BreastfeedLA

Taking Action to Reduce Infant Feeding Inequities in Los Angeles County: Our Collective Responsibility

May 2019

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Executive Summary

In order for a baby to be exclusively breastfed for six months, one must overcome a system of structural barriers that leave certain groups, particularly people of color, with less support to truly make this choice. As we will discuss below, overlapping structural inequities in income, healthcare, and available resources in ones' community lead to differing outcomes for people of color.

The tenth anniversary of BreastfeedLA's summits, held in October 2018, addressed profound issues of social inequality. The fundamental principle underlying the conference was that breastfeeding must be understood as part of reproductive justice, and reproductive justice is embedded in larger dynamics of social justice and injustice.

The following report (a) establishes key analytical concepts and definitions, to be used in work going forward; (b) summarizes research that identifies discrepancies in breastfeeding outcomes among racial/ethnic groups in Los Angeles County, and among various geographic regions and particular hospitals; (c) identifies three priority areas—inequities in hospital experience, access to paid family leave, and postnatal breastfeeding support and supplies—for improving breastfeeding outcomes and equity. BreastfeedLA provides specific recommendations for each priority area.

The priority areas identified in the report are not inclusive of all work that needs to be done. They have been chosen because they build on BreastfeedLA's previous success and have the potential to have the largest impact on breastfeeding, given our limited resources. By examining obstacles along the way, we suggest policy interventions to support all who choose to breastfeed.

Inequities in Hospital Experience

There is a 65.6 percentage point gap between the highest exclusive breastfeeding rate and the lowest exclusive breastfeeding rate for infants of color. When looking at the in-hospital exclusive breastfeeding rate for infants of color, not one hospital in L.A. County meets the Healthy People 2020 goal of 85.8%.

Recommendations

- All birthing hospitals adopt the *10 Steps to Successful Breastfeeding*,[1] while remaining committed to the Baby-Friendly designation as the gold standard for infant feeding support;
- All birthing hospitals analyze internal breastfeeding data in relation to, patient race/ethnicity, insurance payor, zip code, type of birth, provider, location of prenatal care, WIC eligibility, number of lactation professionals and potential determining factors;
- Hospital leadership, other healthcare organizations, and community advocates use aforementioned data to determine, implement and advocate for new and tested approaches to infant feeding support that are focused on eliminating infant feeding disparities such as Baby-Friendly designation and participation in the Regional Hospital Breastfeeding Consortium;*
- All birthing hospitals examine and build relationships with internal and external resources available to surrounding communities to address the social determinants of health that affect breastfeeding success;
- The California Department of Public Health should create a stakeholder taskforce to ensure that implementation of SB402 is equitable and to provide proper enforcement and accountability for violations.

Paid Family Leave

New parents need time off from work to bond with a new child and/or to recover from childbirth. Paid Family Leave (PFL) is associated with longer duration of breastfeeding. When parents are making infant feeding decisions, how soon they have to return to work influences their decision to breastfeed. Every week of PFL matters, with one study finding that each additional week of PFL increased breastfeeding duration by several days.[2] Parents who return to work before six weeks postpartum are three times more likely to stop breastfeeding than those who return later. 50% of white women compared to 41% of Black women have access to paid family leave.[2]

Recommendations

- EDD expand Paid Family Leave and remove eligibility requirements that make PFL inaccessible to some families.†
- EDD make the application process easier by streamlining the application and offering the application in multiple languages.
- Organizations that work with pregnant people and new parents, including clinics, hospitals, WIC, and County offices, obtain training from EDD or respected partner in PFL benefits so that they are able to provide education about how to access PFL.

* Regional Hospital Breastfeeding Consortium Meeting times can be found at breastfeedla.org/events

† Please see page 14 for information about the local efforts to improve paid family leave

Community Breastfeeding Support

Unequal access to breastfeeding and lactation support and supplies contributes to infant feeding disparities. Guidance received and availability of resources from ones' local WIC agency, community clinic, home visitation program, and provider will likely vary. 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. Even if there are resources available, the lactation professionals they encounter may lack cultural humility and or often do not even speak their language.[3] At the 2018 Summit, the need for more training and career opportunities for lactation professionals of color was identified as an important area of focus.

Recommendations

- Any organization that employs a lactation professional pay a living wage to its employee, organizations should not expect lactation professionals to provide their service without compensation;
- Organizations that employ lactation professionals actively work to remove barriers to training and hiring for communities that have been historically underrepresented in the lactation field;
- Insurance providers should increase access to and funding for lactation support and supplies;
- Organizations that serve pregnant people and new parents should conduct an audit to determine where lactation professionals are needed in their organizations and where and when breastfeeding support can be provided;
- Breastfeeding advocates and other maternal child health experts collaborate with other professions and organizations that support new parents including mental health providers, home visitors, doulas, and midwives, removing unhelpful silos;
- Organizations should seek out, hire, and/or train lactation professionals who speak the languages spoken in their community;
- LA County, Department of Public Health should dedicate funds to infant feeding and designate a staff person who can serve as the countywide hub for breast- and chest-feeding support and advocacy on behalf of all County Departments and 88 cities the county serves;
- Clinics, WIC, home visitation, and other postpartum providers should invest in data collection and analysis within prenatal and postpartum care settings to identify inequities and interventions that affect breastfeeding success.

This report is intended to be a starting point for both a discussion about root causes of breastfeeding inequities, as well as policies and strategies that can begin to address infant feeding inequities. When all who work with pregnant and parenting individuals come together to address these disparities, we can improve breastfeeding rates for everyone. We acknowledge that more research should be done to further detail out the challenges and opportunities for breastfeeding success; particularly in connecting the social determinants of health and systemic racism as root causes contributing to infant feeding inequities.

BreastfeedLA is committed to inclusion, diversity, and equity as core values, embracing meaningful participation from diverse stakeholders and actively soliciting varied viewpoints. Our work is grounded in diversity, inclusion, and equity to facilitate our mission of commitment to protecting, promoting, and supporting breastfeeding in the communities we serve. All individuals need culturally appropriate support and policies and practices that enable a healthy pregnancy, birth, and post-delivery experience. We hope you will join us to make this happen.

INSET 1

Definition of Infant Feeding Equity

Infant feeding equity means that every expectant or new parent has access to information, resources, and support that facilitate informed decision making and the ability to feed and maintain feeding their infant in the way they determine is safest, healthiest, and most fitting for their lives. Infant feeding is a progression after pregnancy and birth and is situated within the same historic and current contexts that belittle reproductive freedom. Infant feeding equity means transforming the context and redistributing resources and power to bring forth a foundation of parenthood that is rooted in justice, respect, self-determination and, ultimately, the health of future generations.

Introduction

The *Taking Action to Reduce Infant Feeding Inequities: Our Collective Responsibility* summit, held on October 10th and 11th 2018, marked the 10th anniversary of BreastfeedLA summits. Hundreds gathered for this biennial event with the goal of protecting, promoting and supporting human milk feeding in Los Angeles County. Through its summits, BreastfeedLA has carved out a space to hear and honor the experiences and expertise of health care providers, parents, and policy makers alike. The inaugural summit in 2008 motivated LA County perinatal healthcare providers to prioritize breastfeeding, and to make it a viable and attainable option for families through education and support that promotes breastfeeding. Ten years later, BreastfeedLA's 2018 summit explicitly centered the voices and lived experiences of those least likely to receive such support. The 2018 summit challenged attendees to situate infant feeding disparities within the larger context of historic and present-day inequalities that disenfranchise people of color and low-income families.

This report reflects that work, offering a review of the current landscape of lactation support in LA County and relevant data. The goal of this report is to outline the challenges that remain, as well as the action steps collectively committed to at the 2018 summit in order to address infant feeding inequities. BreastfeedLA is committed to using language inclusive of all families and parents, and in keeping with that goal, we use gender inclusive language to refer to breastfeeding and lactating parents in this report. We thank our collaborators, speakers, and attendees for taking this journey with us.

Our Conceptual Framework

Our approach to this work relies on several key definitions and crucial assumptions. At the summit, we explored white supremacy, hetero-patriarchy and capitalism as three systems that have enormous power over our lives and how parents feed their babies. We use the term "systems" to describe white supremacy, hetero-patriarchy and capitalism because there are structures of power in place to ensure that these forms of hierarchy and discrimination remain entrenched in our society. Please see Appendix A for definitions of several additional key ideas that guided the planning process for the summit and the conceptual framework of this report. We discussed how words and actions can have a harmful impact and how unspoken unintentioned social scripts of race, power, and identity affect the way in which people interact with each other and the delivery of healthcare. When we work together in solidarity to build systems that support our most marginalized families we all benefit.

Elizabeth 'Betita' Martinez, activist and author, defines white supremacy as "a historically based, institutionally perpetuated system of exploitation and oppression of

INSET 2

Definition of Reproductive Justice

Reproductive justice calls attention to the full spectrum of fertile people's reproductive lives, from preconception to lactation, and its interconnectedness with decisions around and access to family planning, contraception, childbirth and lactation. The founders of the reproductive justice movement and framework explain "...all fertile persons and persons who reproduce and become parents require a safe and dignified context for these most fundamental human experiences. Achieving this goal depends on access to specific, community-based resources including high-quality health care, housing and education, a living wage, a healthy environment, and a safety net for times when these resources fail. Safe and dignified fertility management, childbirth, and parenting are impossible without these resources."[8] Put simply, reproductive justice is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."[9]

continents, nations and peoples of color by white peoples and nations of the European continent, for the purposes of maintaining and defending a system of wealth, power and privilege."[4] Many people think of racism only as individual acts of meanness. In this report, when we speak about the system of white supremacy we are not only talking about individual acts, but about systems and institutions that advantage some people and disadvantage others through what we call race. In the United States, examples of systems of white supremacy include colonization, such as the genocide of Native Americans and stealing of their resources and land, institutionalization of slavery and maintenance of anti-black racism, and anti-immigrant policies of confinement, dependency, and war that continue to affect Asian, Latino, and African American communities.

In our system of hetero-patriarchy, the political and social system is configured to institutionalize and maintain superior privileges and decision making power to those who are male, cisgender,* and heterosexual. To illustrate this idea, Black feminist scholar, bell hooks, states that patriarchy is an insistence, "that males are inherently dominating, superior to everything deemed weak, especially females, and endowed with the right to rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence."[5]

Capitalism influences infant feeding practices both in the United States and globally. Through the prioritizing of "free" ideas of competition and individual-over-collective desires, capitalism encourages the privatization of social sectors, commodification of basic needs and services, and grows inequality through worker exploitation—including lack of parental leave and sufficient break times—low-wages, and asset-stripping and degradation of the environment. In for-profit formula industry marketing practices, for example, profit is the priority over the health of parents and infants. Though formula is an inferior product to breastmilk, marketing practices efface the risks of formula feeding, leaving parents to become dependent on it, often at a financial burden to their family. The International Code of Marketing Breast-Milk Substitutes[6] is an important way to limit the influences of formula marketing practices. 84 countries have signed the document and enacted legislation which implement most or all of the provisions and subsequent relevant WHA resolutions of The Code. Sadly, the United States is one of only two countries to NOT sign the document in 1981, in 2010 the U.S. signed, but refused to enact legislation.[7]

While individual thoughts and actions matter, the issues are much greater than any individual person. It will take many of us working together in solidarity to dismantle these systems and create new, more just ways of living together and relating to one another. Inset 1 and 2 are two definitions of what we are working toward.

* "of, relating to, or being a person whose gender identity corresponds with the sex the person had or was identified as having at birth" www.merriam-webster.com/dictionary/cisgender

The Current Infant Feeding Landscape in Los Angeles County

Breastfeeding rates in Los Angeles County, as in most of the nation, fall below both the breastfeeding recommendations from all major healthcare organizations and the Healthcare People 2020 goals.

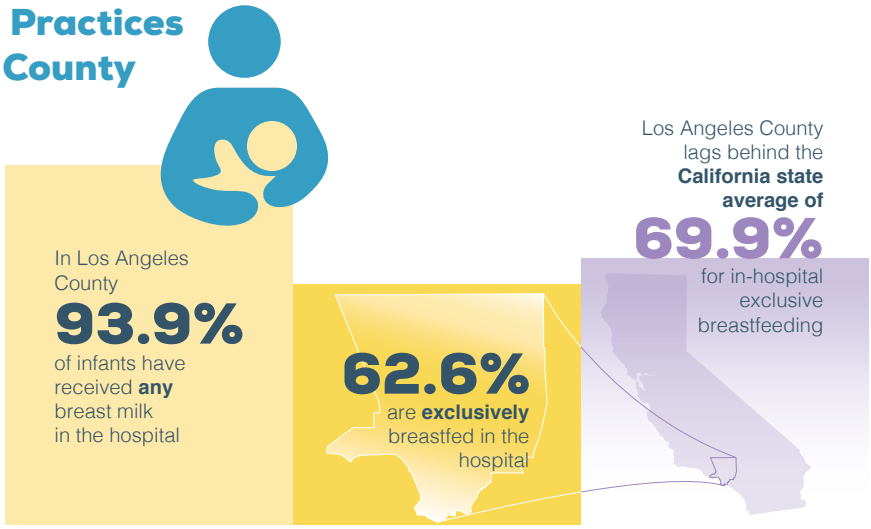
Healthcare Breastfeeding Recommendations

GRAPHIC 3

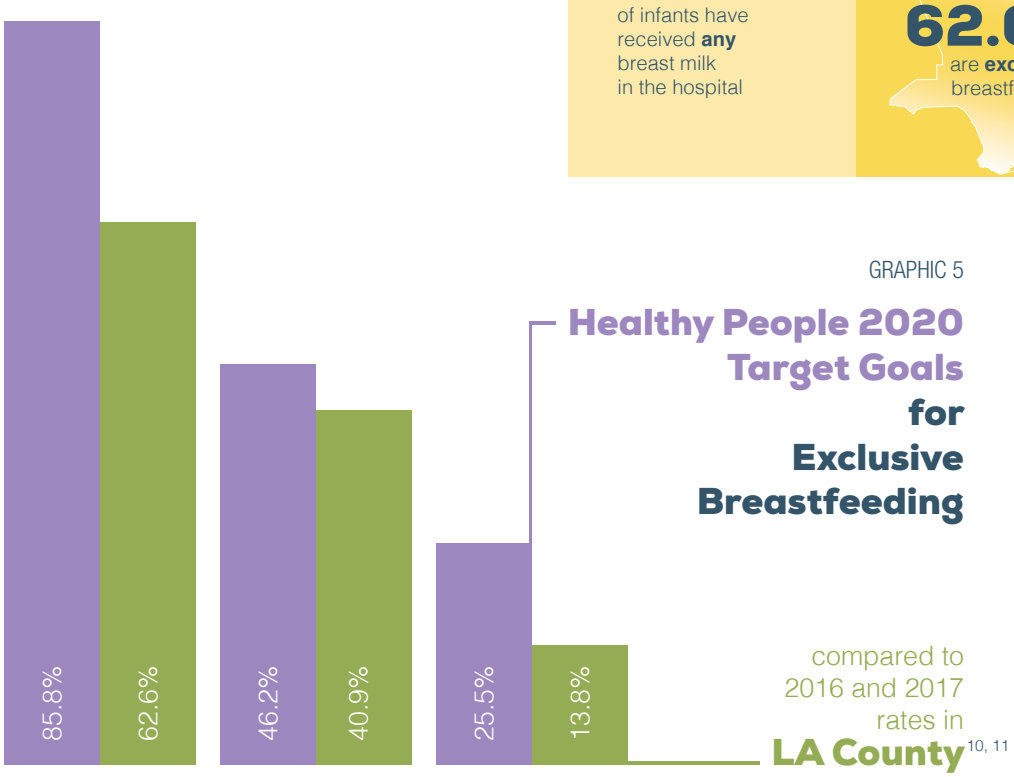
All healthcare organizations recommend exclusive breastfeeding for 6 months.
Breastfeeding is recommended for at least 2 years and for as long as mother and child desire thereafter.

Infant Feeding Practices in Los Angeles County

GRAPHIC 4



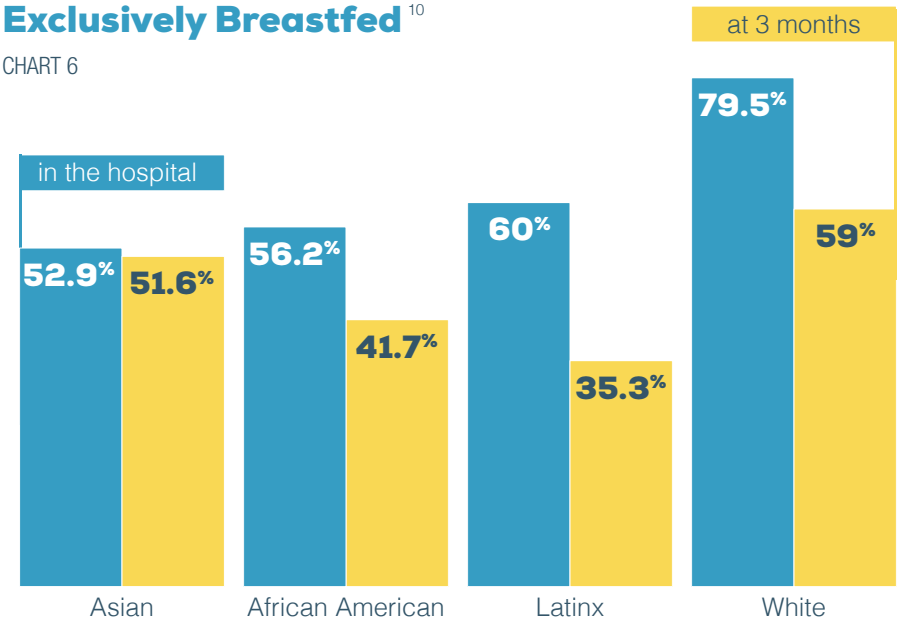
GRAPHIC 5



While much remains to be accomplished to close the gap by race/ethnicity and geographic location, there have been vast improvements in overall breastfeeding rates since 2010 and increases across all ethnic groups and geographic areas of LA County. These improvements can be tied to an increase in hospitals that have achieved the Baby-Friendly* designation and those working toward it, as well as an increased focus on optimal breastfeeding support from several community clinics, healthcare providers, WIC sites, parents and community advocates. Despite these positive changes, stark disparities still remain by race and place of birth. The following chart demonstrates differences in breastfeeding rates between African American, Asian, Latinx and white infants at 3 months.

Los Angeles County Infants Exclusively Breastfed [10]

CHART 6



The data in Chart 6 mirrors other maternal and child health outcomes, such as maternal and infant mortality rates which are worse for people of color. Similar to infant mortality rates, education is not consistently protective.[12] Many experts within the field of maternal child health have acknowledged that hospital culture and our larger society's racism, capitalism, and hetero-patriarchy have disproportionately impacted racially marginalized people and Black women in particular. The dramatic differences in breastfeeding rates by race/ethnicity reveal the systems that contribute to health disparities.

While the data demonstrate infant feeding inequities, the data does not reflect the rich diversity of Angelenos. Due to these data limitations, we are unable to break down each racial category further to better understand the diversity within groups.

For example, across each racial category there are people from a variety of cultural backgrounds and the data can mask subtle, but important nuances. In particular, a birth parent's country of origin, across all racial categories, has been shown to be independently associated with maternal and child health outcomes. For some, the country in which they were living before gives them more protection. For others, coming from countries in which there are ongoing wars and conflict, the outcomes could be worse.

Where we had data regarding the experiences of Asian Pacific Islanders and Native Americans we included it, such as for countywide breastfeeding rates, but often times they are either unavailable or lumped together, creating a general description of the community. Similarly, we do not have current quantitative data about the breastfeeding/chestfeeding experiences of LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual) people in LA County.

While the data give us some insight into patterns and trends, we interpret numbers with the intention of looking at root causes. In the interpretation of racial health disparities, we remind ourselves how the data is only as good as the categories we create and analyze. Knowing this, it is important to challenge our own implicit biases when we look at these numbers and determine what our next steps will be. The categories themselves can cause us to lose sight of the larger context and to locate responsibility—and oftentimes blame—on the individual's behavior. Instead of placing responsibility on the individual parent to "comply" with the recommendation to breastfeed, our hope in sharing the data is to examine other factors that influence infant feeding and to explore interventions that work on systems instead of on modifying individual behavior.

"Shared skin tones
does not mean
the same experience,
Black people are not a monolith."

-Leah DeShay

* The Baby-Friendly Hospital Initiative supports hospitals in giving parents "the information, confidence, and skills necessary to successfully initiate and continue breastfeeding their babies or safely feed with formula, and gives special recognition to hospitals that have done so."[1]

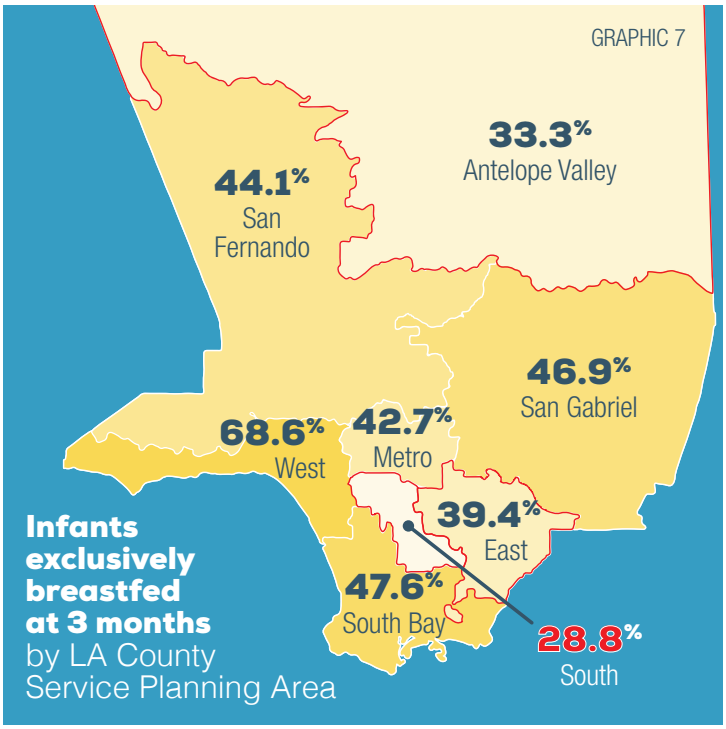
Breastfeeding rates differ significantly based on where people live. Graphic 7 demonstrates the differences in breastfeeding rates by Service Planning Area (SPA). "A Service Planning Area (SPA) is a simply specific geographic region within Los Angeles County. Due to the large size of LA County (4,300 square miles), it has been divided into 8 Service Planning Areas. These distinct regions allow the Department of Public Health to develop and provide more relevant public health and clinical services targeted to the specific health needs of the residents in these different areas."[13]

The Link Between Infant Mortality and Breastfeeding

Infant mortality rates continue to be one of the most widely used indicators of the overall health status of a community. The leading causes of death among infants are birth defects, preterm delivery, low birth weight, Sudden Infant Death Syndrome (SIDS), and maternal complications during pregnancy. The Healthy People 2020 Objective is to reduce the infant mortality rate to no more than 6.0 per 1,000 live births. The infant mortality rate for Los Angeles County has remained stable around 4.3 to 5.4 with an average of 4.9 infant deaths per 1,000 live births between 2003 and 2013. In 2013, African Americans comprised 7.3% (9,319) of all 128,526 live births in Los Angeles County and 16.8% (96) of all 570 infant deaths. The infant mortality rate for African American babies in Los Angeles County is twice as high as the overall Los Angeles County rate and three times that of white babies. Service Planning Areas 1 and 6 in Los Angeles County have the highest rate of preterm births, the highest infant mortality rates in LA County,[14] the lowest exclusive breastfeeding rates at 3 months,* the fewest lactation support resources and the highest number of households with annual incomes between $12,813 and $41,400.† Despite a gradual decline in African American infant mortality in LA County since 2007, African American infants continue to die at more than 3 times the rate observed for white and Asian infants, the two racial/ethnic groups with the lowest infant mortality rates. The low birth weight rate in Los Angeles County has remained stable in the past decade from 7.1% in 2004 to 7.0% in 2013. When comparing the four major races/ethnicities, African American babies in 2013 have the highest rate of low birth weight births at 12.1% compared to 6.5% of Hispanic and white babies.[15]

Breastfeeding rates often mirror other health disparities in our community. There is an important relationship between infant mortality and lack of breastfeeding support in industrialized countries. Where breastfeeding rates are higher there is often lower infant mortality rates and in communities where breastfeeding rates are lower there is often a higher rate of infant mortality.

A 2010 study investigated the contributions of overall breastfeeding duration and exclusive breastfeeding on reducing the risk of hospitalization for infectious causes. The authors analyzed data from a three-stage survey on infant feeding practices and health outcomes in over 10,000 UK women in 2010–2011. The study suggested that exclusive breastfeeding in the initial weeks after childbirth and continuing to breastfeed (either exclusively or partially) for at least



three months, preferably six months, may reduce morbidity due to infectious illness in infants.[16]

A 2016 study synthesized the evidence for effects of optimal breastfeeding on all-cause and infection-related mortality in infants and children aged 0–23 months. The authors found higher rates of mortality among infants never breastfed compared to those exclusively breastfed in the first six months of life and receiving continued breastfeeding beyond.[17]

A 2004 National Institutes of Health study reported that babies in the US who were breastfed had a 21% lower risk of death in their first year, compared with babies never breastfed. The reduction in risk rose to 38% if babies were breastfed for 3 months or more.[18] Longer breastfeeding was associated with lower risk. The effect was the same in both Black and white children. As a result, it is imperative that the County of Los Angeles use breastfeeding as a strategy to lower infant mortality rates in the County.

Factors that Influence Breastfeeding Duration

Statistical modeling using data from the 2016 Los Angeles Mothers and Babies survey[11] suggests that the factors indicated here may influence exclusive breastfeeding rates at three months postpartum. The factors include mother's education, mother's race/ethnicity, type of insurance, number of stressful life events during pregnancy, depressive symptoms during pregnancy, food insecurity before and during pregnancy, WIC services during pregnancy, partner status at delivery, mother's weight before pregnancy, lifetime discrimination, postpartum checkup, depressive symptoms after pregnancy, neighborhood safety, delivery method, NICU stay, low birth weight or preterm birth, and parity.

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* See Chart 7

† See map on page 18

In this model, parents who had a vaginal birth, parents who indicated that they "did not need WIC", parents who completed college, parents who did not consider their neighborhood "unsafe", parents whose infant was not admitted to NICU, and parents whose infants were not low birth weight or preterm, were all more likely to be breastfeeding at 3 months. Further investigation into the relationship between these factors and breastfeeding rates is required to inform future intervention and policy design.

Current and Remaining Challenges

Clearly, much work is needed to ensure that all parents can raise their children in safe environments, free from the toxic effects of poverty and discrimination. In looking to understand the factors that influence low breastfeeding rates, the summit planning committee identified three categories in which improvements are desperately needed and feasible within BreastfeedLA's current scope of influence: inequities in hospital experience, paid family leave, and access to lactation support and supplies.

BreastfeedLA selected these three topics with input from community stakeholders. The hospital experience section focuses on inequities in in-hospital exclusive breastfeeding rates because the first several days of breastfeeding can make or break the breastfeeding relationship. Whether or not a parent has paid family leave significantly affects breastfeeding duration, and inequities in paid family leave awareness and access contribute to infant feeding disparities. Access to support and supplies identifies key areas where more lactation support is needed, and highlights the need for more training and professional opportunities for lactation professionals of color.

Section 1: Inequities in the Hospital Experience

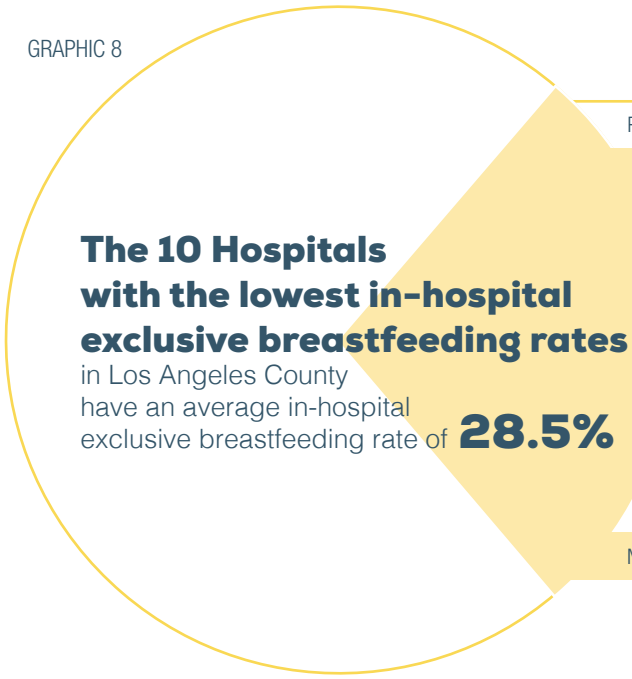
The hospital experience has enormous impacts on the breastfeeding/chestfeeding relationship, as does access to, and quality of, prenatal and postpartum care. This section explores inequities that are apparent in breastfeeding rates during the hospital visit because robust hospital data is widely available, and because BreastfeedLA has historically focused our efforts on changing hospital practices.

There are many important questions to explore about how prenatal care and education and a pregnant person's life experiences and stress impact breastfeeding. Data shows that people who begin prenatal care during the first trimester of pregnancy are more likely to exclusively breastfeed at 3 months when compared to people who enter prenatal care after the first trimester.[11] More investigation is needed to further understand the complexities of these disparities during the perinatal period for both parent and child as well as potential interventions to improve breastfeeding outcomes.

There is significant variation between the hospitals with the highest and lowest rates of exclusive breastfeeding. The disparities between hospitals are particularly pronounced when looking at rates for people of color and by geographic region. Even within an individual hospital, the rates for white patients and patients of color differ substantially. The hospital where a parent gives birth may indicate not only specific practices at that hospital, but may also represent social determinants of health. Social determinants of health that are related to breastfeeding include, working conditions, access to health services, social support, stressful life events, and racial discrimination.[11] If patients who are birthing at a particular hospital have experienced more of these risk factors, then they may be less likely to breastfeed. All birthing hospitals should examine and build relationships with internal and external resources available to surrounding communities to address the social determinants of health that affect breastfeeding success.

Highlighting hospitals that are higher or lower performing is not intended to endorse any particular hospital, rather our intention is to illustrate the influence that place of birth has on a parent's likelihood to exclusively breastfeed. While there are many factors that contribute to in-hospital breastfeeding rates including leadership support, maternity care practices, and Baby-Friendly status, the Joint Commission (TJC) Core Measure for In-Hospital Exclusive Breastfeeding describes its goal of 70% to be "an achievable target for hospitals."[19]

GRAPHIC 8



The 10 Hospitals with the lowest in-hospital exclusive breastfeeding rates
in Los Angeles County have an average in-hospital exclusive breastfeeding rate of **28.5%**

	In-Hospital Exclusive Breastfeeding
Pacifica Hospital of the Valley	7.9%
Whittier Hospital	14.8%
Monterey Park Hospital	19.0%
Downey Regional Medical Center	28.3%
Garfield Medical Center	30.9%
San Dimas Community Hospital	32.4%
Beverly Hospital*	35.4%
Greater El Monte Hospital*	36.3%
Centinela Hospital Medical Center*	38.8%
Memorial Hospital of Gardena*	40.8%

*Baby-Friendly Hospital as of December 2017

In-Hospital Exclusive Breastfeeding Rates

Graphic 8 lists the ten hospitals with the lowest in-hospital exclusive breastfeeding rates in LA County for 2017.[10] The highest in-hospital exclusive breastfeeding rate in LA County was 85% while the lowest performing hospital had an exclusive breastfeeding rate of 7.9%. Such a vast difference in rates requires investigation into many factors including, but not limited to; prenatal care practices, patient health upon admission, hospital practices that are working and not working and how best practices could be adopted at hospitals with lower rates. Please see the recommendations section for more information.

In Table 9, the hospitals are ranked from highest to lowest in-hospital exclusive breastfeeding rates for infants of color.

In 2017, 82.6% of infants born in LA County were infants of color.[10] To improve LA County's breastfeeding rates, focus and efforts must be on people of color. Overall, infants of color are less likely to be exclusively breastfed than white infants, though there is wide variation across the county. For the purposes of this table, the breastfeeding rates for infants of color references rates for African American, Asian and Latinx infants only. If there were fewer than 10 people present from a particular racial/ethnic group at a hospital, that is indicated in the legend as insufficient sample size. As noted in the previous section, these racial/ethnic categories are extremely broad. Unfortunately there was not enough data regarding other racial and ethnic groups, such as Native Americans and Pacific Islanders, to include in this calculation.

There is a 65.6 percentage point gap between the highest exclusive breastfeeding rate and the lowest exclusive breastfeeding rate for infants of color. When looking at the in-hospital exclusive breastfeeding rate for infants of color, not one of the hospitals in LA County meet the Healthy People 2020 goal of 85.8%. The Joint Commission Core Measure for In-Hospital Exclusive Breastfeeding is 70%, which TJC describes as "an achievable target for hospitals."[19] Thirty-six out of 54 birthing hospitals in LA County (67%) do not meet that target for infants of color.

> "In order to increase your breastfeeding rates it's important to acquire systemwide and upper management support for your breastfeeding journey. You need a person or team dedicated to breastfeeding. You also need to continually collect and analyze data to make improvements."
>
> -Mary Radinsky, RN, IBCLC
> Providence Little Company of Mary Medical Center Torrance

Average In-Hospital Exclusive Breastfeeding Rates, by Hospital [10]

TABLE 9

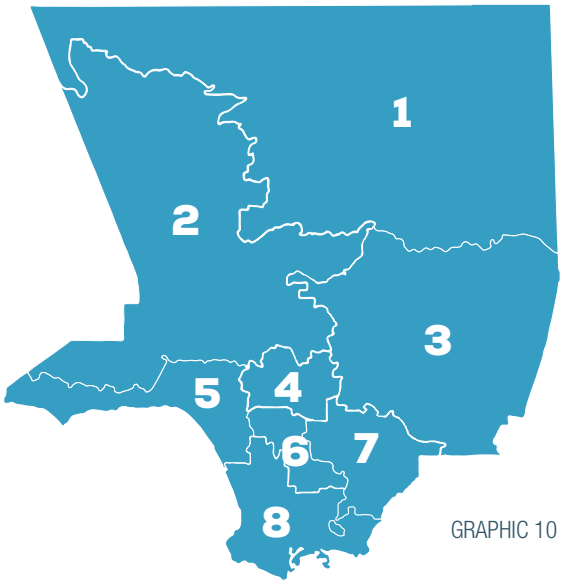
Hospital	EBF Rate for Infants of Color	EBF Rate for White Infants
Providence Little Company of Mary Medical Center Torrance* •	79.5%	89.1%
PIH Health Hospital Whittier*	79.4%	88.2%
Providence Saint John's Health Center	79.1%	87.6%
UCLA Medical Center, Santa Monica	78.5%	84.8%
Ronald Reagan UCLA Medical Center •	77.4%	88.0%
Kaiser Downey	76.3%	88.8%
Kaiser South Bay	76.1%	91.7%
West Hills Hospital and Medical Center	76.1%	76.7%
Olive View-UCLA Medical Center •	75.3%	88.7%
USC Verdugo Hills Hospital*	74.6%	77.7%
Kaiser Woodland Hills	74.3%	85.8%
Torrance Memorial Medical Center	72.9%	82.7%
Kaiser Baldwin Park	72.5%	82.7%
Kaiser West LA	72.1%	92.3%
Henry Mayo Newhall Hospital •	71.4%	75.6%
Glendale Adventist Medical Center	70.4%	71.5%
Miller Children's and Women's Hospital Long Beach	70.2%	89.3%
Martin Luther King, Jr. Community Hospital†	68.9%	94.1%
Antelope Valley Hospital	68.8%	81.6%
Kaiser Panorama City	68.2%	82.6%
Providence Tarzana Medical Center	67.9%	74.3%
LAC/USC Medical Center •	66.7%	55.8%
Northridge Hospital Medical Center •	66.6%	76.5%
Cedars-Sinai Medical Center	63.3%	81.5%
California Hospital Medical Center	63.2%	74.0%
Kaiser Sunset	62.6%	81.7%
Good Samaritan Hospital •	62.3%	92.2%
Pacific Alliance Medical Center • (closed)	61.2%	—
Methodist Hospital of Southern California	61.1%	80.2%
Hollywood Presbyterian Medical Center •	60.7%	72.0%
San Gabriel Valley Medical Center* •	59.0%	65.2%
Valley Presbyterian Hospital •	58.9%	64.3%
Providence Saint Joseph Medical Center •	57.8%	73.3%
Glendale Memorial Hospital •	57.8%	58.5%
Huntington Hospital •	56.6%	75.9%
Queen of the Valley Hospital •	56.6%	64.3%
Foothill Presbyterian Hospital*	54.6%	73.1%
Providence Holy Cross Medical Center	54.5%	79.1%
St. Mary Medical Center •	54.2%	60.8%
White Memorial Medical Center •	52.9%	76.0%
Harbor-UCLA Medical Center •	50.5%	64.3%
Pomona Valley Hospital Medical Center •	49.4%	71.0%
East Los Angeles Doctors Hospital‡ •	46.3%	—
Providence Little Company of Mary Medical Center San Pedro‡ •	44.7%	67.4%
St. Francis Hospital Lynwood •	42.0%	53.5%
Memorial Hospital of Gardena •	40.5%	—
Centinela Hospital† •	37.4%	—
Beverly Hospital* •	34.9%	—
Greater El Monte Hospital‡ •	33.8%	—
Garfield Medical Center*	30.5%	64.7%
Downey Regional Medical Center	27.6%	39.1%
San Dimas Community Hospital*	25.1%	56.5%
Monterey Park Hospital*	18.6%	—
Whittier Hospital*	13.9%	25.0%
Pacifica Hospital of the Valley	No data available (fewer than 10 individuals)	

• Baby Friendly Hospital as of December 2017
* 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

The breastfeeding equity gap (Graphic 10) represents the difference between in-hospital exclusive breastfeeding rates for infants of color and white infants in each Service Planning Area. A higher equity gap indicates greater breastfeeding inequities by race/ethnicity in that region. It is important to note that area with a lower equity gap may have low exclusive breastfeeding rates for infants of color and white infants.[10]

There were 8 hospitals in Los Angeles County who were Baby-Friendly in 2016 but did not maintain their Baby-Friendly designation in 2017 (Chart 11). On average, exclusive breastfeeding rates at discharge decreased by 2.0% in these hospitals, however the decline was most significant for African American, Asian, and Latinx infants. There were several hospitals that did not have a statistically significant number of Pacific Islanders and Native Americans.

Exclusive Breastfeeding Equity Gap by Service Planning Area[10]



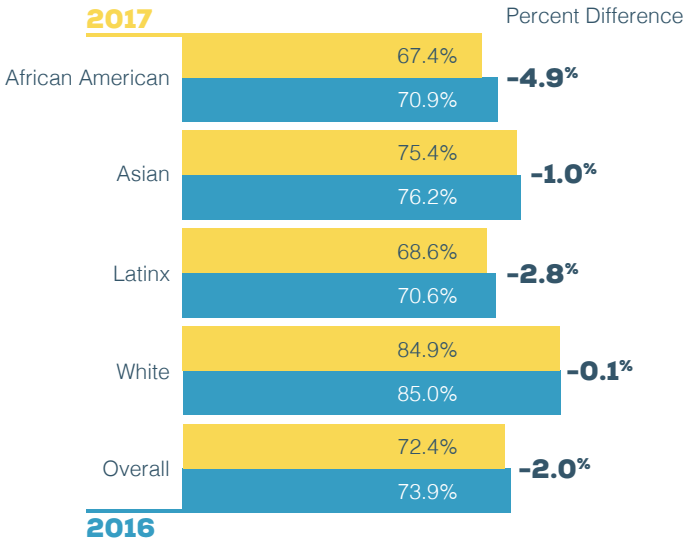
GRAPHIC 10

SPA	% In-Hospital Exclusive Breastfeeding for White Infants	Equity Gap	% In-Hospital Exclusive Breastfeeding for Infants of Color
1	81.65%	15.72%	68.81%
2	75.65%	16.25%	63.36%
3	73.73%	31.66%	50.39%
4	81.18%	25.21%	60.71%
5	87.51%	13.48%	75.71%
6	60.19%	24.48%	46.46%
7	70.90%	27.13%	51.67%
8	86.01%	23.48%	65.81%

In-Hospital Exclusive Breastfeeding Rates for Hospitals who lost their Baby-Friendly Designation in 2017

compared to their 2016 rates while Baby-Friendly[10]

CHART 11



These preliminary results are very concerning and more data is needed to determine what is causing the decrease in breastfeeding rates, particularly for infants of color, as well as how California's model policy will affect breastfeeding rates in the future. BreastfeedLA still recommends the Ten Steps to Successful Breastfeeding as the gold standard for infant feeding. SB 402, which passed in 2013, requires all general acute care hospitals and special hospitals that have a perinatal unit to adopt the "Ten Steps to Successful Breastfeeding" per the Baby-Friendly Hospital Initiative, or an alternate process that includes evidenced-based policies and practices and targeted outcomes, by 2025. While we believe in the premise of SB 402,[20] we worry that without proper enforcement mechanisms, hospitals will not be held accountable to the tenets of Baby-Friendly. We strongly recommend that the California Department of Public Health create a stakeholder taskforce to ensure that implementation of SB402 is equitable and to provide proper enforcement and accountability for violations.

The goal of the Chart 12 is not to endorse any particular hospital. The goal of highlighting the highest and lowest performing hospitals by race and ethnicity is to illustrate that where a parent gives birth influences how likely that parent is to breastfeed. The hospital with the highest in-hospital exclusive breastfeeding rate for African Americans has an 82.9% in-hospital exclusive breastfeeding rate, where as the lowest performing hospital has a 32.2% in-hospital exclusive breastfeeding rate for African Americans. The hospital with the highest

in-hospital exclusive breastfeeding rate for Asians has an 89.7% in-hospital exclusive breastfeeding rate, where as the lowest performing hospital has a 7.3% in-hospital exclusive breastfeeding rate for Asians. The hospital with the highest in-hospital exclusive breastfeeding rate for Latinx has an 79.6% in-hospital exclusive breastfeeding rate, where as the lowest performing hospital has a 20.3% in-hospital exclusive breastfeeding rate for Latinx. The hospital with the highest in-hospital exclusive breastfeeding rate for whites has a 94.1% in-hospital exclusive breastfeeding rate, where as the lowest performing hospital has a 25.0% in-hospital exclusive breastfeeding rate for whites.

While we cannot extrapolate factors other than birthing hospital from this data, and these data are not the only indicator of what kind of maternity care practices are in place at these hospitals, certainly differences as great as these require further investigation into what hospital practices need to change in order to better support new parents. We encourage hospitals to work with community advocates to learn more about how they can best serve the communities who birth at their hospital.

Recommendations

Based on the information presented in this section, BreastfeedLA recommends:

- All birthing hospitals adopt the *10 Steps to Successful Breastfeeding*,[1] while remaining committed to the Baby-Friendly designation as the gold standard for infant feeding support;
- All birthing hospitals analyze internal breastfeeding data in relation to, patient race/ethnicity, insurance payor, zip code, type of birth, provider, location of prenatal care, WIC eligibility, number of lactation professionals and potential determining factors;
- Hospital leadership, other healthcare organizations, and community advocates \use aforementioned data to determine, implement and advocate for new and tested approaches to infant feeding support that are focused on eliminating infant feeding disparities such as Baby-Friendly designation and participation in the Regional Hospital Breastfeeding Consortium;
- All birthing hospitals examine and build relationships with internal and external resources available to surrounding communities to address the social determinants of health that affect breastfeeding success.
- The California Department of Public Health should create a stakeholder taskforce to ensure that implementation of SB402 is equitable and to provide proper enforcement and accountability for violations.

* Regional Hospital Breastfeeding Consortium Meeting times can be found at breastfeedla.org/events

Top 3

Breastfeeding Hospitals by Race/Ethnicity [10]

% Exclusive Breastfeeding

African American	
Providence Saint John's Health Center	82.9%
Providence Little Company of Mary Medical Center Torrance •	73.6%
Kaiser Panorama City	72.1%
Asian	
Providence Little Company of Mary Medical Center Torrance •	89.7%
Kaiser West LA	85.1%
Ronald Reagan UCLA Medical Center •	84.7%
Latinx	
PIH Health Hospital Whittier	79.6%
Santa Monica UCLA Medical Center	78.5%
Providence St. John's Health Center	77.8%
White	
Martin Luther King Jr. Community Hospital	94.1%
Kaiser West LA	92.3%
Good Samaritan Hospital •	92.2%

CHART 12

Bottom 3

Breastfeeding Hospitals by Race/Ethnicity

% Exclusive Breastfeeding

African American	
St. Francis Hospital Lynwood •	33.2%
PIH Health Hospital Downey	32.5%
Memorial Hospital of Gardena •	33.3%
Asian	
Whittier Hospital	7.3%
San Dimas Community Hospital	9.3%
Monterey Park Hospital	11.0%
Latinx	
Whittier Hospital	20.3%
Monterey Park Hospital	24.5%
PIH Health Hospital Downey	26.7%
White	
Whittier Hospital	25.0%
PIH Health Hospital Downey	39.1%
St. Francis Hospital Lynwood •	53.5%

• Baby Friendly Hospital as of December 2017

Section 2: Paid Family Leave

New parents need time off from work to bond with a new child and/or to recover from childbirth. The United States is the only country in the world except for Papua New Guinea that does not guarantee federal paid family leave for new parents.[21] For new parents in LA County, taking time off from work means navigating a complex system of different programs and protections, including pregnancy disability leave, family medical leave and paid family leave. This section will focus on pregnancy disability leave and paid family leave. For more information about other workplace protections see BreastfeedLA's Advocacy Toolkit.

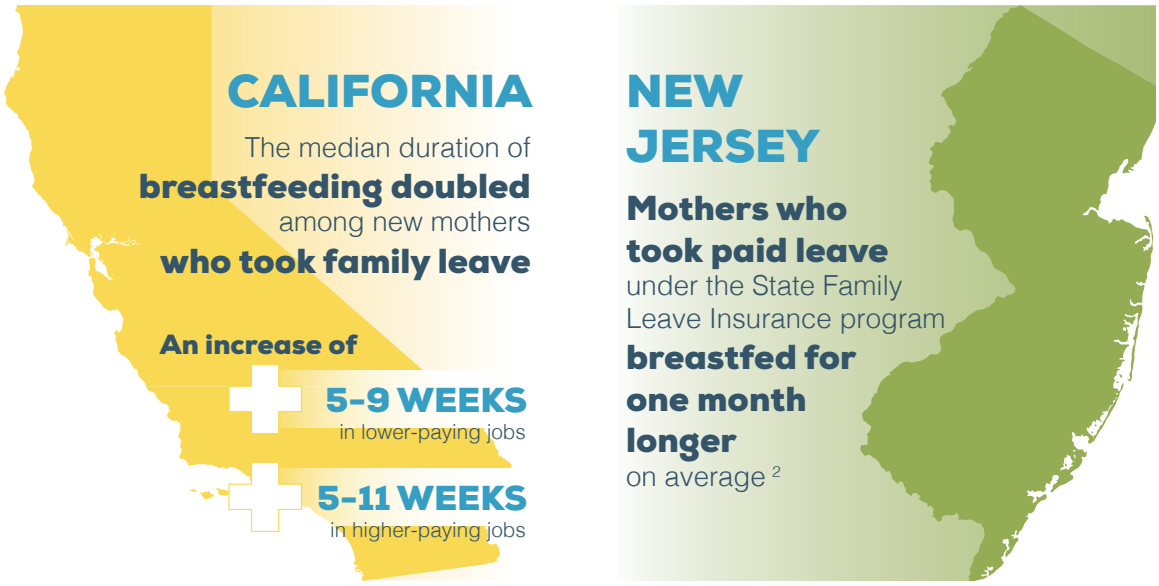
Paid leave is associated with longer duration of breastfeeding[2] (see Graphic 13). When parents are making infant feeding decisions, how soon they have to return to work influences their decision to breastfeed. Every week of PFL matters, with one study finding that each additional week of paid family leave increased breastfeeding duration by several days.

In California, Paid Family Leave (PFL) provides up to six weeks of partial pay to employees who take time off from work to bond with a new child entering the family.

California offers both Pregnancy Disability Leave (PDL) and Paid Family Leave (PFL) programs for eligible residents through State Disability Insurance (SDI). PDL allows up to four months of job-protected time off from work while pregnant and after giving birth, and 60-70% wage replacement during leave depending on income for those who qualify. PFL may similarly replaces 60-70% of the parent's income for up to six weeks of leave.

We do not currently have data on the total number of parents who are eligible and take family leave in LA County. This section explores both the importance of PFL and current barriers to accessing it.

GRAPHIC 13



You are eligible for Paid Family Leave if you:

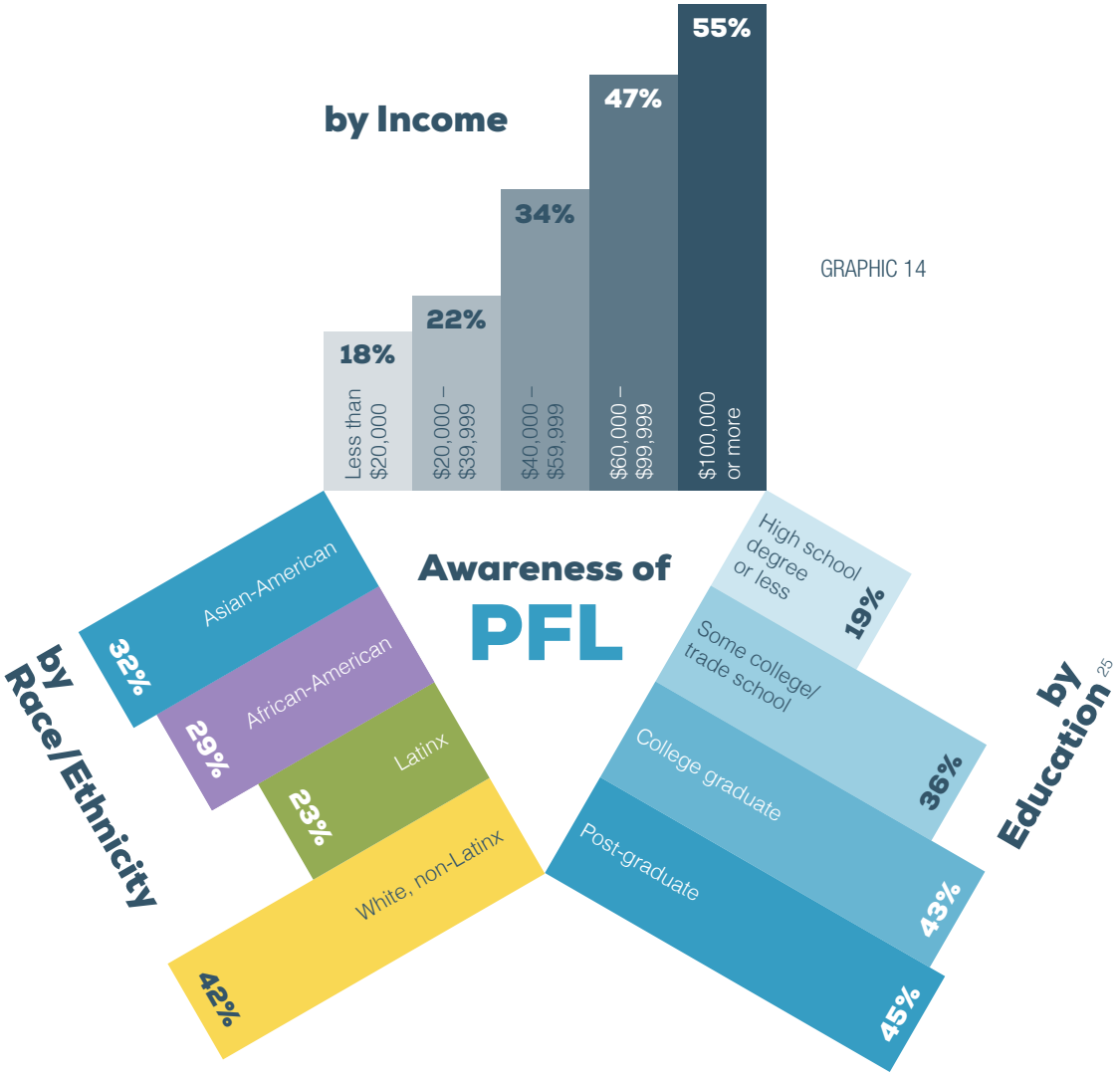
Welcomed a new child into your family less than 12 months ago through giving birth, a partner's pregnancy, adoption, or foster care.

Have paid into State Disability Insurance (noted as "CASDI" on paystubs) in the past 5 to 18 months.

Have not taken the maximum six weeks of PFL in the past 12 months.

If you qualify, you can receive up to 60-70% of your income for up to 6 weeks.[24]

Source: https://www.edd.ca.gov/Disability/PFL_Mothers.htm



GRAPHIC 14

Barriers to Accessing Paid Family Leave

Lack of Awareness

PFL supports families best when there are systems in place to build awareness among new parents of the benefits and other workplace protections to which they have a right.* According to a field poll conducted in 2014 by the California Center for Research on Women & Families,[25] only 36% of all California voters reported having awareness of Paid Family Leave. If people don't know about paid family leave, then they are unable to use it. Lack of awareness differs by race/ethnicity, income level and education level. Additionally, currently 99% of bonding claims are made by biological parents,[25] even though PFL coverage for bonding includes biological, foster, and adoptive parents. Therefore, it is especially important for foster and adoptive parents to be aware of their paid family leave rights.

In a 2014 field poll of California voters, disparities existed in awareness of paid family leave by race, income and education level. Latinx voters had the lowest awareness of PFL, with only 23% responding that they were aware of PFL. African American, Asian and Latinx voters all reported lower awareness of paid family leave than white voters. People earning an annual income of less than $20,000 were least likely to be aware of paid family leave. Only 18% reported that they were aware of PFL, compared with 55% of people earning $100,000 or more. Those with a high school education or less were less likely to be aware of PFL, with only 19% awareness as compared to 45% of people with a postgraduate degree.

LA County and Fresno County
have the lowest rate of PFL usage in California.[25]

Within LA County, people living in coastal cities
(an indicator of wealth) are more likely
to use PFL than those living farther inland.

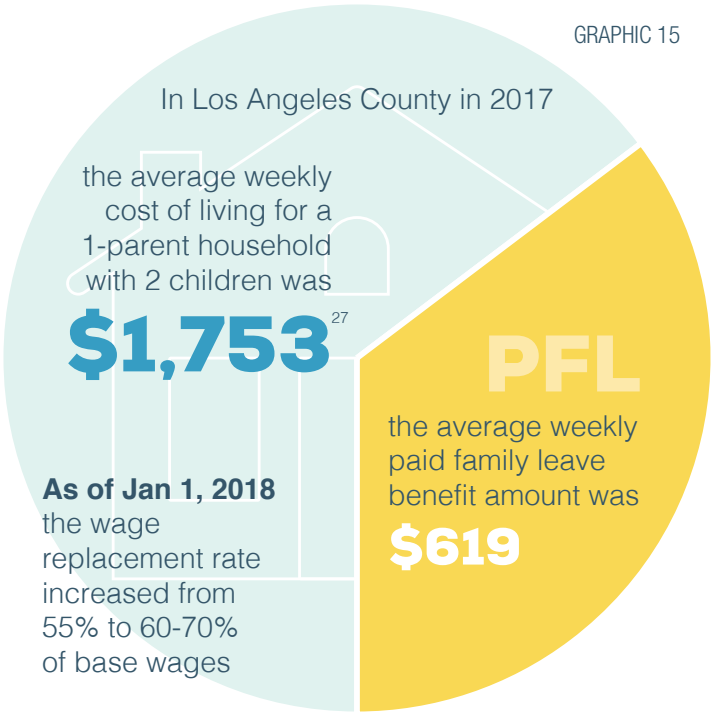
* For more information about laws and protection that cover employed parents visit: https://legalaidatwork.org/factsheet/pregnancy-parenting-my-job/

Paid Family Leave is Out of Reach for Many

PFL has eligibility requirements that make it inaccessible to millions of workers throughout the state. For example public employees and contractors who do not pay into SDI and workers who are paid in cash are among those excluded from PFL eligibility. For instance, the County of Los Angeles is the largest employer in Southern California, and its employees are not eligible for PFL because they do not pay into SDI. Even those who are eligible for PFL may not have enough protections to take the leave. Qualifying for job protection, requires navigating a separate set of requirements than those for taking PFL. This is a significant barrier for many parents, because if they take paid family leave they may lose their job. Similarly, there are workers eligible for PFL who cannot take it because the wage replacement is not sufficient to cover their cost of living. With many families in LA County living paycheck to paycheck, wage replacement of less than 100% is not workable. Women who earned less than $24,000 annually were much less likely to use PFL, according to 2014 EDD data.[25] Before January 1, 2018, benefits were capped at 55% of wages. This has now changed to 60% or 70% in an effort to make taking paid leave more feasible for families.

Graphic 15 provides an example of the financial strain that a family might experience while receiving paid family leave. According to 2017 data, 41% of households in the city of Los Angeles are single parent families.[26] In 2017, the average weekly paid family leave benefit amount for Los Angeles County was $619 while the average weekly cost of living in LA County for a 1-parent household with two children was $1,753. We hope to see a reduction in this gap with the 2018 PFL wage replacement rate increase, but PFL will continue to remain out of reach for many.

GRAPHIC 15



Application Process

Applicants have reported difficulty navigating the application process, and complain about the poor responsiveness of the Employment Development Department (EDD) to questions and concerns. Application forms are available in English only, posing a major barrier to immigrant workers who have limited English proficiency. The EDD is working with community advocates to improve the application process for PFL.

Recommendations

- EDD expand Paid Family Leave and remove eligibility requirements that make PFL inaccessible to some families.
- EDD make the application process easier by streamlining the application and offering the application in multiple languages.
- Organizations that work with pregnant people and new parents, including clinics, hospitals, WIC, and County offices, obtain training from EDD or respected partner in PFL benefits so that they are able to provide education about how to access PFL.

Section 3: Community Breastfeeding Support

Unequal access to breastfeeding and lactation support contributes to infant feeding disparities. At the 2018 Summit, the need for more training and career opportunities for lactation professionals of color was identified as an important area of focus. For many new parents, finding breastfeeding support is a challenge, and the responsibility is often placed on the individual person to discover appropriate resources. Families must navigate a myriad of breastfeeding resources to find support, including WIC agencies, community clinics, home visitation programs, outpatient lactation support, peer support groups and healthcare providers rather than a coordinated system of care and follow up. Even when resources are available, lactation professionals may be costly, not covered by insurance, may be inaccessible due to lack of transportation and distance, may lack cultural humility and often do not even speak their language. BreastfeedLA believes that we need to hold each other and ourselves accountable to best practices for infant feeding support, so that parents receive consistent education and support wherever they receive healthcare.

Despite the diverse racial and ethnic makeup of Los Angeles County, people of color are disproportionately underrepresented in the lactation workforce. While data on this issue was previously lacking, BreastfeedLA recently completed a survey of 310 lactation professionals in Los Angeles County and found that 55.1% of lactation consultants were white,[28] while only 17.4% of infants born in Los Angeles County were white.[10]

Graphic 16 reflects the lactation professionals who responded to BreastfeedLA's survey compared to the number of infants born in LA County by race/ethnicity.

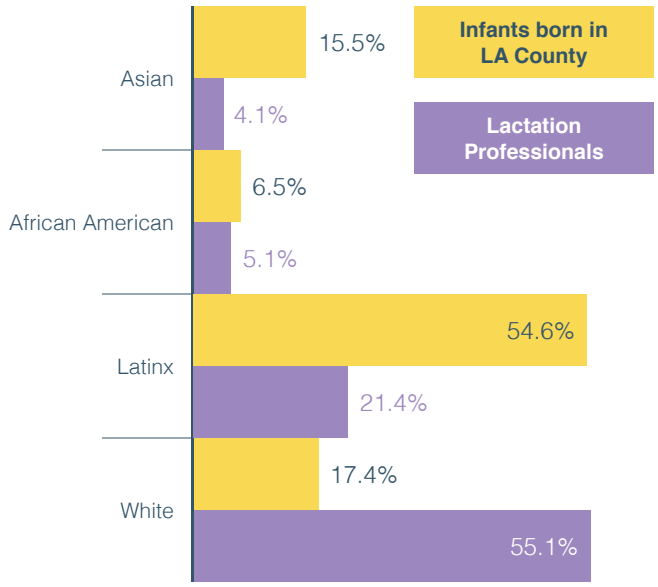
While 11% of Los Angeles County residents speak an Asian or Pacific Islander language at home,[29] only 4.5% of survey respondents spoke one of these languages.[28]

In 2017, the Regional Hospital Breastfeeding Consortium conducted a survey of lactation professionals and the majority of respondents reported that lactation professionals were understaffed in their facilities.[30] This illustrates that there is a need for more lactation professionals, and suggests research is needed to determine how lactation professionals' working conditions relate to the patient care that new parents receive.

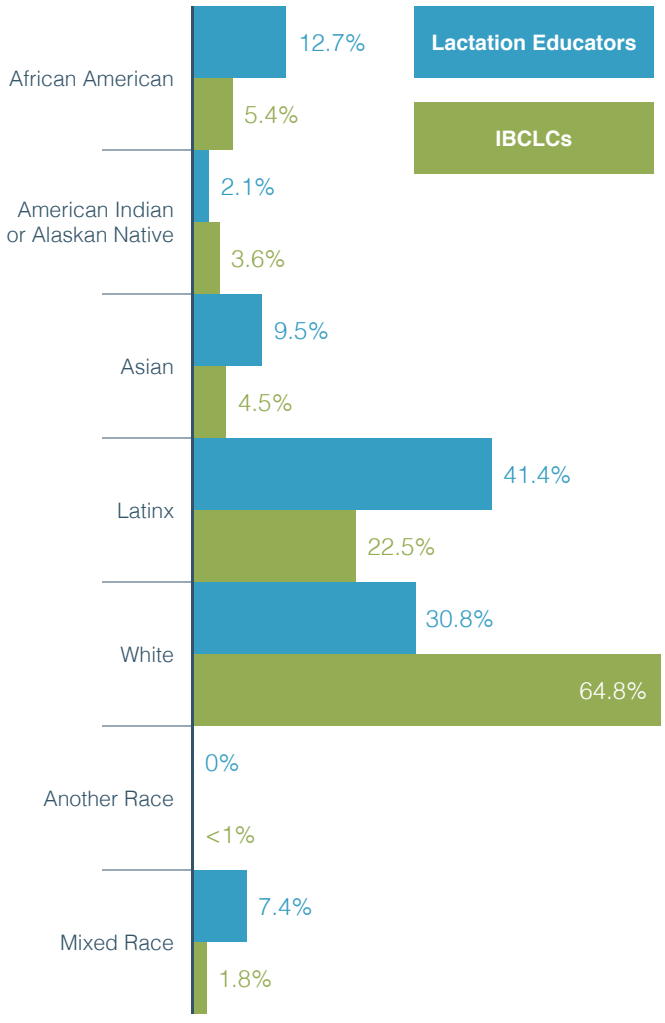
BreastfeedLA's survey of lactation professionals indicates that people of color are under-represented when comparing IBCLCs to lactation educators (Graphic 17). Several respondents identified barriers to becoming an IBCLC after becoming a lactation educator. These barriers included financial cost, obtaining clinical hours, concern of obtaining a job without a nursing degree, lack of tuition reimbursement, and college course requirements.[28]

Gaps in Culturally-Centered Lactation Services

GRAPHIC 16

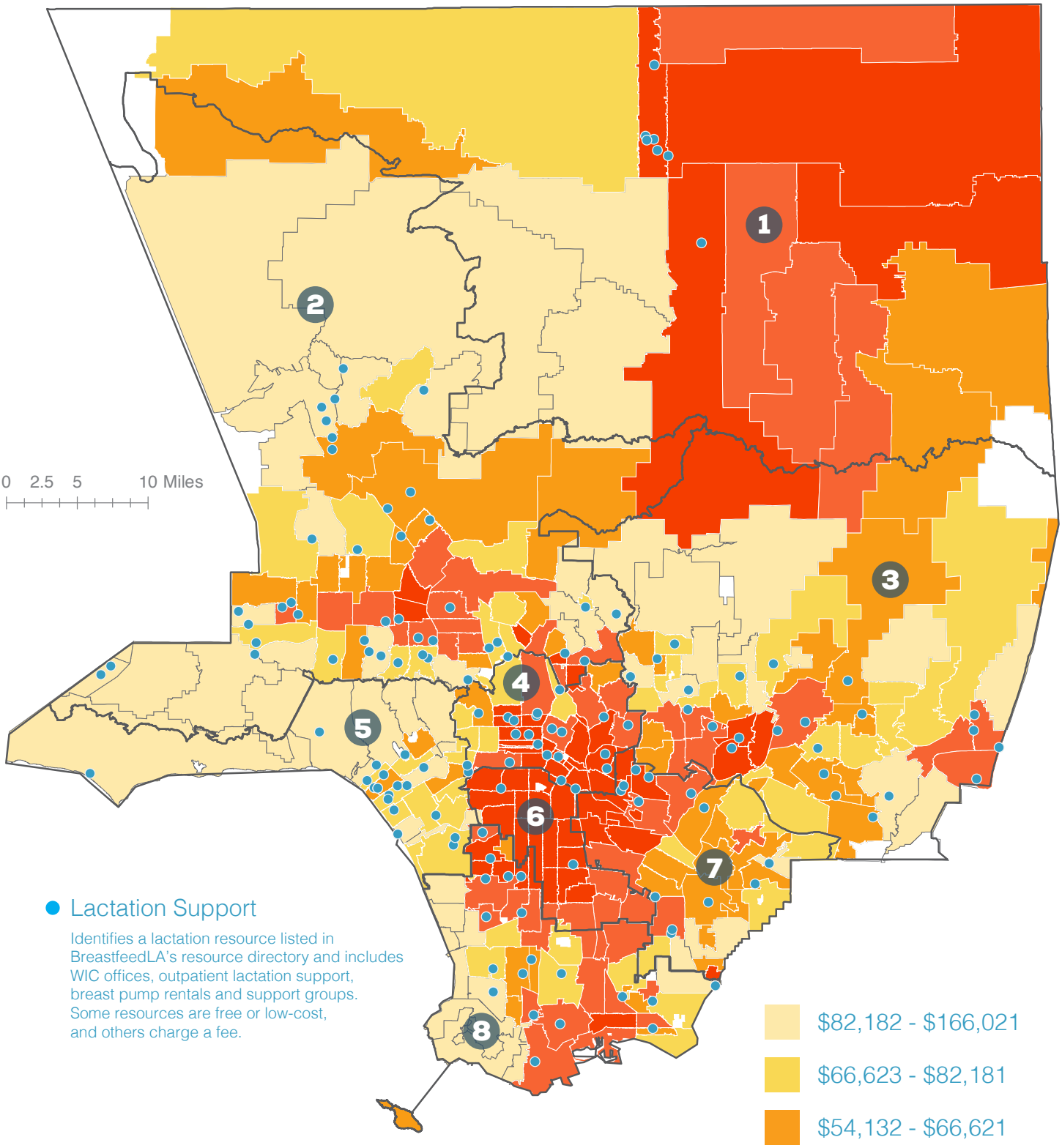


GRAPHIC 17



Lactation Support and Annual Median Household Income by Zip Code

GRAPHIC 18



Source: U.S. Census Bureau 2015

ZIP Codes in white are non-residential, had no median incomes, or are Universities, etc.

There are areas of Los Angeles County with many resources, and there are areas that lack support. SPA 1 and SPA 6 have the highest infant mortality rates in LA County, the lowest exclusive breastfeeding rates at 3 months, the fewest lactation support resources and the highest number of households with annual incomes between $12,813 and $41,400. BreastfeedLA is committed to working with government agencies and community partners to provide free breastfeeding support in the areas of the most need in LA County.

Recommendations

- Any organization that employs a lactation professional pay a living wage to its employee, organizations should not expect lactation professionals to provide their service without compensation;
- Organizations that employ lactation professionals actively work to remove barriers to training and hiring for communities that have been historically underrepresented in the lactation field;
- Insurance providers should increase access to and funding for lactation support and supplies;
- Organizations that serve pregnant people and new parents should conduct an audit to determine where lactation professionals are needed in their organizations and where and when breastfeeding support can be provided;
- Breastfeeding advocates and other maternal child health experts collaborate with other professions and organizations that support new parents including mental health providers, home visitors, doulas, and midwives, removing unhelpful silos;
- Organizations should seek out, hire, and/or train lactation professionals who speak the languages spoken in their community;
- LA County, Department of Public Health should dedicate funds to infant feeding and designate a staff person who can serve as the countywide hub for breast- and chest-feeding support and advocacy on behalf of all County Departments and 88 cities the county serves;
- Clinics, WIC, home visitation, and other postpartum providers should invest in data collection and analysis within prenatal and postpartum care settings to identify inequities and interventions that affect breastfeeding success.

Call to Action

The goal of the 2018 summit was to shift the conversation about breastfeeding and to delve deeper into systemic issues contributing to infant feeding challenges. We wanted to explore what makes it difficult for a parent to breastfeed from broader economic, public health, reproductive justice, and mental health lenses. How do lived experiences, geographic location, and a multitude of social and systemic injustices contribute not only to infant feeding decisions, but to infant feeding options? Equipped with the willingness to address a broader perspective on infant feeding inequities, LA County can lead the way in providing the standard of infant feeding support.

Whether or not a person breastfeeds is often not a choice.[3] At the summit, breast-, chest-, and pump-feeding were contextualized as inseparable from the capitalist, white supremacist, and hetero-patriarchal systems that underlie infant feeding disparities. Speakers exposed attendees to the history of enslaved Black women forced to breastfeed white children and the resulting intergenerational trauma that continues to permeate infant feeding choices for Black families. Attendees heard powerful stories from LA County residents about being treated disrespectfully or dismissed throughout their perinatal care as a result of their race, gender identity or native language, and about not being able to find lactation and mental health support from someone with identities mirroring their own. Correspondingly, lactation professionals of color spoke about barriers they had faced in seeking education and building their businesses because of persistent discrimination and lack of resources to serve their communities.

In the face of each challenge, however, attendees also heard from clinicians and community advocates working to overcome infant feeding inequities by putting their clients', neighbors', and family's voices and needs at the center of their work and by fighting for racial, economic, and reproductive justice. Participants witnessed the support of allies ready to walk hand and hand together to overcome infant feeding inequities. Attendees walked away from the summit with an understanding that each of us has a role in changing the landscape of infant feeding support in LA County and no act is too small.

BreastfeedLA calls on you to listen to the communities in your care and to serve them with humility; to challenge your organization(s) to ensure that all families receive the breastfeeding/chestfeeding support to which they have a right; and to confront those individuals and dismantle those systems that perpetuate injustice. Let our actions protect, empower, and nurture parents and infants.

BreastfeedLA staff and Board
info@breastfeedla.org

> "There is no such thing as a single-issue struggle because we do not live single-issue lives."
>
> -Audre Lorde

Appendix A: Definition of Terms

In preparation for the summit, our goal was to better understand health equity and a different lens through which we could more clearly understand why disproportionate access and unequal breastfeeding rates exist. Highlighted below are key terms, definitions, and frameworks that can increase awareness of how systems, structures, institutions, and bias play a role in the opportunities and lived experiences of all, disadvantaging some and advantaging others. They act as important guides as we work to eliminate infant feeding disparities.

Gender Inclusive Language

In this report we used gender inclusive language because we want to include all breastfeeding/chestfeeding parents. Our language and lactation support services need to expand to include all sexual and gender identities.

Racial Equity

The Center for Social Inclusion defines racial equity "as both an outcome and a process. As an outcome, we achieve racial equity when race no longer determines one's socioeconomic outcomes; when everyone has what they need to thrive, no matter where they live. As a process, we apply racial equity when those most impacted by structural racial inequity are meaningfully involved in the creation and implementation of the institutional policies and practices that impact their lives. When we achieve racial equity:

- People, including people of color, are owners, planners, and decision-makers in the systems that govern their lives.
- We acknowledge and account for past and current inequities, and provide all people, particularly those most impacted by racial inequities, the infrastructure needed to thrive.
- Everyone benefits from a more just, equitable system."[32]

Definition of Race and Racism [31]

Dr. Camara Jones succinctly describes race as a "social classification, not a biological descriptor." Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race')". Racism unfairly disadvantages some communities and individuals, while unfairly advantaging other individuals and communities. It is important for us to understand that race has no biological basis, and that infant feeding disparities do not have a biological basis. As advocates, we need to understand how race and racism operate in our society in order to challenge both our own assumptions about ourselves and others and so that we can see how challenging racism affects infant feeding. "Racism is most often passive, most often shows up as inaction in the face of need."

According to Dr. Camara Jones, racism can manifest in three primary categories. We explored each of these categories in greater depth at the summit because each of these levels of racism play a role in infant feeding disparities. The following definitions are directly quoted from the Dr. Camara Jones TED Talk, which can be viewed here: www.youtube.com/watch?v=GNhcY6fTyBM.

Levels of Racism

Institutionalized racism

- Differential access to the goods, services and opportunities of society by "race"

  Examples
  - Housing, education, employment income
  - Medical facilities
  - Clean environment
  - Information, resources, voice
- Explains the association between racism and social class

Personally-mediated racism

- Differential assumptions about the abilities, motives, and intents of others by "race"
- Differential actions based on those assumptions
- Prejudice and discrimination

Internalized racism

- Acceptance by the stigmatized "races" of negative messages about our own abilities and intrinsic worth

  Examples
  - Self-devaluation
  - "White man's ice is colder" syndrome
  - Resignation, helplessness, hopelessness
- Accepting limitations to our full humanity"

Definition of Capitalism

"Pure capitalism is defined as a system wherein all of the means of production (physical capital) are privately owned and run by the capitalist class for a profit, while most other people are workers who work for a salary or wage (and who do not own the capital or the product)".[33] Capitalism is extremely relevant to infant feeding. The infant formula industry was estimated at $50 billion dollars globally in 2017.[34] In for-profit formula industry marketing practices, for example, profit is the priority over the health of parents and infants. Though formula is an inferior product to breastmilk, marketing practices efface the risks of formula feeding, leaving parents to become dependent on it, often at a financial burden to their family.

The International Code of Marketing Breast-Milk Substitutes is an important way to limit the influences of formula marketing practices. 84 countries have signed the document and enacted legislation which implement most or all of the provisions and subsequent relevant WHA resolutions of The Code. Sadly, the United States is one of only two countries to NOT sign the document in 1981, in 2010 the U.S. signed, but refused to enact legislation. Additionally, in the United States selling health insurance for profit is an industry that has implications for healthcare outcomes. For-profit insurance companies have a profit incentive to deny healthcare coverage to increase profitability.

Definition of White Supremacy

"White supremacy is a historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and peoples of color by white peoples and nations of the European continent, for the purposes of maintaining and defending a system of wealth, power and privilege."

Definition of Patriarchy

According to bell hooks "Patriarchy is a political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence."[5]

Definition of Cisgender

The term cisgender refers to "of, relating to, or being a person whose gender identity corresponds with the sex the person had or was identified as having at birth."[35]

Reproductive Justice

"The human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities."

Intersectionality

Intersectionality is ""the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect, especially in the experiences of marginalized individuals or groups."[36] Scholar and activist Kimberlé Crenshaw coined the term in 1989.[36] Intersectionality gives infant feeding professionals the vocabulary and opportunity to recognize that none of our clients can be defined or pigeon-holed by one aspect of their identity. The client in front of us may be continuously and simultaneously up against discrimination related to language, race, gender, sexual orientation, and care providers must provide care within that ENTIRE context, not pick apart and only treat portions of the person who is one whole.

Equity in Action

Appendix B

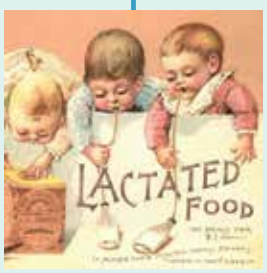
A Brief History of Infant Feeding in the United States [37,38,39]

1619-1865 Enslaved Black women forced to breastfeed White children as wet nurses

pre-1900s White infants breastfed at nearly 100% by their parent or a wet nurse

1800s Invention of modern infant feeding bottles

1865 Invention of commercial infant formula



early 1900s Formula manufacturers begin advertising directly to physicians

1910s Rise of formula bottle feeding

1912 Rubber nipples become available

1940s Rise of sexualization of the breast

1946 Formula-based advertising featuring the Fultz quadruplets directed at black families

1950s Public breastfeeding becomes increasingly taboo

1956 La Leche League founded

1970s Formula-based advertising directed at Black families

1972 Breastfeeding rates in the U.S. hit rock bottom at 22%

A large percentage of Black American babies born into slavery and Native American babies did not receive breastmilk from their biological mother and in some cases received other forms of food

1865-present Enduring legacy of slavery contributes to long standing breastfeeding inequities and lower breastfeeding rates for Black infants

BreastfeedLA is committed to a future in which all infants and parents thrive. This future can only become reality if lactation advocates grapple with the history that brought us to our current state and actively work to dismantle these systems of injustice.

1981

World Health Organization adopts the International Code of Marketing of Breast-milk Substitutes

1990

UNICEF and World Health Organization issue the Innocenti Declaration

1991

Baby-Friendly Hospital Initiative established

1993

FMLA

Passage of federal Family and Medical Leave Act to provide eligible employees with up to 12 weeks of unpaid family leave

1995

United States Breastfeeding Committee founded

1997

California law passed on right to breastfeed in public

2001

Dept. of Health & Human Services releases Blueprint for Action on Breastfeeding

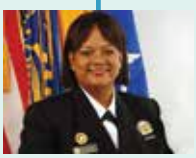
California lactation accommodation laws passed: AB 1025, Labor Code Sections 1030-1033

2007

California law improves access to lactation supports and breast pumps among Medi-Cal recipients

2011

Patient Protection & Affordable Care Act provisions for workplace and healthcare support



The Surgeon General's Call to Action to Support Breastfeeding

2015

83.2% of infants in the U.S. receive any breastmilk

California breastfeeding accommodations for students

Administration opposed international resolution to encourage breastfeeding

2018

BreastfeedLA's Breastfeeding Equity Summit

One million babies born each year in Baby-Friendly facilites

Thank you to Lydia O. Boyd, CLE and Alexandria Goodyear, MPH student at UCLA for your assistance with this project.

Appendix C

Summit History: 10 Years of Progress

BreastfeedLA has come a long way since convening the first summit in 2008.
The conversation has shifted from discussing the importance of breastfeeding, to a focus on equity.

2008	Hospital and community leaders, stakeholders, and advocates came together at BreastfeedLA's inaugural Summit to highlight the far-reaching positive impact of exclusive breastfeeding on the health and wellbeing of infants, families, and communities.
2010	Hospital administrators and staff convened in support of a Call to Action to increase the number of Baby-Friendly Hospitals throughout Los Angeles County.
2012	Hospital administrators and staff came together as part of an effort to gain commitment from hospitals to become Baby-Friendly.
2013	LA Best Babies Network and nine partners convened the "Breastfeeding Policy Roundtable and Call to Action" to improve breastfeeding duration in LA County.
2014	This Summit branched out beyond hospitals to guarantee continuity of skilled care both prenatally and postpartum.
2017	Breastfeeding advocates convened at BreastfeedLA's Advocacy 101 Training to examine current breastfeeding and lactation laws and policies, the protections they provide, and where they fall short.
2018	Advocates, providers, community organizers, and healthcare professionals come together to identify and tackle infant feeding inequities throughout Los Angeles County and promote systems change.

Key outcomes and accomplishments since 2008:

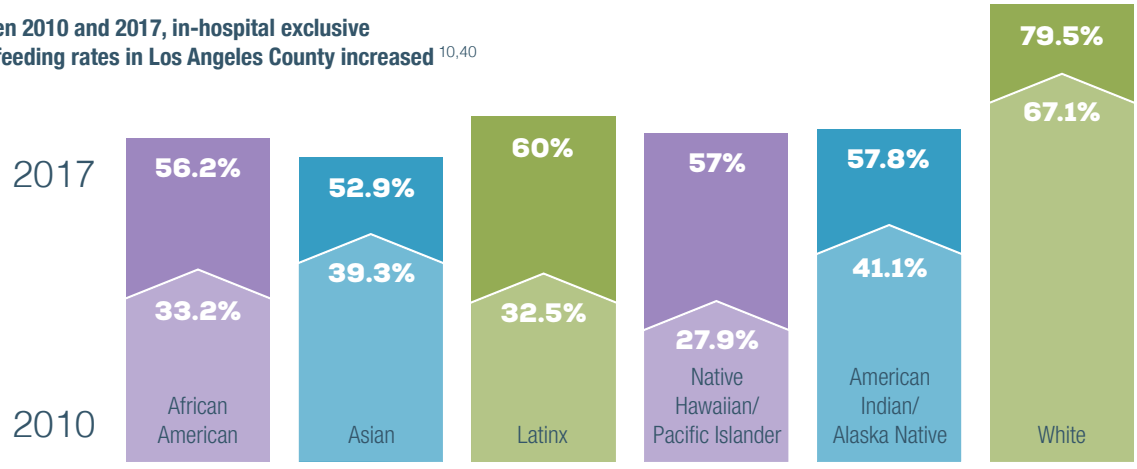
- Elevation of breastfeeding as a public health priority in Los Angeles County
- Increase in the number of Baby-Friendly hospitals throughout Los Angeles County
- Facilitation of cross-sector partnerships to promote and support breastfeeding
- Enhanced capacity of community members and lactation professionals to advocate for laws that support breastfeeding and paid family leave
- Identification of infant feeding inequities as an area of critical importance for breastfeeding advocates

Successes Since the Last Summit

Policy and Legislative Wins	**SB 402**: Hospital adoption of "Ten Steps to Successful Breastfeeding"
	AB 908: Increased wage replacement rates under Paid Family Leave
	SB 63: Expansion of Paid Family Leave benefits to small business employees
	AB 302: Lactation accommodations for students
	BABES Act: Enforcement for special procedures related to breast milk, formula, and infant feeding equipment at all airport security checkpoints
	AB 2507: County jails: infant and toddler breast milk feeding policy
	AB 1976: Workplace lactation accommodations
	AB 2785: Student services: lactation accommodations
Advancing Practice	Increase in Baby-Friendly hospital designations and other hospital practices that support breastfeeding
	Welcome Baby home visitors are trained on a 45 hour lactation education course
	BreastfeedLA established 4 local milk collection sites
	Development of 9 Steps to Breastfeeding Friendly: Guidelines for Community Health Centers and Outpatient Care Settings
Advocacy	BreastfeedLA organized Advocacy Day and created an Advocacy Toolkit
	BreastfeedLA created the Lactation Educator Specialist (LES) training to increase the number of lactation professionals from historically underrepresented communities
Expanding Breastfeeding-Friendly Environments	Mother-Baby Friendly Workplace Award presented to several local organizations
	BreastfeedLA trained 81 school districts in partnership with Los Angeles County Office of Education
	BreastfeedLA trained 31 Title IX coordinators from colleges and universities
	BreastfeedLA created Impact Awards to recognize local leaders and advocates
Advancing Research	BreastfeedLA developed reports to assess K-12 schools, colleges and universities on their lactation accommodations for staff and students

Outcomes

Between 2010 and 2017, in-hospital exclusive breastfeeding rates in Los Angeles County increased [10,40]



Local Priorities	Los Angeles County Board of Supervisors annually proclaim the first week of August as World Breastfeeding Week
	NAACP passed a local breastfeeding resolution
	Development of Los Angeles County Asian Breastfeeding Task Force
	African American infant mortality prevention reinvigorated as a priority countywide

This list of wins is not all-inclusive and encompasses the work of many organizations throughout California.

Appendix D

2018 Summit Overview

Inclusion, Authenticity, Commitment to Change

On October 10th and 11th, 2018, BreastfeedLA held a two-day equity summit at The California Endowment, Center for Healthy Communities. The purpose of the summit was to examine breastfeeding inequities and disparities with those involved in policy, quality improvement, and care coordination for maternal-child services and to inspire them to listen to the community voice and take action to better support families in the perinatal period.

Summit Planning Process

BreastfeedLA's summit was planned by a committee of BreastfeedLA staff, volunteers and community advocates. The key areas of focus for the summit were suggested by a committee of hospital and community stakeholders and later reaffirmed via a community needs assessment conducted by BreastfeedLA where community partners ranked and provided open comment on the areas they felt were most important for the summit to focus on. Moreover, key informant surveys were conducted with lactation professionals to assist in understanding the current landscape in Los Angeles County which identified a marked gap in specific community needs, such as lack of lactation support in the many languages spoken in LA County. Local journalist and advocate, To-wen Tseng addressed the issue of the relatively non-existent culturally- or linguistically relevant lactation support for Chinese Americans, despite Los Angeles County being home to the largest Chinese American population in the USA. The community needs assessment validated her experience as it identified only two out of over 300+ responses from lactation professionals who spoke any Chinese dialect.

Summit Objectives

The summit had the following objectives:

- To explore how race/ethnicity, geographic location, place of birth and other factors have a direct correlation to breastfeeding and human milk feeding.
- To identify barriers to human milk feeding in our community and develop steps to reduce inequities.
- To stay up-to-date on new initiatives & mandates around infant feeding.
- To create and strengthen our partnerships with other hospitals, healthcare providers, clinics, community advocates and public health professionals to improve maternal and child health outcomes.
- To develop an action plan to create change in the infant feeding landscape in LA and our local community.

Zero Weeks Screening

On the evening of October 9th, BreastfeedLA hosted a screening of the film *Zero Weeks* about America's lack of paid family leave and how it affects the health of families and communities. A panel discussion was moderated afterwards by Sarah Shealy, CNM, IBCLC, RN, Assistant Professor of Nursing at Mount St. Mary's University, with experts from ACLU Southern California, California Work and Family Coalition, local unions, and the Los Angeles County Department of Public Health.

Equity Summit Day 1

The summit was moderated by Bita Amani, PhD, MHS from Charles R. Drew University of Medicine and Science. For the morning of the 10th, Barbara Ferrer, MD, MPH, MEd Los Angeles County, Director of Public Health and Wenonah Valentine, MBA, Executive Director of iDREAM for Racial Health Equity, delivered the two keynotes. Dr. Ferrer discussed the landscape of Los Angeles County breastfeeding and health equity data, and why the county Department of Public Health is focused on health equity and infant mortality. Wenonah Valentine discussed the lived experiences of Black women in Los Angeles and made the connection between the data and the families affected by poor health outcomes.

Ash Williams, MA, from Sistersong discussed breastfeeding in the context of reproductive justice and Jadah Parks Chatterjee, BSN, RN, IBCLC facilitated an impactful panel entitled Lactation Professionals of Color. Panelists included Kimberly Durdin, IBCLC, Doula, Student Midwife, founder of Birthing People Foundation, Toy Hightower, Doula, CLE, CAPPA, Community Health Worker for Whole Person Care, Stevie Merino, MA, Doula, CLES, co-creator of the Long Beach Birth Workers of Color Collective, and trainer at BreastfeedLA, Juan Diego Norena, Fatherhood Engagement Coordinator, MOMS Orange County, To-Wen Tseng, Journalist, Asian Breastfeeding Task Force, and Health Connect One, and Leah DeShay, Private Practice IBCLC.

In the afternoon, attendees watched a TED Talk about institutional racism from Dr. Camara Jones entitled, "Allegories on Race and Racism." The afternoon continued with a panel discussion entitled, "The Parent Experience, Mental Health, Breastfeeding, and Intersection of Health Equity." Speakers included Celine Malanum, CLEC, founder of Long Beach Breastfeeds, Santiago Chambers, Chamarra Nguyen MsEd, Raul Martinez, JD, and Alyssa Berlin, PsyD.

Breakouts were held on the following topics:

- How Birth Practices Impact Breastfeeding Equity - Sarah Shealy, CNM, IBCLC, RN Mount Saint Mary's University
- Lactation In Special Cases: Custody, Judicial System, and Immigration Detention - Ruth Dawson, JD, MPH and Aditi Fruitwala, JD, MS, ACLU Southern California
- Please Don't Fire My Patient: How to Support Your Pregnant and Breastfeeding Patients on the Job - Liz Morris, JD Center for Worklife Law
- How Paid Family Leave and Other Supportive Workplace Policies Play a Role in Removing Breastfeeding Barriers and Advance Breastfeeding Equity - Jenna Gerry, JD, Legal Aid at Work and Melisa Acoba, MPH, California Work and Family Coalition
- Optimizing Breastfeeding: Infusing Infant Mental Health within High Risk Infant Populations - L. Hope Wills, MA, RDN, CSP, IBCLC and Patricia Lakatos PHD-USC
- LGBTQIA and Chestfeeding - Stevie Merino and Maricela Renteria de Rivera, CLE

"I learned that health choices are rarely truly voluntary, and certainly breastfeeding is a great example of how we may think we're making a voluntary choice but there's so much baggage behind it. To remove this baggage, education is urgently needed–so that mothers can recognize the real reason behind their choice, and know who they can seek help from.

There's one thing I can always do: keep writing. For 2019, I'm working on a photovoice project with my colleagues at Asian Breastfeeding Taskforce."

-To-Wen Tseng
Journalist and advocate

Equity Summit Day 2

On Day 2, our opening session was a panel entitled, "What's Working to Effectively Reduce Disparities in the Community." The panel was moderated by Jadah Parks Chatterjee, BSN, RN, IBCLC and panel members included Asaiah Harville, IBCLC from Martin Luther King, Jr. Welcome Baby Program and Morgan Ervin, CCN, RDN, CLE from CinnaMoms, PHFE WIC. The second plenary was by Sarah Shealy, CNM, IBCLC, RN from Mount Saint Mary's University reviewed the data and explored implicit bias. Ash Williams from Sistersong reviewed a case study from the National Women of Color Reproductive Collective further exploring our understanding of how reproductive justice and breastfeeding are interrelated.Bita Amani moderated a panel with Ash Williams and Laura Jimenez from California Latinas for Reproductive Justice that explored how infant feeding is an often overlooked part of the reproductive justice movement. In the afternoon we broke into workgroups to begin the development of how we can continue our actions for change beyond the summit. Please see the next section to see workgroup objectives and how to join a workgroup.

Summit Work Groups

There are 6 workgroups that have continued to address infant feeding inequities since the summit. The workgroups reflect areas of priority for BreastfeedLA and areas of focus that were identified during the summit planning process. Each work group has a set of objectives that are designed to influence breastfeeding in the hospital experience, paid leave and access to support and supplies. To join a work-group, email info@breastfeedla.org and include the name of the workgroup(s) that you would like to join in the subject line.

Legal Workgroup
Moderated by the California Women's Law Center and the California Work and Family Coalition (Paid Leave)

- Increase awareness about paid family leave policies in LA County
- Work with local employers to implement paid family leave
- Develop local experts on paid family leave

Patient Care/ Hospital/Healthcare System Workgroup
Moderated by PHFE WIC and North East Valley Health Corporation WIC (Hospital Experience)

- Introduce a racial equity focus to the Regional Hospital Breastfeeding Consortium
- Work with lactation professionals to increase cultural humility and improve communication with patients/clients/participants

Immigration Detention/Incarceration and Breastfeeding
Moderated by Whole Person Care and ACLU of Southern California (Access to Support and Supplies)

- Implement of AB 2507 - County Jails Pump and Pick up Program
- Advocate for all court mandated community service programs to provide lactation accommodations

> "What actually gave me hope was how open the majority of women who attended the summit were to learning more about the struggles that are happening in birth work for African American women, especially when [the leaders of] organizations doing the trainings are usually women that do not look like us."
>
> -Toy Hightower

> "The summit enabled us to acquire a new language to understand and communicate the ways that systemic racism affects breastfeeding rates. By naming the problem, we can begin to heal and build trust between patients and providers."
>
> -Melisa Acoba

Access to Lactation Services Workgroup
Moderated by BreastfeedLA and LA County Department of Public Health (Access to Support and Supplies)

- Collaborate with the Asian Breastfeeding Taskforce, Breastfeeding Welcome Here, African American Infant Mortality workgroup and other grassroots cultural organizations focused on improving lactation support in communities of color
- Support local groups in learning how to fundraise and obtain grants to support their work

Insurance and Billing Workgroup
Moderated by Regional Breastfeeding Liaison, WIC (Hospital Experience, Access to Support and Supplies)

- Understand the current Los Angeles insurance and billing landscape
- Assist local practitioners with billing for lactation services
- Explore new legislation to improve insurance coverage for lactation services and supplies

Data Tracking Workgroup
Moderated by LA County Department of Public Health (all three areas of focus)

- Increase awareness of how people can access the Los Angeles Mothers and Babies Survey
- Share data sources through email listserv
- Provide community feedback for the 2020 Los Angeles Mothers and Babies Survey

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