to understand the multifaceted and complex factors influencing breast/chestfeeding at the following levels: 1) individual, 2) relationship, 3) health care system, 4) community, and 5) societal.

Critical Race Theory (CRT)

In line with the summit's focus on equity, our framework is grounded in CRT to ensure it reflects the enduring systemic inequities, specifically as they relate to systemic racism, that influence disparities in breast/chestfeeding. CRT, coined by Kimberlé Crenshaw, encourages us to consider how race and racism, operating as institutional and systemic phenomena, directly and indirectly affect ethnic minorities.[28] A critical component of CRT, foundational to our framework, is its assertion that racism is omnipresent and deeply embedded in the fabric of existing societal structures and institutions.[28] Within our framework, this perspective is illustrated as the large arrow which encompasses and traverses all levels, indicating racism as a factor influencing every aspect of the SEM and its potential contribution to disparities in breast/chestfeeding.

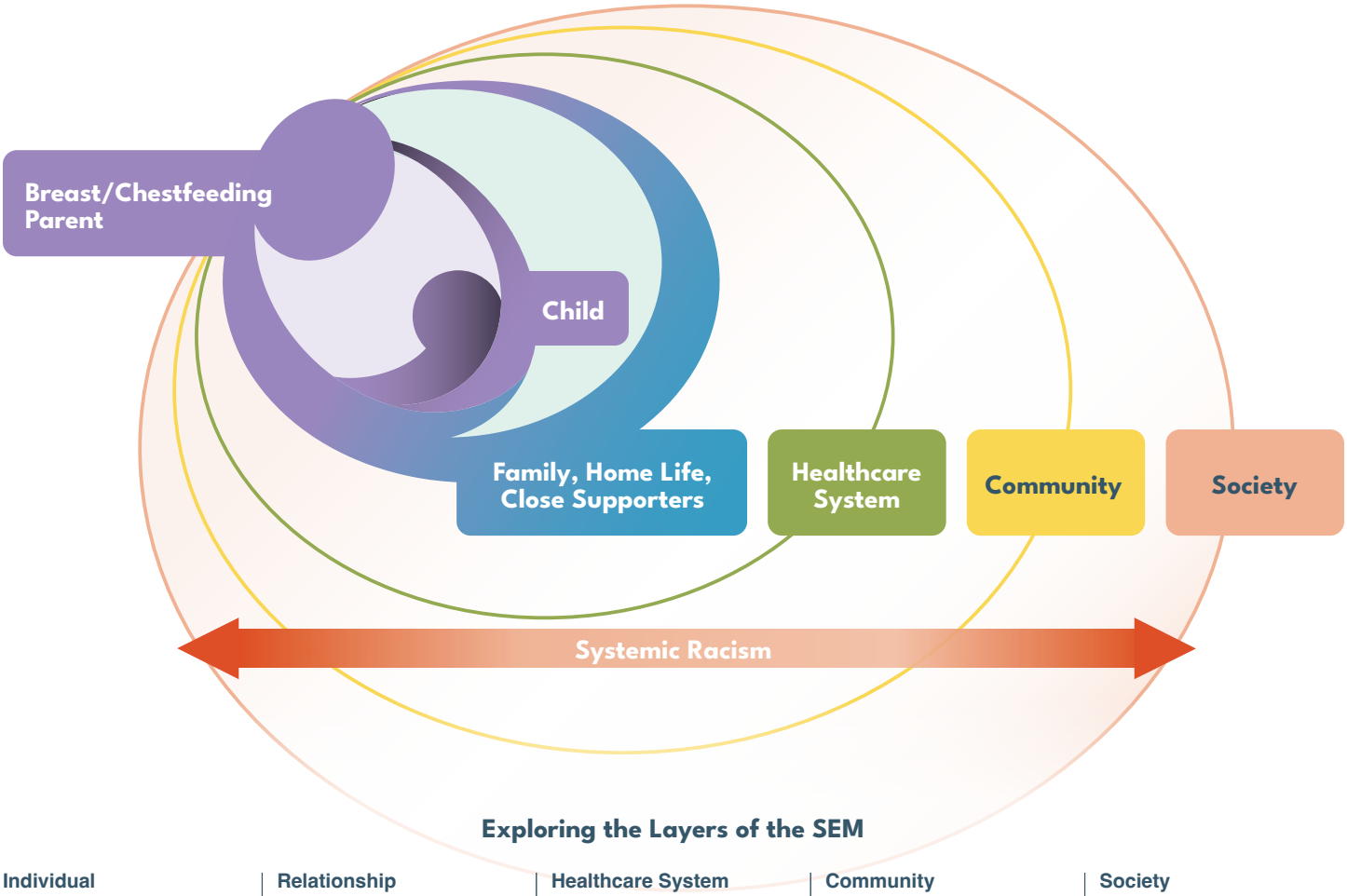
Applying Our Framework

With our framework in mind, the following sections of this report are organized by the different levels of our framework pictured above. As stated earlier, only the highlighted factors within the model are addressed in this report. Furthermore, each section will end with a set of recommendations for actionable suggestions to address the identified disparities and foster equity in breast/chestfeeding.

In an effort to shift our understanding of the factors that impact breast/chestfeeding beyond the individual, we have intentionally omitted a section dedicated solely to the individual level. Instead, discussion of this level was integrated into the report's introduction by highlighting the impact of race on breast/chestfeeding in order to frame the relevance of equity within the broader context of this report. Thus, the first section begins with the relationship level, highlighting the influence of partner, familial, and peer support. The second section addresses the healthcare system level, highlighting the influence of quality of care and policies such as Baby-Friendly Hospital Initiative within hospital settings. The third section addresses the community level, highlighting workplace policies like paid family leave (PFL) and community-based support such as lactation professionals, WIC clinics, Milk Banks, and Baby Cafés. The fourth section addresses the societal level, highlighting social and cultural norms shaped by racial stereotypes, media, and formula marketing, as well as policies advocating for breast/chestfeeding rights that help create a climate in which breast/chestfeeding is promoted or discouraged. This section will also include an exploration of emergency preparedness in times of crisis and an examination of institutions such as Department of Child Services (DHS), carceral systems, and the infant formula industry. Consistent with our framework, each section will emphasize equity and examine disparities within these factors.

The Socio-Ecological Model in the Breast/Chestfeeding Context

Graphic 4. A visual framework of how discriminatory etiology and common factors may influence disparities in breast/chestfeeding.



Exploring the Layers of the SEM

Individual

Identifies biological and personal history factors of birthing parent and infant; such as age, education, race/ethnicity, birth experience, and health status that impact breast/chestfeeding.

Relationship

Examines the impact of close relationships such as those with partners, family members, and peers, and the home environment on breast/chestfeeding.

Healthcare System

Healthcare System: Explores the landscape of healthcare systems including their policies, culture, physical spaces, and quality of care and its impact on breast/chestfeeding.

Community

Explores settings where social relationships take place, such as workplaces, schools, and neighborhoods and their impact on breast/chestfeeding.

Society

Examines the broad societal factors such as social and cultural norms shaped by media and formula marketing, as well as policies advocating for lactation rights that help create a climate in which breast/chestfeeding is promoted or discouraged.

Breast/Chestfeeding Parent
- Birth Experience
- Experience & expectations
- Health status & history
- Knowledge
- Physiological factors
- Social determinants
- Other

Child
- Age
- Birth interventions
- Feeding behaviors
- Health status & history
- Physiological factors
- Other

Family, Home Life, Close Supporters
- Culture
- Extended family & friends
- Family structure & functioning (partner support)
- Physical environment
- Other

Healthcare System
- Access
- Culture
- Physical spaces
- Policies (Baby Friendly)
- Quality of care (inequities, and trainings)
- Clinicians, doulas, lactation professionals
- Other

Community
- Breast/chestfeeding-friendly spaces
- Cultural norms
- Peer support (WIC, milkbanks, baby cafes)
- Social media
- Work & school accomodation
- Other

Society
- Media
- Societal norms & stigma
- Formula marketing
- Child welfare
- Incarceration system
- Emergency preparedness
- Other

Note: Model is adapted from Alberta Health Services.[26]

Section 1: Relationship

The relationship level, indicated by the purple ring in Graphic 4, examines the influence of the birthing parent's close relationships, including partners, family members, and peers. Additionally, it considers the influence of the home environment on breast/chestfeeding, including cultural aspects, family structure, and physical surroundings. This section emphasizes partner and familial support, themes consistently highlighted in the summit discussions.

Partner Support

Partner support is crucial in the success of breast/chestfeeding outcomes, particularly in underserved communities where inadequate family and social support often present barriers.[29] Research indicates that involving partners in lactation support can lead to higher initiation rates and better breast/chestfeeding outcomes.[30] When partners have negative feelings or no feeding preference, parents are more likely to use formula.[31] Partner support, including verbal encouragement, responsiveness, assistance with lactation-related issues, and practical help with household chores and childcare, has been influential in promoting the initiation, duration, and exclusivity of nursing.[32,33]

The importance of partner support was highlighted throughout the summit. During the panel discussion "Is IBCLC The End Goal?: Highlighting Community Care in Lactation" panelist Davion Mauldin emphasized the importance of involving partners in breast/chestfeeding support efforts through initiatives like "Black Daddy Dialogue." This community-led initiative is a social support group for new, expecting, and experienced fathers raising Black children. Their goal is to change the narrative of Black families by offering assistance and education to Black fathers and father figures who support pregnant and birthing parents and children aged 0-5. They also provide loss and grief support services. By engaging partners and family members, particularly within culturally relevant contexts, lactation initiatives like Black Daddy Dialogue can create supportive environments that enhance maternal and infant health outcomes.

Familial Support

Beyond partners, other family members, such as parents and grandparents, also influence infant feeding decisions. Globally, research has shown that family members not only impact a lactating parent's desire to initiate and continue breast/chestfeeding, but they also play an important role in early cessation decisions postpartum.[34] Familial support has been particularly influential in underserved communities, where parents and grandparents often serve as role models for parenting information and support, such as in Asian American, Black/African American, and Latinx American communities.[35–38]

In underserved communities, multi-generational households are more prevalent. Within these households, familial influence extends beyond immediate caregivers to encompass a broader network of relatives.[36] Cultural traditions in these households can influence how breast/chestfeeding is viewed and passed down through generations, affecting family attitudes toward breast/chestfeeding.[39,40]

Overall, partner and familial support networks play a crucial role in shaping infant feeding behaviors. However, much of the current research focuses on mothers and fathers. Further research is needed to understand how other partners and family members, particularly within LGBTQIA+ families, influence breast/chestfeeding outcomes. Understanding the dynamics of support within diverse family structures is crucial for creating environments that support infant and maternal health.

Pictured (from left to right): Nada Dalati, Nichole Banks, Davion Mauldin

Peer Support

Peer support, like partner and familial support, is also important for promoting successful breast/chestfeeding, especially within communities where traditional support systems may be lacking. Studies have shown that peer support can significantly enhance breast/chestfeeding initiation, duration, and exclusivity rates, providing an additional layer of assistance beyond familial and partner networks.[41]

Peers can offer unique insights, emotional reassurance and practical advice based on their own experiences. This shared understanding fosters a sense of support among lactating parents, which can be particularly empowering for those facing challenges or uncertainties. Peer support interventions, such as mother-to-mother support groups or online forums, positively impact breast/chestfeeding outcomes by providing a safe space for sharing knowledge, concerns, and encouragement.[41] Peer support also frequently appears in community-based settings, where peer counselors trained in lactation support can offer guidance and additional help if needed.[42] Community-based support is integral for breast/chestfeeding promotion; for more on this form of peer support, see Section 3: Community.

Additionally, informal networks of friends, colleagues, or community members can also play a crucial role in promoting breast/chestfeeding confidence. Simple acts of listening, sharing personal stories, or offering practical assistance can make a significant difference in a lactating person's journey, particularly during challenging moments. Recognizing the importance of peer support, efforts to promote breast/chestfeeding-friendly environments should include initiatives that facilitate peer connections and knowledge sharing. By harnessing the collective wisdom and solidarity of peer networks, communities can create inclusive and supportive environments that empower parents to make informed choices and nurture their infants optimally.

Recommendations

- **Embrace Family Diversity:** Expand research and programs to encompass diverse family structures, including LGBTQIA+ and multi-generational families, recognizing their unique dynamics and support needs.
- **Educational Empowerment:** Implement educational programs targeting partners and families to enhance their understanding of the benefits and challenges of breast/chestfeeding. Emphasize their pivotal role in supporting the birthing parent through this journey.
- **Practical Support:** Encourage partners to actively engage in practical assistance, such as helping with household chores and childcare, to create a supportive environment for breastfeeding.

The healthcare system level, indicated by the green ring in Graphic 4, explores the landscape of healthcare systems including their policies, culture, physical spaces, and quality of care and its impact on breast/chestfeeding through settings such as hospitals, health clinics, and doctors offices. Within this section of the report, the emphasis will be on the influence of quality of care and policies such as implicit bias training within hospital settings, which were themes consistently highlighted in the summit discussions.

In-Hospital Exclusive Breast/Chestfeeding Disparities

In Los Angeles County, inequities in exclusive breast/chestfeeding rates during hospital stays are evident, especially among lactating persons of color and across geographic regions. Even within individual hospitals, rates differ substantially between white infants and infants of color.

Graphic 5 highlights the ten hospitals in Los Angeles County with the lowest exclusive breast/chestfeeding rates in 2020.[24] Together, these hospitals have an average exclusivity rate of 33.0%,which is significantly lower than the county average of 61.5%.[24] Six of the ten hospitals were also identified in the 2018 report as low performers, with only three showing improvement since then.[1] Furthermore, the lowest performing of these hospitals had an exclusivity rate of 15.5%, while the highest performing of these hospitals had a rate of 46%.[24]

Graphic 5

Hospitals with the lowest in-hospital exclusive breast/chestfeeding rates[24]

in Los Angeles County have an average in-hospital exclusive breast/chestfeeding rate of **33%**

	2022 Percent Exclusively Breast/Chestfeeding In-Hospital	Change since 2020
Beverly Hospital	15.5%	▼
Whittier Hospital	20.0%	▲
East Los Angeles Doctors Hospital	20.1%	▼
San Dimas Community Hospital	30.1%	▼
Glendale Memorial Health Center	35.5%	▼
St. Francis Hospital Medical Center	35.6%	▼
San Gabriel Valley Medical Center	38.5%	▼
Hollywood Presbyterian Medical Center	42.8%	▲
Providence Holy Cross Medical Center	45.8%	▲
Good Samaritan Hospital	46.0%	▲

Graphic 6 presents a ranking of Los Angeles County hospitals (from lowest to highest) based on their in-hospital exclusive breast/chestfeeding rates for infants of color.[24] The data reveals a concerning disparity between infants of color and white infants. In general, infants of color have lower rates of exclusive breast/chestfeeding compared to white infants. This discrepancy is highlighted by the wide range of rates in hospitals across the county. Notably, there is a 67.2 percentage point gap between the hospital with the highest exclusive breast/chestfeeding rate for infants of color and the one with the lowest rate.[24] Whereas, the percentage point gap for white infants is smaller at 53.6. Additionally, the highest

Graphic 6

Average In-Hospital Exclusive Breast/Chestfeeding Rates, by Hospital (2022)[24]

Hospital	EBF Rate for Infants of Color	EBF Rate for White Infants
Beverly Hospital •‡	13.5%	—
East Los Angeles Doctors Hospital •†	18.5%	—
Whittier Hospital*	19.4%	32.3%
San Dimas Community Hospital*	24.5%	50.7%
Glendale Memorial Hospital †◊◊	32.4%	38.6%
St. Francis Hospital Lynwood •	35.2%	43.5%
San Gabriel Valley Medical Center •	37.8%	44.0%
Palmdale Regional Medical Center	38.5%	56.8%
Hollywood Presbyterian Medical Center •	40.5%	68.4%
Providence Saint Joseph Medical Center ◊	40.6%	57.3%
PIH Health Good Samaritan Hospital •	41.4%	80.4%
Providence Holy Cross Medical Center ◊	43.3%	62.7%
California Hospital Medical Center	45.8%	71.4%
Pomona Valley Hospital Medical Center •	46.9%	62.8%
Emanate Health Queen of the Valley Hospital ◊◊	50.6%	60.7%
Adventist Health White Memorial Medical Center •	53.3%	66.1%
Providence Tarzana Medical Center	53.8%	69.8%
St. Mary Medical Center •	54.8%	76.7%
Northridge Hospital Medical Center*	54.9%	68.2%
Huntington Memorial Hospital •	56.9%	72.5%
USC Verdugo Hills Hospital*	59.8%	61.3%
Cedars-Sinai Medical Center	60.2%	74.0%
Henry Mayo Newhall Hospital ◊◊	60.5%	72.3%
Kaiser Sunset ◊	63.1%	79.9%
Harbor-UCLA Medical Center •	63.1%	72.4%
USC Arcadia Hospital*	63.6%	81.3%
Valley Presbyterian Hospital ◊◊	64.5%	67.9%
Garfield Medical Center*	64.7%	76.5%
Kaiser Woodland Hills ◊	65.5%	78.4%
Miller Children's and Women's Hospital •	65.6%	85.3%
Kaiser Panorama City ◊	66.2%	81.8%
Torrance Memorial Medical Center •	67.0%	78.7%
Kaiser Baldwin Park ◊	67.2%	82.4%
Adventist Health Glendale Medical Center	68.9%	69.8%
Antelope Valley Hospital	69.2%	79.8%
Olive View-UCLA Medical Center •	69.4%	73.4%
Los Angeles General Medical Center •	70.9%	63.6%
Kaiser West LA ◊	72.3%	88.5%
Providence Little Company of Mary Medical Center Torrence ◊	72.8%	75.6%
Ronald Reagan UCLA Medical Center •	73.0%	76.8%
Kaiser South Bay ◊	73.3%	87.3%
Martin Luther King, Jr. Community Hospital •†	73.4%	100%
UCLA Medical Center, Santa Monica •	75.0%	88.0%
Kaiser Downey ◊	75.4%	81.4%
PIH Health Hospital Whittier	75.4%	77.8%
Providence Saint John's Health Center	80.7%	85.9%

• Baby Friendly Hospital as of December 2023
* Only includes Asian and Latinx data, insufficient sample size for African Americans
† Only includes African American and Latinx data, insufficient sample size for Asian data
‡ Only includes Latinx data, insufficient sample size for African American and Asian data
◊ Lost Baby Friendly Status between 2016 to 2018
◊◊ Lost Baby Friendly Status between 2018 to 2023
— Insufficient data

Ranked by EBF rate for Infants of Color from low to high.

NOTE: Insufficient sample size indicates a sample size of less than 10 **or** no data.

performing hospital (UCLA Medical Center, Santa Monica) shows a discrepancy between infants of color at 75%, and white infants at 88%.[24] These variations suggest that infants of color may be receiving less optimal lactation support as compared to their White counterparts.

Overall, these data highlight challenges and disparities in lactation support and promotion across hospitals in Los Angeles County. It reveals an existing gap and inconsistency in healthcare quality and lactation support in Los Angeles. To address this, targeted interventions and improved support systems are needed to ensure breast/chestfeeding equity.

Healthcare Facilities and Policies

The hospital experience, such as access to and quality of prenatal and postpartum care, plays an important role in shaping an individual's lactation journey. These experiences are influenced by maternity care policies and practices, such as the Baby-Friendly Hospital Initiative (BFHI) and implicit bias training for staff, which can impact the success of breast/chestfeeding. Therefore, effective lactation support and culturally sensitive care provided by hospitals are not only crucial in the hospital experience, but also for overcoming lactation related challenges.

California Dignity in Pregnancy and Childbirth Act

The California Dignity in Pregnancy and Childbirth Act, effective as of January 2020, mandates that covered facilities must implement evidence-based implicit bias programs for all health care providers involved in perinatal care.[43] This legislation is critical as implicit bias disproportionately affects individuals of color, especially Black/African Americans, and can have ramifications on an individual's breast/chestfeeding journey.[44] Research shows that biased assumptions by healthcare providers, such as assuming Black/African American women will not breast/chestfeed, can impact the quality of lactation support they receive (i.e., fewer referrals for lactation support and limited assistance when problems occur).[44] The passing of this act represents an important first step toward mitigating unconscious racism and implicit biases apparent within the current healthcare system.

Despite the mandate, implementation has been inconsistent.[45] In 2022, California's Department of Justice released a report examining initial compliance of healthcare facilities to the California Dignity in Pregnancy and Childbirth Act.[45] Out of 242 facilities surveyed, 81.44% reported completion of required training among perinatal staff, while 17.35% had completed training for all staff.[45] Although the percentage of hospitals were compliant with the code (training of perinatal staff only), a substantial number of facilities had not even begun training until after receiving an invitation to participate in the study in August 2021.[45] This highlights a large delay in implementation despite the training requirement being effective as of January 1, 2020. Moreover, 76.44% had trained some but not all covered providers, with an average of 77.54% of appropriate providers being trained in these cases.[45] Two facilities (00.82%) reported that none of their staff had finished training, while thirteen facilities (00.05%) failed to provide information related to training.[45]

This report reveals significant gaps in compliance with the California Dignity in Pregnancy and Childbirth Act. The authors attribute the lack of compliance to several factors, including the lack of enforcement or oversight, incentives to update training with new research, repercussions for non-compliance, public compliance data to ensure accountability, and confusing language around which positions require training.[45] The passing of this act represents an important first step toward mitigating unconscious racism and implicit biases apparent within the current healthcare system.[45] While this legislation signifies progress towards mitigating unconscious racism and implicit biases in California's healthcare system, more efforts are needed to address the challenges hindering compliance.[45]

Recommendations

- **Maintain Standards:** Implement targeted interventions and strengthen support systems in California hospitals to ensure compliance with California Health and Safety Code Section 123367.
- **Cultural Competence:** Integrate cultural competence into maternal care practices, particularly in delivering the Ten Steps to Successful Breastfeeding, to address racial disparities in in-hospital breast/chestfeeding rates.
- **Address Bias:** Combat unconscious racism and implicit biases in the healthcare system by prioritizing efforts to overcome challenges hindering compliance with the California Dignity in Pregnancy and Childbirth Act.

Section 3: Community

The community level, indicated by the yellow ring in Graphic 4, explores settings where social relationships take place, such as workplaces, schools, and neighborhoods and their impact on breast/chestfeeding. This level encompasses the availability and accessibility of lactation-related accommodations and support within these settings. Within this section of the report, the emphasis will be community based support such as peer support (i.e., WIC clinics and Baby Cafes), home visitation, lactation professionals, and breast/chestfeeding friendly spaces - which were themes consistently highlighted in the summit discussions. However, it is important to note that this does not encompass all community-level support models.

Distribution of Lactation Support in Los Angeles County

Graphic 7 shows the distribution of lactation support sites across various zip codes in Los Angeles County, classified by annual median household income. Lactation support sites are unevenly distributed, with a higher concentration in areas of medium to high income levels, whereas there are fewer sites in the lowest income areas. The distribution of hospitals also follows a similar pattern, with many hospitals located in higher income or middle-income areas. This suggests that lower-income communities have less access to these critical lactation services, therefore increased efforts to establish lactation support are needed in Los Angeles County.

Community Breast/Chestfeeding Support

Culturally Specific Peer Support

Peer support in the context of breast/chestfeeding involves guidance from individuals who have breast/chestfed before or are currently doing so and includes individual counseling and peer support groups. Cultural peer support is particularly crucial, as it ensures that individuals receive guidance from those who not only share similar experiences but also understand the cultural nuances and challenges they may face. Although there are many forms of peer support, in the following sections we will highlight initiatives in Los Angeles, including Women, Infants and Children's (WIC) CinnaMoms and BreastfeedLA's Baby Cafés.

CinnaMoms

Innovative peer support groups have emerged to expand on WIC's existing breast/chestfeeding support services. One such group, CinnaMoms, developed out of the PHFE WIC program in Los Angeles and was showcased at the summit as an exemplary model of community-driven lactation support.[46] In 2015, CinnaMoms was founded with the mission of increasing breast/chestfeeding rates among Black/African American women both within and outside the PHFE WIC Program.[46] To achieve this, the CinnaMoms model is built on four pillars: 1) virtual breastfeeding and parenthood support groups, 2) early access to the WIC BFPC, 3) tailored text messages, and 4) access to community resources, robust social media platforms, a private Facebook group, and a website.[46] Through these pillars, they are able to create a cultural space that promotes empowerment and self-transformation for Black/African American women, focusing on breast/chestfeeding, parenting, and health throughout the entire life course.[46]

Participation in CinnaMoms shows high levels of satisfaction and comfort among participants. 70% of participants strongly agree they felt comfortable and included during CinnaMoms support circles, while 73% strongly agreed that CinnaMoms meets the needs of Black women and their families.[46] Furthermore, 77% strongly agree that they are satisfied with the CinnaMoms content and topics as relevant to them as Black mothers.[46] Similarly, 77% strongly agreed that they are satisfied with the community resources offered at the CinnaMoms support circles. One participant highlighted the significance of these spaces, stating: "These spaces are important because we're already generalized when we go in to have our children, and there's not many people in there that look like us, so the concerns that we have, we don't often voice. When we have this group [CinnaMoms], and we have concerns, it gives us the confidence to ask because they look like us. Other women might be going through this and might be afraid to speak up to somebody, but in this group, somebody else is going through it and they hear what they should do."

WIC peer support programs, like the BFPC and CinnaMoms, play a critical role in promoting breast/chestfeeding and providing culturally sensitive community-based support to diverse populations. These programs not only increase breast/chestfeeding initiation and duration rates, but they also create empowering spaces where women are understood and supported. To ensure equitable access to support for all lactating persons, especially those from marginalized communities, it is essential to recognize and support these programs.

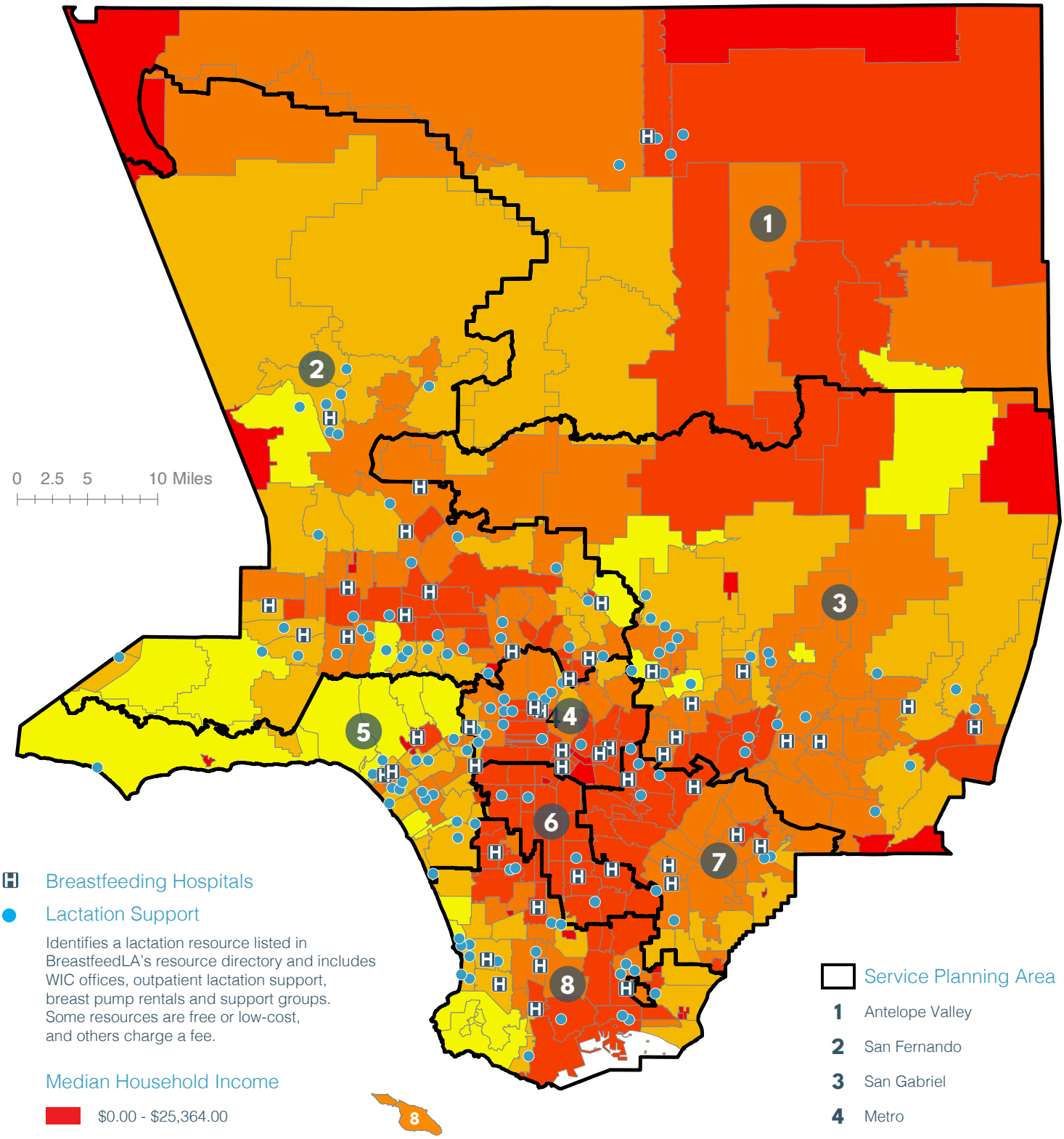
Baby Cafés

Building on the foundation of peer support, Baby Cafés are a critical source of community-based support that provides an additional layer of expertise and guidance for lactating parents by integrating healthcare professionals into their model. These informal "drop-in" centers offer free breast/chestfeeding counseling from healthcare professionals and peers in a friendly, nonclinical setting designed to resemble a café-style environment. Baby Cafés have been described as supportive environments that foster breast/chestfeeding confidence and provide a shared journey experience. They have been shown to increase breast/chestfeeding duration up to 6 months.[47] Given these benefits, Baby Cafés are critical to mitigate disparities in breast/chestfeeding by increasing access to lactation support to communities that lack it.

Graphic 7

Lactation Support Sites

Annual Median Household Income by Zip Code



Source: U.S. Census Bureau American Community Survey, 2019 5-year estimates, calculated from survey data collected over period 2015-2019.

During the summit, a breakout session titled “Baby Cafés: Innovative Response to a Community Need” highlighted several Baby Café initiatives, developed in partnership with BreastfeedLA, across Los Angeles including Dede Diner, New Familia’s Baby Café, and Titties ‘N Tea. These initiatives provide culturally responsive and targeted support to the diverse communities in Los Angeles. While Dede Diner focuses on the Filipino community, New Familia serves the Latinx community, and Titties ‘N Tea supports the Black/African American community. They offer both in-person and virtual support for the convenience of the community. This flexibility has been particularly valued by mothers during the COVID-19 pandemic and post pandemic years as it allows for unscheduled and off-camera interactions.

The initiatives highlighted in the summit showcase how BreastfeedLA has effectively utilized the Baby Café model to form partnerships with various community-based organizations and bring linguistically and culturally congruent care to communities across Los Angeles that lack this support. These initiatives serve as examples that demonstrate the Baby Café model as a promising community support model that can effectively meet community needs. While the effectiveness of Baby Cafés is supported by anecdotal evidence from these initiatives, stronger evaluation methods to further examine their impact are needed.

Lactation Professionals

Lactation professionals are individuals with specialized training in supporting and educating breast/chestfeeding persons and families. At the highest level, International Board Certified Lactation Consultants (IBCLCs) undergo extensive education and clinical training to provide expert guidance in addressing complex breast/chestfeeding challenges. Certified Lactation Education Specialists (CLES), Certified Lactation Educators (CLEs), and Certified Lactation Counselors (CLCs) have training to provide basic breast/chestfeeding education and support, often in community settings. Peer supporters, such as WIC Peer Counselors and La Leche League Leaders, play a crucial role in providing community-based support and increasing breast/chestfeeding initiation and duration by offering support based on their own lactation experiences and training from their organization.[48] By offering valuable support at varying levels of expertise, each of these professionals contributes uniquely to the breast/chestfeeding journey and have the potential to mitigate racial/ethnic disparities in breast/chestfeeding outcomes. Therefore, it is crucial for postpartum support programs to integrate lactation professionals.

Lactation Professional Survey

Although lactation professionals are a critical source of breast/chestfeeding support, there is limited knowledge about their experiences and needs. To address this gap, BreastfeedLA conducted an online survey to gain insights into the challenges, successes, and perspectives of lactation professionals working in Los Angeles. However it is important to note, the sample may not fully represent all lactation professionals in Los Angeles County, as it primarily includes those actively engaged within BreastfeedLA network and its partners.

Table 2

Socio-demographic characteristics of lactation professionals in Los Angeles County (2023) (N=465)

Characteristic	%
Age	
<25 years	4.7
26-35 years	58.7
36-45 years	21.1
46-55 years	9.2
56+ years	6.2
Gender Identity	
Male	14.8
Female	83.4
Transgender	0.2
Non-Binary	0.9
Sexual Orientation	
Asexual	4.1
Bisexual	6.7
Gay/Lesbian	2.8
Heterosexual	72.4
Polysexual	0.6
Pansexual	0.9
Queer	1.1
Race/Ethnicity	
American Indian/Alaskan Native	8.8
Asian	4.1
Black/African American	3.4
Latino/Hispanic	11.8
Native Hawaiian/Pacific Islander	1.7
White	64.7
Mixed	3.9
Language(s) Spoken	
English	92.3
Spanish	14.4
Korean	0.9
Cantonese	2.6
Mandarin	1.9
Tagolog	0.8
Armenian	4.7
Education	
8th grade or less	2.2
Some high school	8.8
High school diploma/GED equivalent	10.5
Some college/associate degree	39.1
College degree or higher	38.9

Despite the diverse racial and ethnic makeup of Los Angeles County, results from the survey reveal that the lactation workforce in Los Angeles County faces a significant lack of diversity. Table 2 presents the sociodemographic characteristics of the survey sample. Among the 465 respondents, the majority identified as female (83%), were between the age range of 26-35 years old (59%), and identified as heterosexual (72.4%). In terms of race/ethnicity, the majority identified as White (64.7%) followed by Hispanic (11.8%), American Indian/Alaskan Native (8.8%), Asian (4.1%), Black/African American (3.4%), and Native Hawaiian/Pacific Islander (1.7%). Regarding the top three languages spoken in California, 92.3% spoke English, 14.4% spoke Spanish, and 4.5% spoke Chinese (2.6% spoke Cantonese, 1.9% spoke Mandarin). Lastly, the majority of the sample either had completed some college or held an associate degree (39.1%) or held a college degree or higher (38.9%).

This lack of diversity becomes particularly apparent when examining the racial composition of lactation consultants in comparison to the diverse population of infants born in the county (Graphic 8). Certain racial groups, such as Latinx, Asian and Black/African American, are underrepresented among lactation professionals compared to their proportion in the infant population. For example, Asian infants make up 13.4% of the population, yet Asian lactation consultants account for only 4.1%. This mismatch raises concerns about the ability of lactation services to effectively meet the cultural and linguistic needs of all community members.

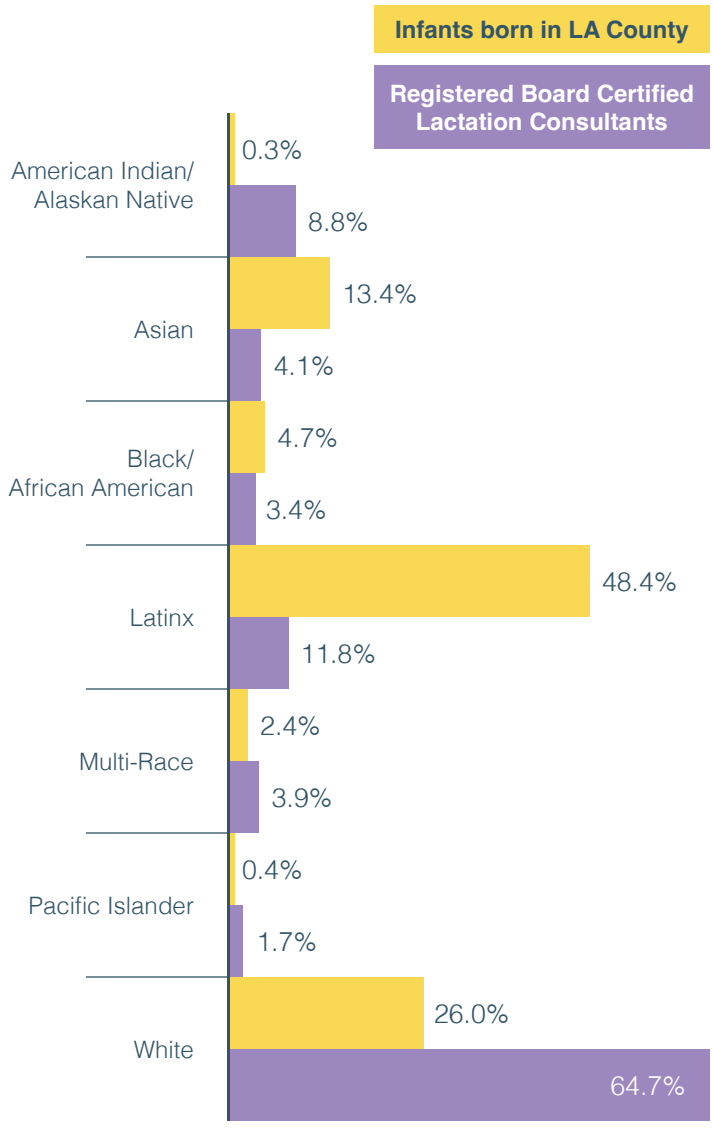
Overall, survey findings suggest a lack of racial, linguistic, gender, and sexual orientation diversity among lactation professionals in Los Angeles County. This flags a gap, as equitable representation is crucial to meeting the diverse needs of clients and communities as well as mitigating racial disparities in breast/chestfeeding outcomes in Los Angeles County. Therefore, efforts to increase diversity and inclusivity within the lactation support profession needs to be prioritized including actively recruiting and training professionals from underrepresented backgrounds. This will increase the profession's capacity to deliver effective and culturally responsive lactation support to a wide range of individuals and communities.

Recommendations

- **Peer and Community-Led Support Programs:** Acknowledge the pivotal role of peer and community-led support programs such as WIC and Baby Cafe in promoting breast/chestfeeding among diverse populations, ensuring equitable access to support by providing necessary recognition and backing for these programs and investigate the effectiveness of these models in addressing the unique needs of diverse communities through formal evaluation methods.
- **Diversity in Professionals:** Prioritize diversity and inclusivity within the lactation profession by actively recruiting and training professionals from underrepresented backgrounds to better meet the needs of diverse lactating persons and communities.

Graphic 8

Gaps in Culturally-Centered Lactation Services[49]



Section 4: Societal

The societal level, indicated by the orange ring in Graphic 4, examines the broad societal factors such as social and cultural norms that are shaped by media and formula marketing as well as policies advocating for breast/chestfeeding rights that help create a climate in which breast/chestfeeding is promoted or discouraged. This section also includes an exploration of the influence of these norms on established lactation related policies and practices within various systems and sectors in society such as the child care industry, carceral system, child welfare system, emergency preparedness and workplace. These were all themes consistently highlighted in summit discussions.

Societal Norms

Societal norms play a significant role in shaping attitudes, beliefs, and behaviors towards breast/chestfeeding. Despite healthcare organizations recommendations to breast/chestfeed, artificial milk feeding is often perceived as the "normal" way to feed infants in the U.S.[29] This dominant perception is especially evident among immigrant parents, where a generational decline in breast/chestfeeding rates, indicates a shift towards U.S. norms over time.[29] The aggressive marketing and widespread distribution of infant formula has been a major factor in the development of artificial milk feeding as a societal norm.[29]

Influence of Formula Marketing

The global infant formula market is expanding rapidly, projected to exceed $119 billion by 2025 with the U.S. market estimated to reach $22.1 billion by the same year.[50] However, in 2023, the US government spent only $9.75 million on the Centers for Disease Control and Prevention's Hospitals Promoting Breastfeeding program and $90 million on the WIC Breastfeeding Peer Counselor program.[51] This gap in funding highlights the need for more funding to support breastfeeding and counter the effects of aggressive formula marketing.

Furthermore, the World Health Organization (WHO) advocates for the global adoption of the International Code of Marketing of Breastmilk, which aims to restrict and protect against inappropriate production, promotion, and sale of breast milk substitutes.[52] Although this International Code was adopted in 1981, the U.S. has been reluctant to adopt the Code or establish similar regulations. This reluctance has raised concerns regarding the widespread and exploitative marketing practices of the infant formal industry (e.g., distributing free formula samples through hospitals) that have been associated with shorter durations of breast/chestfeeding.[53]

Infant formula companies have increasingly employed the rhetoric of "equity" and "access" in their marketing strategies to increase their reach to BIPOC (Black, Indigenous, and People of Color) communities. A glaring example of this is the commercial use of the Fultz Quads— the first identical Black quadruplet babies born in the United States- in the mid 20th

century. Formula companies, particularly Pet Milk, exploited the Fultz Quads in formula advertising campaigns during the mid-20th century, leveraging their image to promote formula feeding to Black/African-American families. This exploitation, often conducted with little regard for the long-term health implications for the targeted communities, reveals a broader pattern of racial bias within the industry.

The pervasive marketing of the infant formula industry not only shapes beliefs about breast/chestfeeding, but reinforces it as the norm. This has led to stigmas and stereotypes around breast/chestfeeding, including the belief that it is inconvenient, embarrassing, or inappropriate in public spaces. These negative stereotypes and stigmas influence individuals' decisions to breast/chestfeed, often resulting in feelings of shame, embarrassment, self-consciousness, judgment, or fear of standing out, especially in environments, like the U.S., where artificial milk feeding is perceived as the norm.[54] Moreover, marketing strategies which leverage the so-called "mommy wars" intensify these feelings. By framing the choice between breast/chestfeeding and formula feeding as merely a personal preference, these tactics contribute to a culture of judgment and competition among parents. These harmful marketing practices effectively reinforce the societal norm of formula feeding, particularly for BIPOC communities, and influence parental decisions in ways that can exacerbate existing health disparities.

Emergency Preparedness

Emergency preparedness refers to the planning and preparation needed for communities to respond effectively to various emergencies including pandemics, acts of terrorism, and natural or weather-related disasters. In times of crises, health organizations including the Center for Disease Control and Prevention (CDC), recommend breast/chestfeeding as the safest way to feed an infant.[55] Often, emergencies can compromise access to clean water and sterile environments needed for safe formula preparation and storage. This is

concerning as it greatly increases the chances of contamination and illness. Breast/chestfeeding eliminates the need for these resources, which makes it a more reliable option during emergencies.

However, conventional response efforts tend to go against the guidance of health organizations by prioritizing the promotion and distribution of infant formula over supporting breast/chestfeeding. These efforts are targeted not only at postpartum and lactating persons but also pregnant and prenatal persons. This prioritization is driven by the infant formula industry's exploitative marketing tactics and extensive distribution networks. The influence of these factors were particularly evident during the COVID-19 pandemic.

During the COVID-19 pandemic, the reliance on infant formula became particularly problematic due to widespread shortages. This was further exacerbated by a formula recall in 2022, when Abbott Nutrition had to close down a major plant due to contamination. During this time, many families faced challenges in obtaining infant formula and reported sold-out stocks, needing to visit multiple stores, and higher costs.[56] Consequently, many families resorted to dangerous feeding practices such as diluting formula with water, juice, cow's milk or rice cereal.[56]

To address the formula shortage, the Biden administration implemented a two-fold response. First, President Biden invoked the Defense Production Act which required suppliers to prioritize the provision of resources to infant formula manufacturers.[57] Second, Operation Fly Formula was launched to expedite the delivery of infant formula overseas using commercial aircrafts.[57] While these efforts were essential to ensure an adequate supply of infant formula for families in need, they also reflect the deep rooted culture of formula feeding in the US and the broader societal issue of not supporting breast/chestfeeding as a resilient and sustainable option for infant nutrition during crises.

Locally, in Los Angeles, the Department of Public Health, in partnership with the Board of Supervisors, organized formula distribution events. While well intentioned, these events established formula distribution to prenatal families and undermined the ability of pregnant individuals to choose breast/chestfeeding. In addition, this created a further shortage in the supply system, by distributing formula unnecessarily to families who may not even need it. This is why there is such a need for a local coordinated effort around supporting lactation through emergency preparedness protocols and procedures. By supporting lactation and relactation, it helps lessen the burden and reliance on formula, and allows it to be provided to families who truly need it.

To counter the pervasive promotion of infant formula during crises, Kimberly Seals Allers, in her keynote presentation at the summit, stressed the importance of building community capacity. She emphasized the need to prioritize funding and resources to support breast/chestfeeding over the promotion of infant formula. For example, she highlighted the need to integrate lactation education and support into formula distribution efforts during emergencies. This integration will not only provide vulnerable lactating persons direct access to resources and information but also address the underlying issues that lead to formula dependence such as lack of knowledge and limited access to support services.

Additionally, she highlighted the significant, yet overlooked, role of milk banks and their ability to provide safe donor milk in formula shortages and emergencies. Her presentation identified a gap in maternal and infant health support during crises and underscored the need to integrate milk banks into conventional emergency response efforts. Overall, strengthening community capacity and resilience, especially during crises, is essential for promoting breastfeeding as a sustainable and safe option for infant nutrition and challenging the societal norm of formula feeding. To achieve this, the same amount of funding directed toward formula production and marketing needs to be comparable to funding directed towards supporting lactation initiatives, education, and support. BreastfeedLA has been working tirelessly to advocate for these changes through the County of Los Angeles Board of Supervisors.

Pictured: Keynote speaker Kimberly Seals Allers

The Child Welfare System

The Child Welfare System (CWS), while intended to protect children from harm, often worsens existing disparities and continues cycles of trauma and injustice, leading to higher rates of incarceration, poor health outcomes, and violence experienced while in foster care.[58] For lactating families, Los Angeles County Department of Children & Family Services (DCFS) involvement can result in separation from infants, disrupting crucial breast/chestfeeding and bonding.[59] Additionally, removal of children from their families because of unproven claims of neglect or domestic violence can often be biased and overlook underlying issues of poverty and lack of resources.[58,60] Moreover, detention practices following involvement with the CWS disproportionately targets Black, Indigenous, and low-income families, worsening racial inequities in child welfare.

In addition to these CWS challenges, requiring pregnant and lactating parents to take unnecessary drug tests introduces additional challenges to an already vulnerable population. Although substance use during pregnancy and lactation can be harmful for maternal and infant health, "a drug test is not a parenting test."[58] Instead of receiving comprehensive prenatal care and substance use treatment, individuals often face judgment and discrimination, further deterring them from seeking help.[61] Furthermore, the lack of accessible resources for substance use disorders and mental health support exacerbates the challenges faced by these families, stopping their ability to recover and thrive. The Los Angeles County Department of Public Health (DPH) has established expected practice guidelines for drug testing that prioritizes confidentiality, fairness, and accuracy.[62] It outlines procedures for random testing, addressing positive results, and protecting individual rights. By emphasizing transparency and adherence to established protocols, these guidelines offer a model for effective and ethical drug testing programs that can support families affected by substance use.

Pictured: Brenda Vieyra, Luz Ticas, and Jennifer Roberson at Lynnwood, Century Regional Detention Facility

The American College of Obstetricians and Gynecologists believes that seeking prenatal care should not expose a person to criminal or civil penalties like the loss of custody.[63] Punishing parents instead of giving them resources to breast/chestfeed and bond, leads to adverse outcomes for both lactating parent and baby.[59] Furthermore, the stress and trauma associated with dealing with child welfare services can worsen mental health issues and stop maternal-infant attachment.[64,65]

To support lactating families, systemic changes are necessary. This means reimagining the role of the CWS to focus on keeping families together and leveraging community-based support over punishment (Reimagine Safety Coalition, 2023). Protocols for reviewing cases of neglect or domestic violence should be reevaluated to ensure families receive help and support, rather than facing punishment.[66] Policies like Guaranteed Basic Income can help alleviate issues like "general neglect", which often serves as a proxy for poverty and could otherwise be addressed by providing resources for families to provide adequate food, clothing, shelter, or medical care.

In regard to drug testing, rather than relying solely on punitive measures, a more compassionate and holistic approach is needed to support pregnant people and lactating families affected by substance use. This includes prioritizing harm reduction strategies and providing comprehensive prenatal care, substance use disorder treatment, mental health support, and social services that address underlying issues like poverty and trauma.[58] The Reimagine Child Safety Coalition, which BreastfeedLA is a member, advocates for comprehensive reforms to dismantle racist systems and ensure equitable access to support services for all families.[58] They envision a world in which all communities and families have the resources and support that they need to thrive; a world in which the safety of children is not determined by the economic status of their families, and parents are not deemed "unsafe" or "unfit" based on the color of their skin. See reimaginechildsafety.org for a full list of their demands to prevent children and families from becoming involved with the system and end the practice of family separation.

Incarceration and Detention

Detention practices are an additional challenge for breast/chestfeeding parents. For lactating parents who are incarcerated, separation from their infants can be particularly traumatic. The inability to breast/chestfeed and nurture their babies during this critical period can lead to profound emotional distress and strain on maternal-infant relationships.[58,67] Immigrant parents who are detained or separated from their children face similar challenges, often enduring trauma and grief due to forced separation.[58]

When an incarcerated or detained individual gives birth, they should have the same opportunities as non incarcerated or detained persons to bond with their newborn. Likewise, if they choose to breast/chestfeed, they should have access to lactation support services.[68] However, many incarcerated and detained lactating parents face significant challenges due to limited access to resources and support. It is important to note that although not all incarcerated and detained pregnant individuals are women, the current literature mainly focuses on those who identify as women and will be referenced as so in this section.

In the United States, there are over 200,000 women in federal and state prisons and jails, with recent estimates showing that 3 to 10% of these women are pregnant when incarcerated.[69–71] Most of these women will give birth while incarcerated, yet comprehensive data on pregnancy and lactation in this population is lacking.[69,70,72] Incarceration is linked to lower rates of breast/chestfeeding initiation, with a preliminary study estimating initiation rates among incarcerated people around 64%, compared to the national average rate of 82%.[70,73] Additionally, Black women are incarcerated at twice the rate of white women, exacerbating breast/chestfeeding initiation disparities.[72,74]

Lactation support for incarcerated or detained parents is crucial for maternal and infant health, bonding, and reducing recidivism rates (i.e. the tendency to commit another crime following a release from incarceration). However, numerous challenges including limited access to resources, stressful environments, and legal barriers, hinder lactation in this population. Forced separation after giving birth increases risk of postpartum depression, self-harm, and suicidal ideation.[72,75]

Incarcerated women reported feelings of sadness during labor and postpartum anxiety in anticipation of separation.[67,76] Additionally, inconsistent maternal contact may affect infants' social and emotional development.[77] Breast/chestfeeding has been shown to minimize these risks, promote bonding, and reduce potentially harmful behaviors.[72,77,78]

Addressing these challenges requires comprehensive policy reforms, increased awareness, and evidence-based interventions to ensure that all lactating parents, regardless of their circumstances, have the support they need to breast/chestfeed successfully. In California, AB 250779 mandates procedures for lactation support including a pump and pick up program that provides all equipment for pumping, storing, and picking up breast/chest milk. AB 73280, passed in 2020, guarantees basic reproductive healthcare and justice including banning shackling, tasering, and pepper spraying of pregnant people; allowing a support person in the delivery room when giving birth; providing prenatal care and prenatal vitamins to pregnant people; requiring lower bunk assignments for pregnant people; and providing free pads and tampons to menstruating people. For a full list of protections and resources incarcerated individuals are entitled to during pregnancy and lactation, see BreastfeedLA's custody toolkit.

Recommendations

- Regulation Advocacy: Advocate for stronger regulations of the International Code of Marketing of Breast/chest milk Substitutes to counteract exploitative marketing practices by the infant formula industry.
- Establish Support Infrastructure & Emergency Preparedness: Integrate lactation education and support into emergency protocols alongside formula distribution efforts to ensure lactating individuals have access to resources during crises. Advocate for the creation of a full-time dedicated staff member in Los Angeles County to oversee and coordinate breast/chestfeeding support efforts, especially during emergencies, ensuring timely and effective assistance for lactating individuals.
- Resource Allocation: Allocate comparable funding for breast/chestfeeding initiatives during crises to match the resources spent on formula distribution, ensuring equitable support for breast/chestfeeding. Maximize the effectiveness and impact of breast/chestfeeding campaigns by increasing their financial backing to match that of the multi-billion-dollar formula industry, ensuring widespread dissemination of accurate information and support for breast/chestfeeding practices.
- Reform Child Welfare: Push for reforms in the child welfare system to prioritize keeping families together and provide comprehensive support services addressing underlying issues such as poverty and lack of resources, thereby fostering environments conducive to breast/chestfeeding.
- Support Incarcerated Parents: Create policies and programs that support breast/chestfeeding among incarcerated and detained parents, ensuring access to lactation support services and resources to promote bonding and child health.

Call to Action

The goal of the 2023 equity summit, "Lactation Justice: Activating Our Community Response," was to shift the conversation around breast/chestfeeding by highlighting the systemic inequities impacting breast/chestfeeding outcomes. Through the summit and this paper, BreastfeedLA wanted to explore the factors that make breast/chestfeeding difficult. Equipped with a commitment to addressing the broader factors that influence infant feeding inequities, LA County can lead the way in providing the standard of infant feeding support.

BreastfeedLA calls on you to attentively listen to the communities in your care and to serve them with humility. Challenge your organization(s) to ensure that families receive the breast/chestfeeding support they rightfully deserve. Confront individuals and dismantle systems that perpetuate injustice. Let our collective actions protect, empower, and nurture parents and infants.

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And thank YOU, our community and changemakers!

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