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14th Breastfeeding and Feminism International Conference: Roots and Wing: Looking Back, Looking Forward

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This year's theme reflects a familiar idea that encourages our movement and discipline to consider *where we come from, where we are, and where we are going*. While La Leche League, the Nestle Boycott, the World Health Assembly's passage of the *International Code of Marketing of Breast Milk Substitutes* (Code), and the Breastfeeding Friendly Hospital Initiative ushered in important new approaches to breastfeeding protection, promotion, and support, our conversations made it clear that our roots extend back to human evolution—nursing mothers have always had challenges and shared parenting, shared lactation, and milk sharing have always been with us: Communities have always found ways to cultivate unique approaches to infant feeding. At BFIC 2019 participants shared ways that we are still navigating in the Code: how we are collectively engaging with, and enhancing support for, populations and communities made vulnerable by discrimination and poverty, and for those who live in challenging physical, geographic, and social environments. We are also challenging racism and homophobia, transforming organizations, advancing feminist frameworks, building new partnerships, and working to advance policies and practices that make it possible to parent, breastfeed, and work. We also explored how we need to care for ourselves, update our research methods, advance the state of our science, and expand partnerships with others who care for communities, families, and children. As we continue to stretch our wings, participants have noted the need for us to remain mindful: that maternal health matters; that health disparities due to race, ethnicity, gender, or sexuality are not acceptable—our language and words can hurt; on the need for our solutions to reflect the diverse character of parents and families; and on the importance of responding with care to infant feeding experiences shaped by global and national policies affecting the migration patterns of populations, climate, and technological changes. Finally, we reflected on the importance of both celebrating our unique stories and listening to each other.

We want to conclude with on a personal note. The *14th Breastfeeding and Feminism International Conference* was the last BFIC directed by us. We want to honor, here, the memory of Dr Miriam Labbok, the conference co-director for the years 2006–2016. We continue to miss her presence, but often feel her spirit. We also want to extend a heartfelt thank you to all of you who have been part of the conference. Over the years, BFIC has provided the opportunity for hundreds of people across multiple disciplines and backgrounds to share their research, their work, and their passions. We feel grateful to have been part of it all.

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4-Minute Presentations

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Breastfeeding is Hard…or is it?

"Breastfeeding is hard." I hear and see this message in social groups, the media, and also in professional groups. I googled the term and 190 entries on 19 pages came back! It does make sense: We know many people have difficulties with lactation. Sore nipples, latch problems, infections, biting. We all know that. And I know many of you can tell lots of stories of difficult experiences.

But is "breastfeeding is hard" a helpful message? Some insist we need to say that because breastfeeding does not come easily and naturally. Rather, it is a skill, and, like learning to ride a bike, it takes work, patience, and persistence to breastfeed with confidence.

There is a risk to this message. When we say "breastfeeding is hard" are we not implying that it is the failure of the parents' or babies' bodies that make it difficult to breastfeed? Are we not placing the responsibility for any difficulties squarely on the shoulders of the breastfeeding dyad?

Who benefits when we say breastfeeding is hard? Our breastfeeding families? Let us think about that: if we are

saying breastfeeding is hard, are we not implying that the alternative, formula, is easy? But, is breastfeeding inherently hard or is it that the conditions in which families live make it hard to breastfeed? In contrast to the US where not even 30% of women breastfed at 12 months[1] in 2011, in Mozambique, 87% of 12–17-month-old children are breastfed[2]. So, if breastfeeding is hard, how is this possible, in a country that has a fraction of the financial resources of the United States? I think many of us in this room know or suspect the answer. My guess is that there is strong family, sisterly, brotherly, and societal support, that it is an accepted practice, passed on from generation to generation. That is a special type of wealth.

So, coming back home:

- What if, in addition to helping the breastfeeding dyad, we create the conditions for them to be successful in the first place?
- What if breastfeeding dyads were welcome in parks, gyms, restaurants, and buses?
- What if all workers were granted 6 months of paid leave upon the birth of their child and all employers unquestioningly provided time and space for expressing milk?
- What if all new mothers were not released from their hospital beds after 24 hr or, even better, births were in beautiful settings that honored this special time in our lives? What if we made sure parents felt comfortable with breastfeeding or were assured good support before sending them home?
- What if, when returning home, (and all new parents and babies need a home to go to), family and friends help with chores and meals so that new parents can focus on their new baby?
- What if a trained doula, lactation counselor, or consultant visited each new parent after birth?
- What if we lived in a society where the breast is desexualized and breastfeeding in public became no big deal?
- What if we did not have to constantly fight the commercial interests that want to thwart and complicate breastfeeding?

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Touching Breasts

I am Ellen Chetwynd and I touch breasts, every clinical day. What does that mean? What are breasts in healthcare? They are an organ. In fact, they are unique: They are the only organ not fully developed at birth. At birth, they are buds—tiny, but full of potential, ready to be bathed at puberty by male or female hormones to reach their full potential and full function in females.

But we do not see breasts as organs. We do not learn about this in high school—not even in college. In my college embryology class, for example, neither textbook described the development of the breast nor did they mention the mammary ridge. Neither word is in the index of *either* book. Breasts are part of the integumentary system, or the skin and associated glands, yet Wikipedia does not mention breasts as part of this system, nor is lactation listed as a function. They are mentioned in the reproductive system, but only to say they do not belong here. Medical sites on the integumentary system also leave breasts out. I kid you not when I tell you that one medical site described the difference between male and female chests as a difference in *hair growth*!

We do not even see breasts—full stop. In one research seminar on the microbiome the researchers had mapped the entire body. They had been up the nostrils and in both ends of the GI system, yet the map had two holes in the chest where the nipple and areola should have been. They even mapped the microbiome *under* the breast, but left out the nipple and areola.

What is going on here? What kind of roots are these? These are the kinds of roots that sexualize the breast and deny its functional role. That describe the biological reproductive journey as ending at the moment of birth, rather than acknowledging that the body is made to enfold lactation as a part of the mother's reproductive journey. These are the kinds of roots that promoted and continue to allow the equalizing of milks, as if milk is a product separate from the human breast. The mother and child engage in the nourishing and nurturing of new life in an active exchange of nutrients and information from mother to child, from breast to intestinal system. It is a system that exists as one across two bodies. Our science is beginning to understand the cost of pulling this system apart—both for mother and child. But a healthcare provider touching breasts? We—healthcare workers—exist in this void, in this invisibility and sexualization of the breast. Our credential is almost completely unlicensed and often inadequately integrated into healthcare. Our care is inconsistently covered by insurance. Federal regulations bizarrely paired coverage of lactation with the provision of a pump, as if getting milk out of the breast with a machine is a necessary part of healthcare! It is not—except when we separate infants from their parents too early because we lack adequate parental leave.

Our research is underfunded or buried in initiatives on obesity, diabetes, or mood disorders. Where is the funding for the clinical care of lactation? Full stop? Lactation itself is important. We, at this conference, and in the breastfeeding field, have work to do. We need to spread our wings, to lift each other up in the work that we do as we advocate for parental leave polices, and research this invisible organ and the relationship between parent and child, as we provide

clinical care and educate clients and colleagues, as we speak amongst ourselves and with others. Our wings are at the intersection of breastfeeding and feminism. Colleagues, let us enjoy this time we have to celebrate touching breasts.

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Human Milk has no Gender: 21st Century Breastfeeding Language

My name is Fiona Jardine and I use she/her/hers pronouns. I am a lactation consultant, postpartum doula, and PhD candidate, and I think we should bring lactation language into the 21st century. To assume that only women and mothers breastfeed ignores gender and bodily diversity and fails to recognize those who do not identify as women or mothers, yet still lactate. These caregivers may breastfeed, chestfeed, and/or express milk; they may call themselves mothers, fathers, parent, or something else entirely. There may be those who lactate to feed children other than their own: For example, grief donors express milk to donate after the loss of a child; gestational surrogates may express milk to feed the child they carried or to donate; others induce lactation to feed a child in an emergency, or a child they adopted, fostered, or who was carried by someone else.

In one-on-one interactions, there is no reason *not* to use 21st century lactation language. Instead of asking "breast or bottle?"—which is also problematic for exclusive pumpers—ask "how are you feeding your baby?" If you are there to give lactation advice, ask "how can I help you?" and you will often organically find out what your client calls what they are doing. Instead of assuming the lactating person is "Mommy" or "Mama," *ask* what their parent name is. Let us normalize providing your own gender pronoun when introducing yourself and simply asking others if you are unsure. It makes the world of difference to those outside the cisgender binary.

To me, the real challenge is in what we do as a discipline (in the English language: I can only speak to my native language!). We can talk about the biological process as lactation: "when a person lactates," for example. No need for "mother" or "woman" in that sentence. I vehemently defend the singular "they" as grammatically acceptable. While "human milk" feels a little less warm and fuzzy compared to breast milk, it is logical when compared to cow milk, goat milk, or nut milk. By now you should see why to avoid "mother's milk" entirely: use "parents' own milk" when we know that's the source.

I remain conflicted about the umbrella term for the *act* of feeding a child human milk. For example, when I wrote the abstract for this 4-min essay, I used "breastfeeding" because, biologically speaking, isn't that technically correct? Do we not all have breast tissue and is it not required to produce milk? However, that does not really solve the problem of perpetuating the dysphoria for those whose breasts contributed to those feelings—especially during a time when their dysphoria may be at an all-time high. Chest-slash-breastfeeding does not roll off the tongue and probably is not compact enough to be widely accepted in titles and organization names. Nursing suggests directly from the source and therefore excludes pumping.

If breast milk is human milk, then why can breastfeeding not be human feeding? Human milk feeding? That works for less "fluffy" settings like academia, but I cannot imagine parents cooing over their cute babies saying, "our human milk feeding journey has been just magical." Perhaps breastfeeding, while a less-than-perfect umbrella term, is the least-worst option with the greatest appeal. I think no matter what we decide, we need to define what we mean by the words we use, while also being inclusive of gender and lactational diversity.

But why does this all matter anyway? Legal protection: if laws only protect "breastfeeding mothers," are you protected if you are a "chestfeeding father?" Research: if you are recruiting "nursing women," can you participate if you are a "genderfluid exclusive pumper?" Support: would a group with the slogan "Happy Mothers, Breast Fed Babies" be a place to find support if you are "Papa" "Maddy," or "Ren" to your baby?

Finally, acceptance: if we are intentional and purposeful in the language we use, we can make sure everybody is included in the promotion, protection, and support of breastfeeding, so that both they and their child have the very best physical, emotional, and developmental outcomes.

Abstracts

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Comply with Confidence! Avoiding Conflicts-of-Interest Under the International Code of Marketing of Breast-milk Substitutes

Background: More hospitals are seeking designation under the *Baby-Friendly Hospital Initiative*, with the attendant requirement for *International Code of Marketing of Breast-Milk Substitutes* ("Code") compliance. Understanding the Code is a simple conflict-of-interest (COI) analysis for clinicians, researchers, and public health advocates. Many practitioners dread learning about it, for fear they will get it wrong (and suffer peer criticism). In countries that have no Code legislation (e.g., the United States), or countries where there may be minimal Code law, those who work with breast/chestfeeding families, or in the field of parent–child health, are often unaware of the COI tensions triggered by Code-violative predatory marketing practices to parents, and to

health workers, of infant formula, bottles, teats, and early weaning foods.

Purpose: This workshop explored the modern-day prevalence of predatory marketing, tips, and techniques to avoid a COI, and easy methods to correct or report Code violations. Compliance is easy with a few concepts firmly in mind.

Narrative: The history of the Code was learned, examples of violations evaluated, global resources for advocacy shared, and on-line reporting forms of violations used. COIs (direct and implied) were explained. A 196-character motto, posted on Twitter in March 2019, summarizes how any health worker can always be confident they are avoiding COIs with any pharmaceutical or medical device manufacturer, and any Code product marketer:

Do not take freebies/gifts of any kind and
ANY IBCLC (BFg Helper or HCP) can talk to
ANY parent about
ANY product—even by brand name—
In a 1-on-1 clinical or educational setting and
ANY person may buy, and
ANY person may sell
ANY Code-covered product

Conclusion: Public health advocates and healthcare workers have a primary fiduciary duty to provide evidence-based policy advocacy and healthcare to clients, patients, and the public. Commercial entities have a primary fiduciary duty to provide profits to the company owners. These interests can co-exist, but, when they overlap, a COI occurs. Health worker behaviors in providing care are influenced by corporate techniques of marketing and persuasion—often on a subconscious level. That can harm optimal health outcomes for families that seek to meet their infant-feeding goal to breast/chestfeed. The basic rudiments of COI and Code analysis are easily mastered by practitioners, and allow them to provide optimal care free of corporate influence.

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Transforming Universities Into Breastfeeding-Friendly Environments

Background: Two of the key inhibitors for breastfeeding in high-income countries such as Australia are returning to work and breastfeeding in public.

Research aims: This mixed methods study aimed to explore the barriers and facilitators for maintaining ongoing breastfeeding at one higher educational institution in Australia. The study captures the experiences of both staff and students through an online survey and in-depth interviews.

Methods: Previous, or current, breastfeeding women ($n = 108$) from the university responded to an online survey; key informants ($n = 8$) and breastfeeding staff/students ($n = 10$) also participated in an in-depth, audio recorded, interview. The findings revealed a level of dissatisfaction with the availability and utility of breastfeeding facilities on campus, as well as discomfort associated with breastfeeding in public on campus. Some staff reported that their supervisor was a barrier to ongoing breastfeeding and others reported having to seek alternative venues to express milk, as no suitable facility was available on their campus. Female students, and casual academics, reported the worst experiences, when compared with permanent employed staff. Whilst the university ensured there were more than 17 accessible spaces across the eight university campuses, available rooms lacked access to essential provisions (e.g., a designated fridge, a privacy screen, a power point, and hand washing facilities) as well as signage that clearly indicated the room use and whether it was occupied, capacity to lock the room from the inside, and a detailed users' guide. Many staff and students chose to use other non-designated spaces to breastfeed or express milk (e.g., their own office, a car, or a supervisor's office) or to return home during the day to express and store milk.

Conclusion: While the policy provisions at the university met many of the workplace requirements for enabling women to continue breastfeeding, the reality of maintaining breastfeeding on campus did not match expectations. Despite obvious attempts, to accommodate breastfeeding women, the on-campus breastfeeding facilities did not meet the minimum requirements for a "Breastfeeding-Friendly Workplace". The university has responded to this research project by convening a Breastfeeding Accreditation working party and is currently making all of the necessary adjustments to meet the accreditation standard. Later this year the university will be applying for the Australian Breastfeeding Association's "Breastfeeding Friendly Workplace Accreditation."

Publication of this project is currently in press:

Burns, E. Triandafilidis, Z. (2019) Taking the path of least resistance: A qualitative analysis of return to work or study while breastfeeding, *International Breastfeeding Journal*. doi:10.1186/s13006-019-0209-x

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Prioritizing Breastfeeding in the Face of Homelessness and Gentrification

Background: Communities of color across the United States are experiencing gentrification. Soaring housing costs and decreases in affordable housing are responsible for the growing homeless problem in cities such as San Francisco and Oakland, California; Seattle, Washington; and Brooklyn, New York. In the San Francisco Bay Area, with the rise in tech companies, homelessness has reached epic proportions. The lack of shelters and affordable housing has contributed to the rise in tent cities and multiple families sharing single-family housing. Pregnant women and families with infants and children make up 35% of the homeless population in the Bay Area. Homeless children are at increased risk for emotional and behavioral problems, and high risk for other serious health problems. Homeless women with inadequate shelter are at increased risk for pregnancy complications and poor birth outcomes. Given the risk factors to homeless pregnant women and infants, breastfeeding is an important strategy in mitigating health risk to both the mother and child in the face of homelessness.

Narrative: Identifying and supporting high-risk pregnant and postpartum women should be a public health priority. However, many public health initiatives, including those that are focused on infant feeding and safe sleep, fail to address the unique circumstances faced by homeless families. When families lack access to clean running water, adequate sleep surfaces, and a stable shelter, they are left to find alternative means to make ends meet. The housing crisis, in many ways, is similar to conditions faced by families that have been displaced by natural disasters. Since clear guidelines and recommendations for breastfeeding and infant feeding in disasters exist, it seems that they can also be applied in communities with high rates of homelessness. This presentation is focused on (1) the impact of gentrification and homelessness on pregnant people and families; (2) the potential risks for the homeless population and considerations when supporting homeless families with breastfeeding; and (3) how to apply recommendations for infant feeding in disasters to communities with high rates of homelessness and housing instability.

Conclusion: Communities of color are disproportionately affected by gentrification and homelessness. Special considerations are necessary to identify, address, and support homeless families through pregnancy and breastfeeding. A protocol will be developed to provide education, recommendations, and continuity of care for homeless families.

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Climate Change Impacts of the Infant Nutrition Transition: Estimates of Greenhouse gas Emissions From Milk Formula Production

Background: Global markets in milk formula are booming, with unrecognized environmental costs.

Research aim: To evaluate greenhouse gas (GHG) emission influences of milk formula production for selected Asian Pacific countries.

Methods: A life cycle assessment approach was used to estimate kg CO2 eq. emissions per kg of milk formula, using GHG emission factors for milk powder, vegetable oils, and sugars identified from a literature review. Proportions of ingredients were calculated using the United Nation's Food and Agricultural Organization's *Codex Alimentarius* guidance on macronutrient composition and ingredients for milk formula products. Estimates were for production and processing of individual ingredients from cradle to factory gate. This excluded GHG impacts of packaging and transportation to retail outlets, and preparation and use by consumers. Annual sales data were sourced from Euromonitor International to provide descriptive analyses of emissions for six countries between 2012–2017. Six lower-middle, upper-middle, and high-income countries (Australia, South Korea, China, Malaysia, India, Philippines) were considered. Milk formula is for infants and young children (0–less than 36 months).

Results: Annual emissions per kg for the production of milk formula ranged from 3.95–4.04 kg CO2 eq. Projected emissions for China for 2017 were 4, 219, 052 tons CO2 eq. Milk formula use in the six countries contributed 2, 893, 030 tons CO2 eq. to global GHG emissions in 2012, including food waste, excluding emissions associated with blending, and with distribution and consumer use phases. Aggregate emissions were highest for follow-up milk formula products.

Conclusion: Food production, most particularly dairy, is a major drain on world water resources, and agricultural land use changes also have direct and indirect effects on GHG and biodiversity. The United Nation's Food and Agriculture Organization now recommends considering climate change impact when developing dietary guidelines and policies. We suggest that promoting optimal breastfeeding is also an important but neglected element of global and national strategies for the sustainability of food systems. For just six countries, milk formula emissions are equivalent to driving 6.9 billion miles. In particular, toddler formula (TF) sales in China, Malaysia, and the Philippines, were the largest sources of GHG emissions from MF, despite the World Health Organization considering these food product categories as unnecessary for children's nutrition, and potentially harmful to health. Shifting children's diets to optimal breastfeeding, and away from ultra-processed formula products, improves dietary quality and health, and contributes

significantly to improved sustainability of the food system and the environment.

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A Retrospective Analysis of Presentations to a Breastfeeding Support Service

Background: The Australian Breastfeeding Association (ABA), amongst other activities, offers a 24-hr breastfeeding helpline, local peer support group meetings, and training for breastfeeding peer counsellors and educators. In 2011, a Breastfeeding Lounge was developed at the New South Wales ABA branch office to fill a perceived gap in service provision for women with ongoing breastfeeding problems who required face-to-face support from a dedicated, and free, breastfeeding service. Confidential records were kept after every consultation. A thorough breastfeeding assessment was conducted for each mother and baby with assistance given to improve feeding comfort and effectiveness and, if indicated, mothers and babies were referred to health professionals.

Research aims: To explore women's experiences of attending the ABA drop-in service and the breastfeeding outcomes following engagement with the service.

Methods: A retrospective file audit ($n = 239$ mothers who attended the service) and an online survey ($n = 53$ responses) was conducted to capture participants' reasons for accessing the service provided, referrals to health providers, and breastfeeding outcomes.

Results: Over the 2-year period (2011–2013) women and baby pairs ($N = 239$) presented. Here, we report some of the quantitative data collected (e.g., the age of the infants, reasons for attending the service, and breastfeeding outcomes). A key finding from the survey and retrospective audit was the large number of infants identified with tongue-tie (177/239 [74%], 36/53 [70%] respectively) affecting breastfeeding.

Conclusion: Many women who attended the service had been struggling with breastfeeding for some time and found that their attendance at the service had enabled them to achieve their breastfeeding goals.

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Is the Relationship Important for Providing Effective Breastfeeding Support?

Background: Breastfeeding mothers receive support from many and differing sources, especially during the early establishment phase, including health professionals, peer supporters, and family/friends. The language used when providing support can impact on how a mother views her baby and her body. This workshop draws on the findings from three discrete research projects which explored breastfeeding communication by health professionals and peers.

Research aim: The aim of this workshop was for participants to consider a variety of communication styles for providing breastfeeding support, and to reflect on the impact that relationship-based support has on the mother–infant dyad.

Narrative: The findings from three research projects informed this workshop. These included observations of breastfeeding support encounters between women and midwives, IBCLCs, and peer supporters, as well as online support using a dedicated Facebook group. Roleplaying of these interactions exposed the negative influence of domineering support styles, which positioned the woman as a novice and prioritized health professional knowledge. The workshop showcased facilitative support styles characterized by a focus on developing a rapport with the woman and prioritizing the relationship between the mother and baby. Communication skills, which were found to be supportive across all three studies, included characteristics of congruence (being authentic), empathy (understanding what it is like for that mother), unconditional positive regard (accepting in a non-judgmental way), open questioning, reflection, offering suggestions rather than advice, and collaborative language.

Conclusions: When supporting a breastfeeding mother communication style matters. A communication style that focuses on relationships builds confidence in the woman and enhances mother–infant synchrony. Ongoing reflection on our own communication style is important to ensure that our language and support leaves each mother feeling that she and her baby have the skills to overcome any breastfeeding challenges they may experience.

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Awareness of the Low Breastfeeding Rate in China

Background: China has one of the largest populations in the world. There are around 1.4 billion people, according to 2016 data. Around 17.2 million babies were born in China in

2017. The exclusive breastfeeding rate in China was less than 20%, according to UNICEF 2018.

Purpose: To discuss how a food safety incident in China is linked to low breastfeeding rates.

Narrative: The 2008 Chinese milk scandal was a widespread food safety incident. Melamine is a type of plastic that is illegally added to formula to increase its apparent protein content. Fake infant formulas provide little or no nutrition. At least 50 Chinese babies died and over 100 were severely malnourished after being fed this "fake" milk formula. The fake formulas were widespread in China's poorest provinces, which have an average rural household income of about US$1 a day. Buying infant formula is a really scary thing in China. It has led to Chinese parents seeking out formula from overseas, in the belief that it will be safer for their baby. Due to unsafe local baby formula, why do Chinese mothers still persistently avoid or reject breastfeeding? By the end of 1970s, there was rapid economic development in China; breastfeeding was considered old-fashioned and to be practiced only by those who could not afford infant formula. It was especially discouraged by medical providers and the media. The corruption between the healthcare industry, government officials, and healthcare providers has been the main issue.

Conclusion: Minimizing corruption in China is an almost impossible dream. This concurrent discussion highlights the benefits that breastfeeding can bring to both the health and welfare of babies and mothers in Asian communities in the US and China.

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A Framework for Understanding the Health Consequences of Breastfeeding at the Breast and Milk Expression

Background: The number of women expressing human milk has increased over time with researchers reporting up to 98% of mothers expressing milk at some point. Despite the vast number of women utilizing expressed milk, the consequences of feeding at the breast versus the feeding of expressed milk are not well understood.

Research aims: 1) Does the expression of milk improve breastfeeding rates? 2) What are the health impacts of the act of expressing milk on the mother and child? 3) What are the health impacts of feeding expressed milk to the child? 4) What are the impacts of milk expression and storage on the milk itself? 5) What are the political implications that arise with increased use of breast pumps?

Methods: A literature review was conducted after searching PubMed to identify relevant articles. A "snowball" approach was used to identify other relevant articles ($N = 39$), which were categorized by type of influences on maternal or child health. Conclusions were drawn where the literature allowed and, where it did not, the need for more research was noted.

Results: We identified positive influences of milk expression on increasing breastfeeding rates, relieving pain/discomfort, and improving or maintaining milk supply. Regarding bonding, there was no difference found between milk expression and direct feeding. There were some negative influences of milk expression documented on the risk of overweight/obesity, swallowing/suckling problems, speech disorders, breathing problems, infectious disease, contamination, and nutrient and immunological degradation. There were no findings identified for issues of latching or political implications.

Conclusions: The overall evidence on the influences of milk expression were mixed. The literature about the health consequences of milk expression is quite limited, with many studies relying only on qualitative findings, small sample sizes, and low generalizability. Further research is urgently needed on the health effects of using expressed milk.

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Breastfeeding in Disaster Relief Camps: A Critical Ethnography

Background: Disaster relief camps are one of the most vulnerable settings where women are at risk of discontinuing their breastfeeding. Although challenges associated with continued breastfeeding during disasters and displacements are prevalent globally, they are particularly problematic in Pakistan. Pakistan is a low-middle income country where infant and child mortality rates are high. This country often faces natural disasters (e.g., earthquakes and floods) that exacerbate the discontinuation of breastfeeding.

Research aim: To explore the facilitators and barriers to breastfeeding practices of internally displaced mothers residing in the disaster relief camps of Pakistan.

Methods: Critical ethnography was the study design used to uncover the breastfeeding experiences of mothers in the disaster relief camps and situate their experiences within the intersections of maternal, sociocultural, economic, and geopolitical factors. The theoretical perspective that guided this study was critical feminist theory combined with the critical

realist ontology and constructivist epistemology. Data were collected using multiple methods, including field observation, document analysis, and in-depth interviews with displaced mothers ($N = 18$) who were residing in disaster relief camps in northern Pakistan and who had young children aged 1 day to 36 months. Mothers were eligible to participate in the study regardless of their breastfeeding practices.

Findings: Three main themes were: "facilitators of breastfeeding," "barriers to breastfeeding," and "recommendations." A wide range of maternal (micro-level), sociocultural (meso-level), economic (exo-level), and geo-political (macro-level) factors directly and indirectly affected breastfeeding practices. Recommendations shared by the participants reflected their perspectives about possible solutions to their challenges.

Conclusion: Multi-layered, context specific, and interdisciplinary interventions at the micro-, meso-, exo- and macro-level are essential to promote, protect, and support the breastfeeding practices of mothers residing in disaster relief camps.

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Using a Gendered Analysis of the World Breastfeeding Trends Initiative to Prioritize Advocacy Work: The Case of Australia

Background: To help Australia go from "roots to wings," a group of advocates recently benchmarked its commitment to breastfeeding in 2018 and has embarked on generating social change for women. The World Breastfeeding Trends Initiative (WBTi) is an easy to use assessment tool designed to enable the systematic analysis of a nation's progress against the Global Strategy for Infant and Young Child Feeding, developed by the International Baby Food Action Network. Its structure requires a collaborative and participatory approach that supports outcomes in advocacy and impact. The assessment tool is used to highlight the existing policy gaps, celebrate strengths, and advocate for change.

Research aims: To benchmark Australia's current infant feeding policy situation and make recommendations to address gaps in these policies. While doing this, the group also sought to increase grassroots action by stimulating collaboration between various individuals and organizations.

Narrative: In Australia the WBTi group comprises academics, health professionals, feminists, and breastfeeding activists, collaborating since 2017 to complete the assessment. Data were collected and validated in early 2018. The assessment also explicitly highlighted the gender bias in budgeting and the lack of adequate funding to implement policies designed to address structural and systemic barriers to breastfeeding. This gender analysis makes the WBTi Australia report unique. Our report recommendations included developing a national breastfeeding policy, establishing a national Infant and Young Child Feeding advisory committee, establishing and funding an independent body to administer the *Baby Friendly Health Initiative*, legislating the *WHO Code of Marketing of Breastmilk Substitutes* and all subsequent World Health Assembly resolutions, including breastfeeding in pre-service education for health professionals, and standardizing data collection systems.

WBTi Australia has used this assessment to engage with relevant parliamentarians, policy writers, organizations, and stakeholders, presenting evidence of assessment results, along with policy solutions. It expanded the policy conversation from breastfeeding as "something some mums do at home" to "how do we support women in every stage of life?" The report has informed the Australian National Breastfeeding Strategy and helped to source the evidence required to get this issue on public health and early childhood agendas. In recent weeks two major political parties have promised significant funding towards the support and protection of breastfeeding.

Conclusion: The World Breastfeeding Trends initiative assessment of Australia demonstrated strengths and weaknesses in Australia's policy environment and bought together individuals and organizations to create an increase in grass roots advocacy. Australia's report can be found at http://www.worldbreastfeedingtrends.org/GenerateReports/countrysubmit.php?country=AU

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Breastfeeding Without Nursing: What Should we do About the Prejudice Against Exclusive Pumping?

Background: Human milk is optimal nutrition for infants and, perhaps more importantly, most caregivers want to breastfeed. However, a variety of external barriers to breastfeeding exist (e.g., problems establishing a latch, getting milk to flow, or poor infant weight gain) and internal barriers, (e.g., a perception that human milk alone is not sufficient and a desire for others to be involved in infant feeding) are also responsible for breastfeeding cessation. "Exclusive pumping," defined as only expressing milk and not directly nursing at the breast, can—and successfully does—provide the solution to many of these barriers while still providing the benefits of feeding human milk.

Purpose: Despite the increasing rates of exclusive pumping, little is known about the reasons for exclusive pumping

initiation and cessation, the support and information needs of exclusive pumpers, or exclusive pumpers' lived experiences. My research entailed online surveys that collected qualitative and quantitative data from current and past exclusive pumpers, as both a snapshot in time ($N = 2,007$) and longitudinally through a series of follow-up surveys ($n = 341$). This presentation focuses on the reactions respondents experienced when others found out they were exclusive pumpers and how this contributed to their feelings about exclusive pumping.

Narrative: While many respondents reported positive reactions to, and support of, exclusive pumping, an alarming number reported the opposite; especially from health and lactation care providers. Together with poor advice, this lack of appropriate support of exclusive pumping often contributed to respondents feeling frustrated and unsupported, threatening the exclusivity and duration of their breastfeeding journey.

Conclusion: It is essential that health and lactation care providers identify why some breastfeeders exclusively pump rather than feed directly at the breast and recognize the range of feelings that they may have about exclusive pumping, especially in relation to others' negative reactions to, and support of, this form of breastfeeding. Providers must advocate for the inclusion of exclusive pumping within the policy, practice, and/or language of their organization and implement a range of measures to support exclusive pumpers.

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Racial/Ethnic Differences in Breastfeeding Cessation Among a National Sample of Women Participating in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Background: Participation in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) has been associated with the early discontinuation of breastfeeding. Black and Hispanic women make up the largest minority proportion of the WIC population. Thus, understanding the differences in reasons for breastfeeding cessation among these racial/ethnic groups may help tailor interventions to optimize breastfeeding success.

Research aim: To assess racial/ethnic differences in self-reported reasons for breastfeeding cessations during the first year postpartum among a national sample of women participating in WIC.

Methods: Data from 4,095 mothers (34% non-Hispanic white, 26% non-Hispanic black and 40% Hispanic) who participated in the WIC Infant Toddler Feeding Practices Study-2 (ITFPS-2) were analyzed. Initial in-person and telephone follow-up interviews were conducted with mothers prenatally and follow-up at 1–13 months postpartum. At each time point, mothers were asked whether they were currently breastfeeding and, if not, which of the 11 specified reasons influenced their decision. Based on previous research, the following five reasons were selected for exploration in this analysis: (i) the baby had trouble sucking/latching, (ii) the baby lost interest in nursing, (iii) the mother felt she did not have enough milk, (iv) the mother was sick or had to take medicine, and (v) the mother wanted someone else to feed her baby. Logistic regression models were built for each racial/ethnic group separately in order to assess the influences the sociodemographic variables on each reason for stopping breastfeeding.

Results: Breastfeeding initiation was significantly higher among Hispanic (91%) compared with white (76%) and black (74%) mothers. At 6 months postpartum, only 30% of Hispanic mothers and 22% of black mothers were still breastfeeding, while these rates were lower at 12 months (19% and 18%, respectively). A significant proportion (46%) of Hispanic mothers stopped breastfeeding because their babies had troubling sucking or latching on or lost interest in nursing. In contrast, significantly fewer black women stopped breastfeeding because they did not have enough milk (37.4%). Primiparous black mothers were almost twice as likely to stop breastfeeding due to trouble sucking/latching than multiparous mothers. Foreign-born Hispanic and black women were more likely ($OR = 3.44$, 95% CI [2.00–5.89] and $OR = 1.96$, 95% CI [1.48–2.58] respectively) to stop breastfeeding because the baby lost interest compared to U.S.-born mothers. Compared to their food-secure counterparts, Hispanic mothers with very low food security were more likely (1.64, 1.09–2.46) to stop breastfeeding because they did not have enough milk, and non-Hispanic black women with very low food security were more likely to stop because they wanted someone else to feed their babies.

Conclusions: Reasons for breastfeeding cessation varied by race/ethnicity. Parity, country of birth, and food security increased the likelihood of breastfeeding cessation in four out of five reasons across racial/ethnic groups. Our results suggested that counselling and interventions to overcome breastfeeding barriers should be targeted differently based on a mother's race/ethnicity.

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"We Just Kind of had to Figure it out": Information Needs of Mothers who Express Breastmilk

Background: Human milk expression, primarily by pump, is practiced by the majority of breastfeeding mothers in affluent countries. Existing literature is focused on determining prevalence and duration rates, and the factors behind this trend. There is less research exploring mothers' perspectives and experiences related to expression.

Research aim: To gather the experiential wisdom of mothers with a focus on their sources of information and information needs related to expression.

Methods: Audiotaped interviews were conducted with mothers in western Canada ($N = 35$) of infants aged birth to 24 months, who had expressed milk at least once. This study was guided by interpretive description, an applied qualitative research approach.

Results: Nurses and lactation consultants were the most common sources of information. The internet, friends/family, and other mothers were also important. Inconsistent expression advice was confusing for participants, and many reported that health care providers did not address all their expression learning needs. Desired topic areas included practical advice on how to express, determining expression frequency/timing/duration, milk storage guidelines, the influence of expression on milk supply, product information, and general support/encouragement.

Conclusion: Assessment of expression learning needs should be part of routine lactation support at each encounter. Nonjudgmental, factual guidance will assist mothers in making evidence-informed decisions related to expression practices that are consistent with their unique breastfeeding goals. Reputable online resources that provide timely and accurate information, as well as efforts to connect mothers with peer support groups, should supplement this.

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The Backlash to Breastfeeding: Towards a Unified Response

Background: From Hanna Rosin's 2009 "Case against Breastfeeding" in the Atlantic, to Jung's "Lactivism" and Tuteur's "Push Back," feminists and doctors, mothers and journalists, academics and laypeople, have raised indignant voices against pro-breastfeeding promotion, policy, and practice, targeting the science, the motives of practitioners, and the culture of coercion and guilt, which breastfeeding advocacy has been said to have created. Some, including the founders of "Fed is Best," even call breastfeeding dangerous. This workshop is in response to concerns around this increasingly strident movement opposing breastfeeding, compounded by a fairly muted response within the professional lactation community. While interest is finally growing within lactation circles around breastfeeding as a social and cultural phenomenon, it is evident that there remains a gulf between lactation professionals and academic feminists when it comes to the promotion of breastfeeding and reproductive rights in the western world.

Research aim: In this workshop context, the aims were to discuss themes within anti-breastfeeding discourse, and to critically discuss existing barriers to a unified response to anti-breastfeeding ideology and policy. In addition, we aimed to look at how infant feeding debates, including the language of risk, are situated historically within feminist and non-feminist movements to broaden women's infant-feeding options, and how breastfeeding has emerged as a political and moral "hot button" topic, with connections to concerns around reproductive justice.

Narrative: The workshop used story-telling, interactive discussion, and case studies. Since individuals come to these debates in very distinct ways drawing on their personal values, political involvements, and intimate relationships, story-telling is often a valuable introduction. This can be related, as well, to the way that stories have been used by those opposing pro-breastfeeding narratives. Facilitated discussion focused on the relationship between breastfeeding promotion and themes within the backlash, and dealt with common points of contention such as risk-based messaging, language of promotion and "choice" language, the moralization of infant-feeding, equality versus difference, the role of science, the strength of evidence for breastfeeding, and the limitations on breastfeeding in public life. Case studies illustrating polarized debates on breastfeeding topics were also presented and proposed methods of engagement were discussed.

Conclusion: It may surprise many of us working to support breastfeeding families that all reproductive health advocates do not necessarily support our methods. Yet, given the strength of the anti-breastfeeding lobby (which have effectively usurped the language of empowerment) we clearly need to engage with those on the all sides of the infant feeding conversation to craft effective policies that promote the well-being of young families around the world.

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*How Breastfeeding Became an International "*Cause Celebre*"*

Background: In May, 1981 the World Health Assembly adopted the WHO/UNICEF *International Code of Marketing of Breastmilk Substitutes*. A 6-year,

many faceted campaign aimed at challenging the unethical promotion of the baby foods industry, preceded and led to the adoption of the Code.

Research aim: This presentation highlighted aspects of this campaign through the lens of my own personal experience, as one of the campaign's leaders.

Narrative: In the early 1970s, as part of the Women's Liberation Movement, I researched the threat to democracy posed by global corporations acting beyond national law. This led to working on the book *Hungry for Profits* edited by Robert Ledogar, specifically on the chapter *Formula For Malnutrition*. I was later hired by the Interfaith Center on Corporate Responsibility (ICCR) to help promote socially responsible investing. I shared the research about unethical promotion by formula companies, and the ICCR Board agreed to challenge the United States-based companies to change their marketing practices. At the time, I really did not know anything about breastfeeding—I, too, had a long learning curve. But I was convinced that aggressively marketing breast milk substitutes where there was no clean water, no refrigeration, no way to sterilize bottles and nipples, and insufficient income to buy enough of the product—was a recipe for disaster.

A turning point came in 1976 when one ICCR member, The Sisters of The Precious Blood, filed a lawsuit, with ICCR help, against Enfamil, the makers. We spent months gathering marketing data affidavits from 19 developing countries to file in court; much of the data were about Nestle. I attended a conference in Switzerland, where a student group had republished a UK expose called *The Baby Killer* as *Nestle Kills Babies*. Nestle sued for libel and, although Nestle "won," the student group was fined US$1, and Nestle was admonished to change their marketing practices. I proposed a boycott, but the students declined.

I realized we needed a national grass roots campaign in the United States, and began looking around for allies. A small group coalesced in December 1976 and formed the Infant Formula Action Coalition (INFACT). A Minneapolis group agreed to launch the Nestle Boycott. Successful fundraising meant INFACT went from volunteers to a staff of 20 in about 18 months. Next, ICCR and INFACT asked Senator Edward Kennedy to hold Senate hearings. Kennedy's staff told us we had to demonstrate that people all over the country thought this was an important issue. In 6 months we deposited more than 50,000 letters on Senator Kennedy's desk. Hearings were held in May 1978 with testimony from doctors and nurses from third world countries, nutrition/medical experts, including some from the WHO, corporate executives, and advocates challenging corporate marketing. I testified, but the president of Nestle, Brazil, turned out to be the star witness. He showed a total lack of compassion or any corporate responsibility for the damage Nestle was causing. (A hearing excerpt can be retrieved at https://www.youtube.com /watch?v=uG0rw7bpUlQ).

Senator Kennedy appealed to the WHO to develop a plan for restricting the inappropriate marketing of breast milk substitutes. The WHO hosted an "Expert Group Meeting" in 1979 to develop recommendations for action. I attended as an official delegate. Outside the meeting, a small group of NGOs coalesced to form IBFAN (International Baby Foods Action Network). Our plan: get each subgroup at the official meeting to recommend that the WHO develop a Code of Marketing.

Two years of contentious negotiations followed. When the Code came up for a vote at the World Health Assembly (WHA), the United States, under President Reagan, was the only country to vote "No." This international uproar just re-surfaced at the last WHA when the United States again opposed the protection, promotion, and support of breastfeeding!

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An Exploration of Breastfeeding: African American Mothers' Intergenerational Connections to Their Roots and Wings

Background: Within the scholarly literature on African American breastfeeding patterns, there is the tendency to focus on deficit patterns to the exclusion of successful breastfeeding. A number of researchers, however, highlight how supportive grandmothers are important in facilitating increased breastfeeding rates among their daughters. Studies are needed that capture the socioeconomic diversity of "successful" breastfeeding African American mothers and that also consider the extended family, particularly the grandmother, in discussions of ways to increase rates. This investigation is unique because it focuses on a sample of African American mothers from diverse economic backgrounds and their beliefs and perspectives, while also including interviews that glean their mothers' (the babies' grandmothers) perspectives.

Research Aims: We aimed to describe African American women who have been/are successful in breastfeeding their children, and in what ways and to what extent their mothers (i.e., the babies' grandmothers') beliefs about feeding influenced their daughters' decisions to breastfeed, and in what ways and to what extent their mothers' own experiences of breastfeeding influenced their perspectives

Narrative: Cross-sectional qualitative semi-structured interviews were conducted with African American breastfeeding mothers ($N = 8$), and their mothers ($N = 6$). The inclusion

criteria for the breastfeeding mothers were to be at least 18 years old, living in the greater St. Louis area, economically diverse, and having an infant no older than 24 months. For an iterative analysis of the narratives one member of the team did coding with checking by other members.

There were 47 codes, and five patterns emerged. The first pattern, Intergenerational Connections, were the ways the mother–grandmother dyad spoke about their relationships with infant feeding. The second pattern, Changes in Breastfeeding Experiences Over Time, were the ways in which mother–grandmother dyad changed over time, such as agency, sources of information and support, and the changing gender roles of husbands/partners. The third pattern, Going With the Flow, were mothers' ability to weave breastfeeding into life circumstances, despite complexities and difficulties, in order to maintain the baby–mother nursing relationship. The fourth pattern, I Need to be a Strong Black Woman, were the abilities of the mother and/or grandmother to mask their needs for breastfeeding help in order to demonstrate they are able to do it all independently, including breastfeeding the baby. The fifth pattern, Living Within a non-Supportive Society, were ways the mother and grandmother were able to navigate cultural norms perceived to be negative about breastfeeding.

Conclusions: Attention to social-class dynamics and the need for greater autonomy in the workplace regarding accommodations for pumping at work are needed. Further examination of daughters' roles in introduction or bringing grandmothers back into the culture of breasting needs exploring. Future research is needed regarding the impact of social media on increasing breastfeeding initiation and duration rates.

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Embodying Loving Connection in Innovative Technological Approaches to Extend Lactation Care

Background: As increasing numbers of families in historically underserved communities strive for successful lactation experiences, their need for timely accessible support calls for innovative efforts to extend lactation care beyond geographic, language, and cultural barriers. Even with skilled lactation professionals and well-matched peer support available, our experience in rural Hawai'i is that too often those parents in greatest need never find their way to an office visit or support group. Intrigued by the potential to utilize cell phones in innovative ways to extend loving postpartum and lactation care to parents when and where it is needed, our Newborn Enhanced Support Team (NEST) waded boldly into the world of technology. Our goal was to build a reliable, efficient, and confidential platform for delivering infant feeding and emotional support on a scale well beyond our individual capacities.

Purpose: To create a semi-automated two-way SMS texting platform that aspires to bring a knowledgeable and comforting voice, akin to the traditional village midwife, to cell phone screens in underserved communities.

Narrative: In 2014, our small team powered primarily by breastfeeding peer counselors and IBCLCs, made a commitment to explore the potential for emerging technology to stabilize our program and strengthen the safety net we weave for families of infants in an area with limited perinatal care, geographic isolation, and diverse language and cultural needs. For a few hundred dollars per family, we tackled the task of extending the connection built during our brief hospital-based contact to provide anticipatory guidance and social support throughout each infant's first year of life. Had we known how steep our technological learning curve could be, we may well have held tight to our late-20th century communication strategies for serving today's young families, but we were propelled forward by the need to amplify the reach of our overextended staff, and heartened by encouraging testimonials from parents in our pilot. Together we crafted a "storyline" of frequent personalized messages for new parents to support optimal feeding, attachment, and mental wellness. We waded through the arduous task of adapting a texting platform originally built for pharmaceutical research to create a warmly personalized, well-accepted tool for engaging with parents at critical moments in their infants' lives.

Conclusion: Supporting parents through our First Connections (FC) texting system has proven effective and efficient, with over 500 families at a time reliant on our small team for guidance, problem solving, compassion, and reassurance. Parents regularly provide our team with encouraging feedback (e.g., "I don't know how I could've done this without you," or, "This was exactly what I needed."). Although we continue to grapple with building meaningful and ongoing connections within the constraints of screen-based communication, the FC system works well to deliver highly personalized and engaging support that meets the desires of both participants and staff for a convenient and familiar means of engagement. As technology offers new ways to reach families, we must hold fast to the roots of what we know as deeply human-centered, compassionate, trauma-informed care during the critical first months of life.

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Advancing the Global Agenda

Background: In 2015, the 17 Sustainable Development Goals (SDGs) were launched and set the global development agenda until 2030. The World Alliance for Breastfeeding Action (WABA) took the opportunity to make links between the SDGs and breastfeeding. The popularity of the 2016 World Breastfeeding Week (WBW) theme "Breastfeeding: A key to sustainable development" indicated that positioning breastfeeding in the context of the SDGs was both timely and relevant. WBW continues to link breastfeeding to the SDGs and, in 2019, the WBW slogan was "Empower parents, enable breastfeeding" focusing on gender equity and the right to parental social protection. WABA's three main campaigns: World Breastfeeding Week (WBW), the Warm Chain of Support for Breastfeeding, and the Empowering Parents Campaign, serve to create an enabling and supportive environment for breastfeeding by promoting a systems approach, and being gender inclusive and transformational.

Purpose: Global trends in breastfeeding rates only show modest increases between 2000 and 2015. Currently about 40% of babies younger than 6 months are exclusively breastfed and several barriers about the structural, setting, and individual levels exist. As a member of the Global Breastfeeding Collective, WABA advocates for the seven policies to encourage a greater investment in breastfeeding. The 2018 Collective scorecard evaluated 194 low-, middle-, and high-income countries on factors including financial investment, health care services, workplace protections, and community supports for breastfeeding. It showed that no countries score highly on all eight policy and program indicators and only 23 countries have met the 2030 global goal (70%) of exclusive breastfeeding for 6 months. A lot more needs to be done to achieve the 2030 goal, and effective partnerships are essential, bearing in mind the need to avoid conflicts of interest.

Narrative: One of the largest barriers to exclusive breastfeeding is a lack of supportive legislation and workplace programs. Currently only 53% of the countries of the world offer the minimum standard of maternity leave outlined by the ILO Convention (C183). Paternity and parental leave are also similarly lacking. Programs also need to engage fathers, partners, and families to support breastfeeding. The Empowering Parents Campaign addresses these barriers by promoting social protection that will facilitate the integration of parents' productive and reproductive work in both formal and informal settings.

Conclusions: WABA's Warm Chain campaign places the mother–baby dyad at its core and strives to link different actors by coordinating efforts at all levels to provide a continuum of care during the first 1000 days. A local application of the Warm Chain is the "Making Penang Breastfeeding Friendly" initiative coordinated by WABA in Penang, Malaysia. It links stakeholders from the health, community and workplace sectors with local authorities to work on ensuring that the State of Penang becomes breastfeeding-friendly within 5 year. This can become a model to replicate in other states of Malaysia and beyond. Think global and act local!

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Racial Equity and Access to Pasteurized Donor Human Milk in a Hospital Setting

Background: For decades, the focus on health disparities research in the United States has been based on the mapping of associations between demographic categories and health outcomes. This kind of research has been important in building an evidence-base with which to document health disparities in the country. However, many scholars engaged with reproductive justice have recently challenged conventional health disparities' orientations.

Purpose: Our purpose for the Discussion Session is to focus on the challenges and potentials of conducting clinical and public health research about breastfeeding-related health disparities using electronic medical records.

Narrative: In this Discussion Session, several members from our research team discussed the evolution of a project designed to examine race/ethnicity-based disparities in the use of pasteurized donor human milk in a hospital setting. Discussants brought unique perspectives as clinicians, public health practitioners, community-based lactation supporters, and social and behavioral scientists, into a conversation on research ethics, methodologies, theoretical frameworks used to interpret study findings, applications of the research, and future directions for research and practice. Specifically, we discussed challenges related to the ethical considerations of using electronic medical records in communities of color/historically oppressed groups; (1) without written consent or knowledge that their information would be used in research, even when it is de-identified, (2) reliance on white mothers' data as a standard comparison point for outcomes, (3) the burden of blame in the language of health disparities research,

(4) the context of structural racism and implicit bias in patient decision-making, and related issues.

Conclusion: Clinical research related to health disparities are strengthened by integrating critical race theory, intersectionality, historical trauma, colonialism, and other related systems of oppression on black, indigenous people, and people of color (BIPOC) into study design, analyses, the interpretation of findings, and the translation of research into health interventions.

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Feminist, Abolitionist, non-Profit Organization Serving Criminalized Women in the Perinatal Period

Background: Over the past 10 years, the number of federally incarcerated women in Canada rose to 37%. Although crime rates are falling, women are the fastest-growing population in federal prisons. Indigenous women and women of color are significantly overrepresented in the Canadian carceral system. It is estimated that two-thirds of incarcerated women in Canada are mothers and 5% are currently pregnant. In recent years, the carceral infrastructure for women and mothers in Canada expanded. In 2014, the Correctional Service of Canada added 114 minimum security beds to its facilities for women, and 15 new rooms specifically for mother–child pairs for young children to co-reside with their mothers. Most incarcerated women have histories of trauma and enter facilities experiencing addiction and mental illness. Incarceration, solitary confinement, strip-searching, and physical restraints can be triggering and harmful to women's mental health. Incarcerated women lack access to health services, prenatal education, and social and family support. Incarceration for mothers may be particularly difficult, as separation from children can cause distress and anxiety.

Purpose: We described the work of Women's Wellness Within, a registered non-profit organization serving criminalized women in Nova Scotia in the perinatal period.

Narrative: Women's Wellness Within espouses an anti-racist, feminist, abolitionist philosophy, and works through three approaches: direct client support, education, and advocacy. Our services include volunteer doula support, lactation support, facilitating educational workshops for women, collaboration with clients on resource creation, political advocacy, and developing public, student, and health professional understanding of the intersection of women's health and criminalization. Our members have security clearance to serve women who are incarcerated during the perinatal period at the Nova Scotia provincial jail in Dartmouth, the federal prison for women in Truro, and the youth detention facility in Waterville. We also serve women in halfway houses and in the community. Members include women with first-hand experience of criminalization, lactation consultants, doulas, lawyers, social workers, nurses, midwives, physicians, researchers, and public servants. In 2018, Women's Wellness Within began training women with experience of criminalization and women working directly with women experiencing criminalization, such as halfway house employees, to become doulas and provide peer support.

Outcomes: Since 2014, Women's Wellness Within has served over 30 women one-on-one for perinatal support. Hundreds of women have participated in our monthly women's wellness workshops inside the provincial jail, on topics raised by women inside. We have led dozens of political advocacy campaigns on issues such as shackling during medical appointments and the use of solitary confinement among pregnant and postpartum women. Based on needs assessment and consultation with criminalized women, we first produced a community resource guide in 2016 (updated annually) to facilitate release planning. We partner with health, housing, family resource, and legal organizations for transformational change.

Conclusion: Women's Wellness Within is the only non-profit organization dedicated to support, advocacy, and education for the perinatal health of criminalized women in Canada.

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Whither Breastfeeding? The State of the Science for Women-Centered Perinatal Health Research in Carceral Contexts

Research Question: The aim of this scoping review is to center women in a synthesis of existing research on the perinatal health outcomes of incarcerated women. Most research on incarcerated women in the perinatal period is focused on non-maternal outcomes (e.g., birth weight), non-health outcomes (e.g., recidivism), and risk factors that do not emerge from the perinatal experience specifically (e.g., substance use). This review is based in a compassionate philosophy that considers incarcerated women worthy of healthful pregnancies, breastfeeding, and parenting experiences.

Theoretical Framework: Intersectional feminism was our guiding framework. Intersectional feminism examines overlapping layers of identities (e.g., racism, ableism, homophobia, cissexism, and class privilege), which influences social and economic experiences. It is not only an analytical tool for conducting research but aims to create solutions for

advancing health equity. Gender, race, and class are key considerations in this research as perinatal health, breastfeeding, and newborn care are experiences that disproportionately affect women, and carceral experiences are demonstrably race and class biased.

Methods: Scoping reviews intend to synthesize the types of research and findings in an area using a systematic approach. Support of an experienced medical research librarian was used to develop and implement our search strategy. Databases included CINAHL, PubMed, and PsycInfo. We included empirical studies published in English or French, with no pre-defined date range. The population of interest included women or transgender individuals who were incarcerated at any point during the perinatal period.

Results: Women prisoners experience complex health histories, including disproportionate victimization, poverty, mental illness, and substance use disorders. Indigenous women and women of color are significantly over-represented in carceral systems, compounding the social and economic determinants of ill-health. Keeping the mother and child together and facilitating breastfeeding may have uniquely positive influences for incarcerated women. Residential Mother–Child programs exist in prisons around the world, and yet the associated maternal health influences are not well researched. The United Nations Bangkok Rules (2010) assert the international right for female prisoners to health care in pregnancy and for breastfeeding, and yet there is a lack of transparency regarding how those rights are upheld.

Forty-five studies met the pre-set systematic review criteria and were reviewed in full text, and 13 studies met consensus for inclusion. Included studies were published between 1989–2014; 12 were based in the United States and one in Australia. Outcomes of interest included operative deliveries, gestational complications, depression, stress, experiences, bonding, and sterilization. Only one mentioned breastfeeding.

Discussion: A recognized public health imperative, there is a need for the in-depth examination of breastfeeding with this population. Research needs to examine the prevalence and impact of carceral force (e.g., shackling, solitary confinement, strip-searching, and restraints, in pregnancy, birth, and postpartum). Health care providers must be conscious of the intersecting layers of discrimination and trauma incarcerated women experience and their impact on maternal health in the perinatal period. Health care providers have a duty to advocacy, compassion, beneficence, and preservation of patient dignity and autonomy.

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Employee Perceptions of the Social-Cognitive Factors Related to Workplace Lactation Support

Background: Researchers have indicated that returning to work is a major barrier to continued breastfeeding duration. The Patient Protection and Affordable Care Act Section 4207 requires specified employers to provide reasonable break time and space other than a bathroom for milk expression. Organizational development research is needed to identify employees' perceptions of the social and built environment at work that influence employees' decision to continue to pump at work.

Purpose: To elicit employees' perceptions of the social-cognitive factors related to workplace lactation support that enable employees to achieve their breastfeeding duration goals.

Methods: A semi-structured guide was used to conduct interviews with employees ($n = 14$) from a healthcare company. The interview guide was developed based on social cognitive theory. Interviews were recorded and transcribed verbatim. A thematic content analysis was conducted. Employees' breastfeeding behavior was quantified including breastfeeding intentions and duration. Employees were stratified based on who reached and did not reach their breastfeeding goals.

Results: Of interviewed employees, 79% breastfed for 6 months or more, and 86% breastfed for as long as intended. Personal cognitive factors related to pumping at work included increased self-efficacy, a determined attitude, decreased anxiety, and knowledge of workplace lactation accommodations. The environment for pumping at work included reliable lactation spaces, flexible schedules or dedicated time to pump, manager and coworker support, problem-solving with a lactation consultant, and normalizing pumping. Pumping behavior at work included specific breastfeeding intentions, pumping efficiency and skills, planning and being prepared, and advocacy skills. The employees who breastfed as long as intended emphasized the supportive social-cognitive factors.

Conclusions: Pumping self-efficacy, reliable lactation spaces, and specific breastfeeding intentions were the main factors associated with longer breastfeeding duration. Pumping self-efficacy is a novel concept compared to previous research that measures breastfeeding self-efficacy at birth and 2 months postpartum. Employers could use these strategies to prioritize space and time accommodations for breastfeeding employees.

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Maternal Health Matters

Background: Changes to both perinatal and postpartum care during the 1990s have contributed to many women feeling unable to care for themselves and their newborns for 2 or more months after delivery. Dramatic increases in both the induction of labor (IOL) and cesarean section (C/S) rates have been associated with postpartum women experiencing high levels of fatigue and pain. IOLs are associated with longer labors (1–3 days vs. 12–24 hours for spontaneous labors), increased medical interventions (e.g., continuous fetal monitoring), and subsequent maternal sleep and food deprivation. C/S adds a surgical component to childbirth recovery and is associated with a greater risk of postpartum pain, infection, blood transfusions, and venous thromboembolism. In 2013, over half of women in the United States had their labor induced and, in 2015, approximately one-third of women underwent a C/S. Recently, researchers have demonstrated that many women characterize their 2–3-night postpartum hospitalization stay as baby-care focused, with numerous interruptions from staff and visitors, a lack of privacy, excessive paperwork, and overwhelming amounts of information. Many women report feeling overwhelmed post-delivery in the hospital and attribute sleep deprivation to interfering with their ability to adjust to motherhood. Since 2008, postpartum and partner fatigue have been linked to 600–1600 in-hospital infant falls annually.

Research aims: Previously, researchers examining the relationship between 24-hr mother–baby rooming-in and maternal sleep quality predated the dramatic rise in IOLs and C/S yet many women recovering from these procedures must still adhere to 24-hr rooming-in policies. The aim of this presentation is to demonstrate the lack of evidence related to the efficacy and safety of 24-hr rooming-in on maternal, newborn, and family outcomes. Most research related to rooming-in has primarily focused on breastfeeding exclusivity and duration rates.

Narrative: A systematic review was undertaken to examine the relationship between 24-hr mother-baby rooming-in and postpartum fatigue, stress, anxiety, and pain during the postpartum hospitalization period. Studies ($N = 7$) were identified by searching PudMed, CINAHL, and PsycInfo and were included if they occurred in the United States between 1997–2017. Postpartum fatigue, stress, anxiety, and pain were found to be among the most common and problematic experiences reported by participants, often interfering with routine daily activities, sometimes for months. These conditions directly and indirectly impact newborn development and maternal–child attachment, as well as adversely affect partners' mental health, further disrupting optimal family functioning. High anxiety levels during the postpartum hospitalization period have been associated with reduced breastfeeding exclusivity and duration rates.

Conclusion: Researchers have found that rooming-in is not significantly associated with breastfeeding duration, but rather that sending the baby to a nursery periodically was protective of exclusive breastfeeding. Although fatigue, stress, anxiety, and pain are part of childbirth, healthcare providers are obligated to provide care that meets the variable needs of women, and optimizes maternal recovery and health. More research is needed to understand the impact of 24-hr mother-baby rooming-in on women recovering from an IOL or C/S prior to concluding that 24-hr rooming-in is ideal for all women and their newborns.

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"It's my Body, it's my Choice": Reproductive Autonomy Among Mothers of Premature Infants in the Neonatal Intensive Care Unit

Background: Highly effective contraception and the provision of mothers' own milk during the first month of the neonatal intensive care unit stay are evidence-based strategies that reduce the health and economic burdens of prematurity. Contraception targets short inter-pregnancy intervals to reduce the risk of repeat preterm birth, and mother's own milk feedings reduce the risk of potentially preventable prematurity-related morbidities. However, virtually nothing is known about the influence on lactation outcomes of long-acting, reversible contraception and other hormonal contraceptive methods given in the immediate postpartum period in mothers who deliver prematurely.

Research aim: To determine the knowledge-base and priorities for postpartum contraception and lactation.

Methods: Mothers of premature infants ($N = 25$) hospitalized in a tertiary neonatal intensive care unit were recruited to participate in a mixed-methods study using a multiple-choice contraceptive survey and a semi-structured, in-person interview in the first 2 weeks postpartum.

Discussion: Every participant prioritized providing milk to "do what is best for the baby" over the use of immediate hormonal contraception. They reported concerns related to the potential effect of contraception on breastfeeding and expressed frustration with the timing, content, and conduct of the contraceptive counseling offered during the postpartum hospitalization when they were recovering from a traumatic birth and coping with the critical health status of the infant. The majority of participants opted to forgo immediate hormonal contraceptive use and preferred to seek counsel from their own healthcare provider for either administration or a discussion of postpartum contraception at the 6–8 week visit. Participants stated that to protect their milk supply they

would either abstain from sexual intercourse or use condoms. Lastly, participants had limited knowledge of risks for repeat preterm birth (e.g., short inter-pregnancy intervals).

Conclusions: Our findings underscore the importance of discussing contraceptive options with breast pump-dependent mothers of premature infants within the context of the infants' neonatal intensive care unit admission and their prioritization of mother's own milk.

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Facilitators and Barriers to Implementing the Breastfeeding-Friendly Childcare Initiative in Florida

Background: Currently, 83% of American women initiate breastfeeding. However, many discontinue within 6 weeks, and few women (25%) meet the American Academy of Pediatrics and World Health Organization recommendations of exclusive milk provision for 6 months. Mothers returning to work may impede breastfeeding continuation, representing an opportunity for intervention, as 59% of working women return to work within the first 12 weeks postpartum. Considering 72% of infants in the US are regularly cared for outside of their home, childcare providers represent an important, and perhaps untapped, public health resource for supporting families who feed their children human milk. Yet, childcare providers may have limited knowledge about breastfeeding or human milk provision, and may discourage mothers from continuing to provide human milk for their babies.

Research aim: Currently, 11 states, including Florida, have established breastfeeding-friendly childcare designation programs, which offer training and guidance regarding breastfeeding-friendly childcare practices. This qualitative research study was designed to uncover barriers and facilitators to the success of implementing the breastfeeding-friendly childcare initiative in Florida childcare centers.

Methods: To examine the perceived barriers and facilitators to implementing the Florida Breastfeeding-Friendly Childcare Initiative, we conducted semi-structured interviews with childcare administrators ($N = 28$) in the Tampa Bay area.

Results: Our findings suggest an unresolved tension between childcare administrators' breastfeeding beliefs and experiences. Participants described a sense of dissonance shaped by biomedical and public health discourse on the benefits of breastfeeding and the larger socio-political, economic, and cultural meanings of women's bodies. This suggests breastfeeding-friendly childcare designation programs (e.g., the one in Florida) need an innovative approach to the uptake of these initiatives that involves evidenced-based research, as well as working with childcare providers to make these programs acceptable, feasible, and effective.

Conclusions: Childcare provider support for breastfeeding and providing human milk to infants in their care may be an important component to supporting working mothers and prolonging breastfeeding duration. Understanding the barriers and facilitators to implementing a breastfeeding-friendly childcare initiative is the first step to leveraging childcare providers as possible human milk advocates and a source of breastfeeding support and public health resources.

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When the Breastfed/Chestfed Child has Dysphagia

Background: Increasingly, families desire to breastfeed/chestfeed or offer their own human milk as the primary source of nutrition for their infants who are born premature or with a disability. Neonatal Intensive Care Units encourage families to offer human milk and provide donor milk following the World Health Organization's recommendation that it is the best source of nutrition and antibodies for the neonate. Knowledgeable professionals are important for breastfeeding/chestfeeding success, especially for infants who have dysphagia, a condition in which one or more of the phases of swallow are not functioning efficiently. A multidisciplinary approach with lactation consultants (IBCLC) and speech–language pathologists (SLP), who are specialists in deglutition (swallowing) and dysphagia, leads to higher breastfeeding/chestfeeding success. Awareness and respect for each other's roles as well as forming a partnership will only improve the quality of care provided.

Researchers have indicated that infants have increased stability at the breast/chest. Artificial nipple feeding strives to mimic breastfeeding/chestfeeding with techniques including positioning baby in elevated side lying, offering a slower flow bottle, and observing closely for signs of stress. Instrumental swallow assessments, videofluoroscopic swallow study, and fiberoptic endoscopic examination of swallowing, are conducted to gather objective information about the physiology and safety of the swallow by assessing it with various liquid consistencies and presentations. These assessments are conducted with artificial nipples due to limitations and accessibility in conducting them during breastfeeding. Management decisions are of particular concern when a breastfed infant's swallow function is assessed with artificial

nipples, as this will never simulate breastfeeding closely enough for speech–language pathologists to be confident in a recommendation for direct breastfeeding and the best interest of the infant and parent.

Research aims: There were five workshop session aims: (a) describe the different but overlapping roles of lactation consultants and speech–language pathologists; (b) describe the current state of the literature for infants who have dysphagia and whose parent(s) desire(s) to offer their own milk; (c) describe ways to foster collaboration between fields; and (d) list ways to encourage and support patients/clients who desire to offer a parent's own milk.

Narrative: The workshop reviewed current research and practice for dysphagia and how this affects breastfeeding/chestfeeding. We discussed the following topics in detail: (a) variation in practices around lip and tongue-tie; (b) how ankyloglossia may impact pharyngeal function and safety; (c) benefits of the non-nutritive suck in learning to coordinate suck-swallow-breath and how this can be facilitated at the breast/chest; (d) lack of standardization in flow-rate of artificial nipples; (e) when supplementation is advised, how bottle feeding can be most supportive of breastfeeding/chestfeeding; and f) How to foster collaboration between the fields of lactation and speech–language pathology in the community.

Conclusion: Collaboration between lactation consultants and speech–language pathologists for assessment and recommendations is important in supporting the goals of the family and in supporting human lactation. Speech–language pathologists need to be conscious of how the recommendations following an instrumental swallow assessment may impact a family that desires to breastfeed/chestfeed. Further research is needed on the swallow function of breastfeeding/chestfeeding.

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Making Mothers' Milk Count: Using Economic Approaches to the Benefits and Costs of Breastfeeding

Background: Breastfeeding is central to the food system for children, but is uncounted in economic statistics. The international system for measuring "the economy"—gross national product (GNP)—excluded non-market household production from the 1950s.

Research aim: This study aimed to illustrate the usefulness of feminist economic approaches to the benefits and costs of breastfeeding, through making breastfeeding more visible to policymakers, and improving understanding of economic incentives affecting breastfeeding.

Methods: Economic values: Influential feminist critiques since the 1980s have brought greater scope to recognize women's economic productivity in the GNP. The invisibility of women's work in this key measure of the economy was argued to bias policymaking and distort budget priority setting.

The macroeconomic value of human milk has been discussed at international conferences of national income accounting academics and officials since 2012 and has now been published for multiple countries. Availability of market prices for human milk facilitates estimations. Resource cost savings: The economic value of breastfeeding is also indicated by identifying resource cost savings from breastfeeding. These include avoided health system costs, as well as maternal and child morbidity and mortality costs, and environmental costs. Economic, commercial and institutional drivers of breastfeeding: There was a rapid decline in breastfeeding rates across many countries in the 1950s and 1960s. This "mass mammary malfunction" reflected interacting economic, commercial, and institutional drivers of breastfeeding practices, not biology. Breastfeeding is not economically costless to women, as "time is money." An Australian study of 156 mothers found that exclusive breastfeeding at 6 months took around 18 hr a week. This highlights the significance of paid maternity leave policies which resource women to invest time in breastfeeding. Mothers who are "too busy to breastfeed" are more vulnerable to marketing (e.g., marketing that promotes baby sleep products or snack foods). An industry report revealed how sales of baby food were affected by changes in paid maternity leave policies—longer leave was anticipated to reduce sales, while shorter entitlement would reduce breastfeeding and increase sales. Apparent motives for the industry to advocate against paid maternity leave highlights the "political economy" of breastfeeding. In the 1950s, trade liberalization and competition in the formula industry was associated with price reductions, heavier marketing to health professionals and via health channels, and increased promotion of milk formula to women. Since the 1990s, strategies including "pregnancy" or "toddler" milk formulas have targeted mothers' vulnerabilities while circumventing restraints on marketing.

Conclusion: The global value of human milk production is large, estimated in 2012 at around US $1,982 billion. Improving breastfeeding incentives through enhanced maternity leave policies, and ending inappropriate marketing and conflicts of interest in the health system, would improve the economy, and enhance gender equity.

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Dismantling Dichotomies Using Breastfeeding

Background: Modern neoliberal capitalism isolates individual subjects and atomizes them, making them austere and rigid entrepreneurial subjects. In doing so, neoliberalism asserts a dangerous dichotomy between the mind and the body, relegating the work of the body to the domestic sphere and insisting that it remain unseen, because it does not produce capital. This dichotomy creates a false narrative about the value of breastfeeding, and it propagates patriarchal norms that oppress the female body. Neoliberalism's rejection of the work of breastfeeding, since breastfeeding does not produce physical capital, propels the problematic myth that the female body is less valuable than the male body.

Research aim: To showcase the revolutionary nature of breastfeeding as an act that has intrinsic and inherent value, and as an act that dismantles neoliberalism's dangerous patriarchal norms.

Narrative: This project is grounded in a theoretical feminist framework that proves and uses the revolutionary feminist nature of breastfeeding to deconstruct the myths neoliberalism has created regarding the female body. The work ends with a call to action, asking listeners to take up space with their breastfeeding, in spheres public and private, personal and political, because breastfeeding is the work of the mind and of the body, and has intrinsic value. Furthermore, the participants in the communal discussion will be asked to identify ways that neoliberalism visibly disembodies and devalues the work of breastfeeding in society, as well as ways in which breastfeeding is economically and socially beneficial outside of ways that benefit neoliberalism.

Conclusion: The goal of neoliberalism is to isolate the political subject and to assert that individuals abide by a solely rational-actor model of decision making, weighing options and making choices underneath the guise of cost-benefit analysis. Neoliberalism, in this way, does not value time spent breastfeeding. But breastfeeding is a revolutionary act that dispels myths about the female body and breaks down barriers between false dichotomies, simply because of its natural assertion of connectivity and relationship. Breastfeeding dismantles the idea that we are individuals, only focused on payoffs, and it does so in a revolutionary way that exemplifies the fortitude and beauty of the female body and, in this way, frees us from our neoliberal shackles.

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Lactation Support in the Workplace: Perspectives, Outcomes and Opportunities

Background: Workplace lactation support policies and programs can play an important role in women achieving their breastfeeding goals. In the United States, where mothers of young children make up over half of the workforce, women return to work at 3–6 weeks postpartum on average, and women in low-income jobs often return sooner. Barriers to breastfeeding in the workplace can include lack of time, lack of a private space to express milk, lack of managerial support, and lack of childcare options close to work. Although accommodations for lactating employees are becoming more commonplace in the United States, substantial variation exists by state, employer, and industry. Efforts to sustain and expand upon these initiatives require a better understanding of the perspectives and experiences of employees and employers with workplace lactation support.

Research aim: To discuss findings from recent research studies about employee and employer perceptions of workplace lactation support in the United States and to spur dialogue regarding strategies to a) reduce variation in workplace lactation support; b) increase representation of low-income and minority women in breastfeeding research; c) identify and measure lactation support outcomes that are meaningful to employers; and d) increase the rigor of research on workplace lactation support.

Narrative: Our literature review included peer-reviewed studies ($N = 18$) published between 2006–2016, that assessed employee and employer perceptions and experiences with workplace lactation support in the United States and included quantitative outcomes. Results were summarized by the following four non-exclusive themes: (i) employee perceptions of workplace lactation support; (ii) employer perceptions of workplace lactation support; (iii) association between workplace lactation support and business outcomes; and (iv) association between workplace lactation support and breastfeeding outcomes. Overall, researchers suggested that there was notable variability in the implementation of, and experiences with, workplace lactation support by employment setting and by employees' demographic and employment characteristics. We also found that maternity leave and having break time and a space to express milk have received the most attention in the literature, with fewer researchers examining employer-sponsored childcare, or perceptions of colleagues and managers regarding breastfeeding. Researchers' findings suggested a positive association between breastfeeding duration and the following accommodations: maternity leave, break time for pumping, and having a space to pump. The associations between perceptions of workplace support and breastfeeding duration were inconsistent, with some suggesting a positive influence and others no influence.

Conclusion: More work needs to be done to ensure that women in all industries and job roles get the support they need to continue breastfeeding after returning to work. Identifying and implementing policies and programs that improve mothers' experiences with workplace lactation support in various settings would be a useful next step. Research to better understand the experiences of low-income and minority women with workplace lactation support, as well as associations with job satisfaction and other business-focused outcomes, is recommended.

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When Motherhood Starts With Violence: Narratives of Infant Feeding After Traumatic or Violent Birth

Background: Parents who experience traumatic birth cite interactions with caregivers as one of the primary factors contributing to their experience. For these families, infant feeding is initiated within the context of recent and typically unresolved trauma. Little is understood about the role of birth trauma on infant feeding experiences, or the potential for the infant feeding to facilitate healing and growth following birth trauma. We utilized narrative analysis to identify the interactive pathways between birth trauma and infant feeding to optimize maternal wellbeing.

Research aim: To describe, using narrative interview protocols, the birth, postpartum, and infant feeding experiences of a diverse group of birthing parents in an effort to identify the ways that traumatic birth experiences and subsequent infant feeding experiences may inform each other in the context of maternal psychological wellbeing.

Narrative: Twenty-three original narratives of birth and infant feeding experiences were recorded and transcribed. Data were then coded using a phenomenological approach to identify antecedents of positive and negative infant feeding experiences following traumatic birth. Four birth-infant feeding relationship trajectories emerged: 1) a promotive relationship resulted from a positive birth experience and subsequent positive infant feeding experiences ($n = 6$); 2) a negating relationship resulted from a positive birth experience and subsequent negative infant feeding experiences ($n = 1$); 3) an exacerbating relationship resulted from a negative birth experience and subsequent negative infant feeding experiences ($n = 5$); and 4) a redemptive relationship resulted from a negative birth experience and subsequent positive infant feeding experiences ($n = 8$). Redemptive infant feeding experiences were characterized by reclamation of agency over one's maternal body, the presence of active and supporting caregivers and caring networks, and developing confidence and competency in parenting skills via the infant feeding context. In contrast, exacerbating and negating infant feeding experiences were either unrelated to the birth experience via disconnect with the maternal body, or exacerbated the negative psychological impact of traumatic birth by further undermining the perception of maternal agency and competence. Importantly, redemptive infant feeding experiences were more likely than any other infant experience to include references to pain or nursing injury, as well as equally as likely as negating experiences to include infant feeding challenges or difficulties.

Conclusion: Positive infant feeding experiences are critical for promoting psychological wellbeing following traumatic birth experiences. Infant feeding experiences do not need to be easy or simple in order to be positive; in fact, successfully overcoming infant feeding challenges may promote positive, redemptive experiences. Infant feeding may serve as an opportunity for reclaiming agency after a traumatic or difficult birth as a strategy to promote postpartum wellbeing by allowing mothers to feel autonomy over their bodies. Caregiving authorities should prioritize empowered decision-making in efforts to support redemptive experiences in the postpartum period via infant feeding.

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Self-Objectification: An Intrapersonal Barrier for Breastfeeding

Background: Although breastfeeding initiation rates in the United States have increased, close to 20% of American mothers do not initiate breastfeeding and nearly 43% cease to breastfeed before 6 months. To increase breastfeeding rates, factors involved in a mother's decision to breastfeed must be identified.

Research aims: To clarify the concept of self-objectification in the context of breastfeeding and to provide an optimal operational definition that can be used in research and practice.

Methods: A concept analysis following the 8-step Walker & Avant method was conducted incorporating a literature review using the key terms "self-objectification" and "breastfeeding" using the databases CINAHL, MEDLINE, PUBMED, and Google Scholar. A total of 22 articles from 1989–2018 were incorporated in the synthesis of the concept analysis.

Results: Self-objectification in the context of breastfeeding occurs when a woman prioritizes the physical attributes of

the breast over the breastfeeding benefits it may provide, while continuing to consciously monitor her physical appearance as a result of living in a sexualized society and internalizing the societal objectification of women. Consequences of self-objectification include negative attitudes towards breastfeeding practices that result in poor breastfeeding initiation, early breastfeeding cessation, and negative views of public breastfeeding.

Conclusions: The concept analysis provided an enhanced and universal understanding of self-objectification in the context of breastfeeding. The concept of self-objectification enlightened the degree to which societal and cultural norms affect maternal breastfeeding attitudes. Negative consequences of self-objectification provide several implications in the field of maternal health that can direct future research, education, practice, and policy.

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Organizing Asian Communities to Decrease Inequities and Normalize Breastfeeding in Los Angeles County

Background: Los Angeles County is home to the largest Asian American population in the United States. Over half a million Asian Americans and 7,000 native Hawaiians and Pacific Islanders reside in the San Gabriel and Pomona Valleys. In 2015, two-thirds of babies born at one local hospital in this area were Asian. Hospital data from several hospitals in the area showed that most births were from first generation immigrants from Asia, primarily China. There are numerous barriers to breastfeeding in this community. Corporate interests promote formula as superior to human milk. The lack of lactation education for physicians results in clinical practices that are not breastfeeding-friendly. While 15.3% of Los Angeles County residents identify as Asian, only 6% of the lactation professionals are Asian. Almost half of Asian Americans in the San Gabriel Valley have limited English proficiency, yet prenatal medical visits offer little language-appropriate materials for breastfeeding education. Furthermore, parenting style is deeply rooted in culture, but Baby-Friendly Hospital practices are not always congruent with Asian culture.

Research aim: The Asian Breastfeeding Task Force recognizes the unique cultural and educational needs of Asian and Asian American new parents. The Task Force seeks to decrease inequities and normalize breastfeeding in Los Angeles County's Asian communities by improving breastfeeding education and support practices, and by removing systemic barriers that prevent breastfeeding from flourishing.

Narrative: In August 2017, concerned community members, health professionals, the Special Supplemental Nutrition Program for Women, Infants, and Children (administered by Public Health Foundation Enterprises), BreastfeedLA, and the Los Angeles County Department of Public Health formed the Asian Breastfeeding Task Force to address low rates of Asian breastfeeding observed at hospitals and local nutrition agencies. Organized and recruited by community members, the Task Force discussed barriers to breastfeeding faced by Asian families and identified potential strategies for overcoming them. Members successfully sought funding for projects.

Current projects work to reduce breastfeeding disparities. Some of these projects include provider engagement that trains staff at Asian obstetric offices to provide prenatal breastfeeding education, community engagement utilizing targeted social media, and a website with Asian-language resources that has had 292 views since January 2019, as well as a photo exhibit with eight images for a public campaign to normalize breastfeeding. Future initiatives include a plan for sustainability that evaluates task force impact and expands membership to include Asian businesses, advocacy groups, and more healthcare facilities. Further provider engagement will utilize key informant interviews with Asian health professionals in order to develop more targeted breastfeeding education and effective strategies for systemic changes. Workforce development by identifying existing Asian International Board Certified Lactation Consultants and creating pathways to cultivate more lactation professionals through BreastfeedLA's Lactation Education Specialist training program will increase access to culturally- and linguistically-appropriate lactation services in Los Angeles County.

Conclusion: The Asian Breastfeeding Task Force is a community-developed, multi-level intervention to help breastfeeding flourish in Los Angeles' Asian communities by normalizing practices, improving support, and dismantling systemic barriers.

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Breastfeeding/Feeding and Infants with Neonatal Abstinence Syndrome

Background: There is an increase to drug exposure, not just in the United States, but internationally. With this increase, more infants are being born addicted, or minimally exposed to drugs in utero. Feeding specialists are seeing a rise in

infants with difficulties feeding related to their prenatal exposure.

Research aim: To help identify ways multidisciplinary teams may collaborate to provide the most successful and long-term feeding success for infants and their families and caregivers.

Narrative: In this presentation we discuss the role of feeding therapy, breastfeeding, and family dynamics with infants with neonatal abstinence syndrome. These baby/family dynamics can be complex situations and feeding difficulties are extremely common. Breastfeeding education/information can be offered prior to birth, along with other education for families, to promote more infant/family bonding and reduce the stress on the infant of being born in substance exposure. Breastfeeding dramatically reduces stress signs in infants exposed to substances neonatally. Working together as an interdisciplinary team, we can set these families up for more successful feeding opportunities and decreased stress in developmental care.

Conclusion: In knowing how we can combat some of these feeding difficulties early on, we can strive to help these infants become successful feeders across their lifespan. Proper feeding and swallowing development leads to a more nutritionally sound foundation for infants and their families. Proper feeding development can also help decrease behavioral difficulties these patients may develop as a result not only of their neonatal drug exposure, but of the behaviors that can develop as a result of poor feeding experiences early in life.

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Complex Negotiations: A Proposed Feminist Poststructural Exploration of Infant Feeding Support in the Neonatal Intensive Care Unit (NICU)

Background: Considered a key area influencing children's survival and the promotion of their healthy growth and development, infant nutrition remains a global public health priority. Situated within a web of gendered, social, political, institutional, and cultural dynamics, decisions surrounding infant feeding are complex and multifaceted. National and international health agencies (e.g., the American Public Health Association, Health Canada, and the World Health Organization) all advocate human milk as the optimal form of infant nutrition for the first 6 months of life and beyond. Nevertheless, when breast(chest)feeding is not possible or sustainable, many families opt for, or require, alternatives to their own milk to nourish their infants. For families of premature or critically ill infants hospitalized in the Neonatal Intensive Care Unit (NICU), the infant feeding process involves unique challenges and barriers. Ensuring optimal nutrition is a key concern for NICU providers in light of the medical fragility of the neonates under their care. As a result, feeding support for families in the NICU often focuses on the mechanical transfer of essential nutrition as opposed to the relational dimensions of the feeding experience for both mother and baby. In an environment where the decision to breast(chest)feed or to use alternative methods/modalities of feeding often goes beyond choice, NICU nurses and families engage in a unique feeding support dynamic. While infant feeding support has been previously studied in both qualitative and quantitative research domains, this area remains largely under-explored using a feminist lens within the neonatal intensive care environment.

Purpose: Using a feminist, poststructural approach, the purpose of the proposed study is to deconstruct infant support interactions between primary feeding parents and nurses in the neonatal intensive care unit.

Narrative: Primary feeding parents whose infants are admitted to a Level III NICU in Atlantic Canada will be recruited for participation. While individual, semi-structured, face-to-face interviews will be the primary method of data collection, participant observation during infant feeding support interactions is also planned. Interview transcripts and field notes taken during observation will be interrogated and interpreted using Discourse Analysis (DA), which is a cornerstone in feminist poststructural methodology.

Conclusion: The results of the proposed study are intended to bring voice to the "unseeable" and "unsaid" complexities embedded in the interactions that nurses and primary feeding parents have in the NICU setting. In doing so, there exists the possibility of not only challenging the status quo but also identifying opportunities for necessary change and action.

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Feminist Theories & Frameworks: Applicability to Breast(chest)feeding Support in the Neonatal Intensive Care Unit (NICU)

Background: Globally, childbearing and childrearing families are faced with a variety of complex and conflicting discourses related to infant feeding. These narratives are

entrenched in a web of gendered, sociopolitical, and institutional dynamics that contribute to the complexities of infant feeding decision-making and support for both parents and care providers. For parents of preterm and/or critically ill infants who are admitted to neonatal intensive care units (NICUs)m and the providers who collaborate with them, this area remains significantly under-explored through a feminist lens.

Research aim: To examine the applicability of various feminist theories and frameworks in exploring the unique challenges of supporting breast(chest)feeding parents in the neonatal intensive care unit (NICU).

Narrative: This session involved a brief overview on the complexities of breast(chest)feeding support in the NICU as well as the influence of feminist theory and frameworks on current research and practice in maternal-child health nursing. Following this, participants were invited to engage in a thoughtful and critical conversation on this topic, exploring how feminist theories have influenced supportive care practices around breast(chest)feeding in the past, and how, going forward, they may be useful and particularly relevant in deconstructing feeding support interactions in the NICU.

Conclusion: Aligned with the 2019 Breastfeeding and Feminism International Conference theme "Roots and Wings: Looking Back, Looking Forward," this dialogue allowed those participating to highlight new possibilities and innovative breast(chest)feeding support strategies through a feminist lens while also appreciating the role that feminism has had on shaping nursing care in this complex environment.

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Decolonizing Response to Disasters in the USA

Background: Natural disasters lead to population displacement and the breakdown of public health infrastructure, which increase vulnerability to disease, violence, suffering, and death. They may have immediate and long-term impacts on health, well-being, environments, and livelihoods. While domestic response to emergencies is guided by the principles of human rights and public health, in practice, disaster relief in US aid commonly fails to meet the needs of vulnerable people in historically marginalized, oppressed communities of color. The extent to which individuals, communities, societies, and nations are able to prepare for, respond to, and recover from crisis is circumscribed by historical, structural, political, and economic factors. Disaster relief is not universally effective or accessible for all people. In many cases response leads to even greater violence and suffering.

Research aim: In this Discussion Session we provide a conceptual framework for understanding the historical roots of inequitable emergency response. We also present action steps that advance decolonized approaches to emergency preparedness, response, and recovery. Finally, we provide case studies related to infant and young child feeding in the United States mainland and in Puerto Rico.

Narrative: In this Discussion Session, several discussants shared their lived experiences translating community-based lactation support into frontline emergency response to historically marginalized and oppressed communities of color in the United States. They provided examples of supporting families after Hurricane Maria, after ICE raids during the Flint Water Crisis, and in emergency homeless shelters. Moreover, as members of the communities that they serve, many also shared their lived experience during humanitarian crises and colonial emergency responses. Group members offered perspectives on the importance of strengthening communities to support their own preparedness, response, and resilience.

Conclusion: There are many challenges that communities face when relying on an emergency response system, which has been built on colonial and military structures and the different kinds of violence that state- and federally-organized emergency response perpetuates. A social justice lens facilitates convergence on the future of this work, which more fully integrates reproductive justice into disaster preparedness, response, and recovery.

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The Impact of Postpartum Depression on Process and Product Breastfeeding Intensity

Background: Postpartum Depression (PPD) affects up to 1 in 7 women annually. Untreated PPD can have serious long-term consequences for children, including a negative influence on a mother's accordance with recommended care practices. One care practice integral for child development is breastfeeding. While the benefits of breastfeeding are clear, the influence that PPD has on breastfeeding practices is still largely unclear.

Research aim: To test the hypothesis that women receiving treatment for PPD, as compared to women with PPD who are

not being treated, will have significantly higher breastfeeding intensity scores at 3 weeks, 3 months, and 6 months postpartum.

Narrative: Analyses were conducted twice to test the secondary hypotheses that the aforementioned hypothesis would remain true under both a process and a product ratio for breastfeeding intensity. The process ratio was calculated using feedings at the breast exclusively and the product ratio was calculated to include both feedings at the breast and expressed milk feedings. Data used were collected at the Catholic Medical Center, Manchester, New Hampshire, United States. Women who participated in the study ($N = 553$) completed surveys, responding to questions about postpartum depression and feeding practices prior to discharge and at 3 weeks, 3 months, and 6 months postpartum. Postpartum depression was analyzed by grouping participants based on treatment and their scores on the Edinburgh Postnatal Depression scale at 3 weeks postpartum. The three groups were as follows: Women receiving treatment for postpartum depression by 3 weeks postpartum, women with moderate to high signs of postpartum depression (EPDS $\geq$ 10), and women with low signs of postpartum depression (EPDS $<$ 10). Statistical analyses, specifically repeated measures analysis of variances were conducted using SPSS software to test the research hypotheses. Analyses were first conducted using the process ratio for breastfeeding intensity and were later conducted using the product ratio. The results of statistical analyses were then summarized and compared.

Conclusion: Participants who received treatment for postpartum depression had higher breastfeeding intensity scores; although, the difference was not statistically significant. Participants with low signs of postpartum depression had significantly lower breastfeeding intensity scores than participants with moderate to high signs of postpartum depression. Results using the product ratio for breastfeeding intensity showed similar results. For this reason, process and product breastfeeding intensity ratios were not found to significantly influence the relationship between breastfeeding intensity and postpartum depression from 3 weeks to 6 months postpartum. Results highlight the need for early diagnosis and treatment of postpartum depression.

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Spoiling That Baby and Other Myths That Impact Feeding and Development

Background: Researchers have made it clear that children will not be spoiled simply by having their needs and even their desires met. Yet, in too many hospitals and households, grandmothers and well-meaning aunties are discouraging beneficial attachment, bonding, and breastfeeding practices, in order to prevent a new mother from spoiling her child. The irony is that, in fact, cooperative independence, emotional and physical well-being, and positive behavior patterns develop more completely if a child's needs are fulfilled.

Research aim: The bonding and early life attachment between the infant and caregiver is a dynamic, bidirectional process involving caregiver nurturing of the infant, as well as complementary infant behavior that elicits parental care. Attachment appears to have a dual function. The first function is to ensure that the infant remains close to the caregiver in order to receive necessary care for survival. The second is that the quality of attachment and its associated sensory stimuli organize the brain to define the infant's cognitive and emotional development.

Narrative: As a society we have ideological, financial, and cultural challenges supporting new mothers, because we have lost sight of what new babies are really like. We have begun interpreting normal baby behavior as something being bad, broken, or inconvenient. Detaching from infants, placing them on schedules, and in isolation, makes breastfeeding more challenging for those who are fearful of spoiling their children. Missed cues and feeding opportunities can diminish a milk supply and can cause both physical and emotional harm to an infant, which influences the larger family, and the community as a whole. The amount of physical contact between infants and their caregivers can affect children at the molecular level. Researchers of DNA methylation patterns have showed that children who were more distressed as infants, and received less physical contact, had a molecular profile that was underdeveloped for their age.

Conclusion: Rooted in colonialism, capitalism, and racism, the current ideas around biologically and anthropologically normal attachment have a negative impact on infant feeding and infant development. Debunking the myth of spoiling, and reinforcing attachment, empowers parents, and builds strong breastfeeding practices, taking lactation support from "Roots to Wings". Understanding and appreciating the developmental norms of infancy is an important part of parenting, counseling, marketing to, and serving families. Convincing parents either that something is wrong with their child, or that they will ruin it, when the child is exhibiting normal behavior, sets the child and parents up for unnecessary challenges, perhaps over a lifetime. Equipping parents with fundamental information about biological, physiological, and social-emotional norms, as well as time for uninterrupted newborn care—that is, paid family leave—will provide the tools that are needed for longer breastfeeding, healthier development, and happier families, altogether.

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Women's Status and Breastfeeding in the United States

Background: Women's status in society, defined by political, economic, social, and reproductive health access and rights, affects women's and children's health. One pathway through which women's status could affect health is breastfeeding. It is not clear how women's status affects breastfeeding outcomes, nor how it may influence breastfeeding support related to breastfeeding outcomes.

Research aim: To analyze how the status of women influences the association between certain kinds of breastfeeding support and breastfeeding prevalence.

Methods: We created a dataset with publicly available data about breastfeeding outcomes and state-level support from CDC Breastfeeding Report Cards (2018), and indicators of the status of women for each state from the Institute for Women's Policy Research reports (2015). We conducted an ecological study with statistical analyses using SAS version 9.

Results: In bivariate analyses, the work and family index was not associated with either breastfeeding outcome. The reproductive rights index was associated with breastfeeding at 12 months but not with exclusive breastfeeding at 6 months. All other status of women indicators (political participation, employment and earnings, poverty) were associated with both outcomes. The number of IBCLCs and La Leche League Leaders per 1000 live births were associated with both exclusive breastfeeding at 6 months (1.70 and 4.35) and breastfeeding at 12 months (2.32 and 6.48), respectively. However, the percentage of live births occurring in Baby-Friendly facilities was not associated with either outcome. In multivariable analyses controlling for the percentage of the black population and weighted by state population, political participation and poverty indicators were associated with exclusive breastfeeding at 6 months. For every 1-unit increase in the political participation index, the prevalence of exclusive breastfeeding at 6 months increased by 0.0042 percentage points, and for each 1-unit increase in poverty, prevalence decreased by 0.6 percentage points. Only employment and earnings was associated with breastfeeding at 12 months. For every 1-unit increase in that index, the prevalence of breastfeeding at 12 months increased by 0.1 percentage points. Controlling for status of women indicators, only IBCLCs were significantly associated with exclusive breastfeeding at 6 months and with breastfeeding at 12 months, among the breastfeeding support indicators. For every 1-point increase in IBCLCs (number per 1000 live births), the prevalence of exclusive breastfeeding at 6 months increased by 1.74 (95% CI [0.93–2.54]) percentage points and the prevalence of breastfeeding at 12 months increased by 1.47 (95% CI [0.38–2.57]) percentage points, on average, across the states.

Conclusions: We estimated the limited influence of political participation and poverty on breastfeeding prevalence. The construction of women's status indices may obscure the influence of key indicators on breastfeeding practices. Future research should test associations of different indicators with breastfeeding outcomes to ascertain predictors of breastfeeding practices. In addition, the status of women attenuated most associations between breastfeeding support and breastfeeding outcomes. Given the current status of women in the United States, increasing the number of IBCLCs may have a small effect on breastfeeding practices at the population level.