Okay let's go ahead and get started welcome we are

so pleased that you all joined us this afternoon

for a Division of Nutrition Physical Activity and

Obesity Seminar Series that focuses on community

actions to improve breastfeeding rates CDC's

Division of Nutrition Physical Activity and

Obesity DNPAO our seminar series showcases

the science and practice of our work um

I hope sorry my screen just

shifted and the seminar

series is intended for partners

for practitioners in the field for

everyone to kind of get a better sense of

what's going on and opportunities in the future.

I'm Janelle Gunn. I serve as Associate Director

for Policy Partnerships and Communication in CDC's

Division of Nutrition Physical Activity

Obesity and I'll be your moderator today

today's seminar will highlight community

actions to improve breastfeeding rates

increasing breastfeeding rates and

supporting optimal breastfeeding practices

is a priority for DNPAO we've seen improvements

in breastfeeding initiation about 84 of infants

in 2018 have received breast milk at some

point but there's still work to be done most

infants are not exclusively breastfeeding or

continuing to breastfeed as long as recommended

only 26 of infants are breastfeeding

exclusively at six months as recommended

frustrating initiation rates vary geographically

with large racial ethnic disparities nationally

and at state and territorial levels focusing

on communities with lower breastfeeding rates

can reduce this barriers and improve infant nutrition and health so we have some really

wonderful panelists today I think you all will really enjoy today's presentation

they'll describe their work to support community breastfeeding at the community level. Just a few

quick housekeeping reminders for our time today this zoom seminar call is being recorded so if

you're not comfortable with being on a recorded call we ask that you disconnect at this time

to have the best experience we encourage you to use the zoom webinar app to view

slides and to participate in today's meetings all participants will be muted following our

three presentations we will have a question and answer session so the q a box is open at any time

throughout the talk today if you have a

question go ahead and load it into the box

and we'll do our best to get to as many questions

as we can with the time that we have. I am super

excited about our panelists today

so I want to do a quick introduction

of of all of them to you so our first um is one

of the DNPAO's own Jasmine Nakayama. She's an

epidemic intelligence officer

or what we call at CDC an EIS

officer in CDC's National Center for Chronic

Disease Prevention and Health Promotion in DNPAO

in her role on the maternal infant and toddler

nutrition team Jasmine leads CDC's first analysis

of county-level breastfeeding rates she received

her PhD in nursing from Emory University's

Nell Hodgson Woodruff School of Nursing and has a clinical experience in inpatient outpatient and

emergency care settings and research experience using large electronic health record data sets.

Harumi Reis Riley is a public health professional nutritionist and international board certified

lactation consultant. She is a lead program analyst at the National Association of County

and City Health Officials or NACCHO and where she oversees the reducing breastfeeding disparities

through county continuity of care project this project aims to improve public health

breastfeeding systems next we have a team of presenters so Cindy Young is co-founder

of the Asian American and Native Hawaiian Pacific Islander Lactation Collaborative of California

and the Asian Pacific Islander breastfeeding task

force she is a program manager with Breastfeed

LA an organization dedicated to improving the
health and well-being of infants and families

through education outreach and advocacy and her
co-presenter is Tanya Lang also a co-founder of

the Asian American and Native Hawaiian Pacific
Islander Lactation Collaborative of California

and a member of the steering committee of
the Alameda County Breastfeeding Coalition.

She is an international board certified lactation
consultant a certified health education specialist

and has supported chest breastfeeding and
human milk feeding families for about 16 years.

So first for our agenda today Dr Nakayama will
discuss why breastfeeding is important how CDC

monitors breastfeeding rates new efforts to
monitor county level breastfeeding initiation

rates using birth certificate data and uses

and uses for county level breastfeeding data.

Harumi will discuss the recently released

continuity of care and breastfeeding support

blueprint for communities focusing on specific

recommendations strategies and examples for

communities to strengthen local infant

feeding data and then our final presenters

Cindy and Tanya will discuss the diversity

within the Asian American Native Hawaiian

Pacific Islander communities review current

breastfeeding and chest feeding data and their

limitations and share current efforts to

include and promote AANHPI voices in lactation

so without further ado I would love to hand

it over to my colleague Dr Nakayama Jasmine.

Thank you good afternoon I'm excited to

see everyone here it looks like there's a

very lively audience I can see everyone

in the chat chiming in so thank you um

this presentation will review why breastfeeding

is important why breastfeeding is important

it will also summarize how CDC monitors

breastfeeding rates share new efforts to

monitor local level breastfeeding initiation rates

and discuss uses of these local data I want to

provide a quick reminder of the importance of this

work breastfeeding is the optimal nutrition for

most infants and protects against many illnesses

and infections such as asthma and ear infections

in addition to promoting bonding between mother

and infant breastfeeding also provides health

benefits for the mother including decreased

risk for some chronic diseases such as high

blood pressure and type 2 diabetes one of our data

sources for national breastfeeding surveillance

is the National Immunization Survey or

NIS. NIS are the data that CDC reports on

our website every August on the Breastfeeding

Report Card and for healthy people indicators NIS

is an annual nationally representative

survey that is conducted by CDC

using random digit dialing its primary objective

is to assess vaccine coverage among children

and since 2001 questions on breastfeeding

have been asked to caregivers of children

aged 19 to 35 months to assess breastfeeding

rates at national and state levels by birth year

the responses to these questions

allow us to track breastfeeding

initiation breastfeeding duration formula

supplementation and exclusive breastfeeding

next I want to describe another breastfeeding

surveillance system that our team has recently

started using which is birth certificate data

the National Center for Health Statistics

National Vital Statistics system is the federal

compilation of birth certificate data which

are collected between the time of delivery of an

infant and the time of discharge from the facility

or for infants that had home births the time

of the completion of the birth certificate form

the U.S. standard certificate of live

birth collects data on many variables

one of the questions asks whether an infant is

being breastfed or discharged which is defined

as receiving any breast milk or colostrum during the period between delivery and discharge from the birth facility or completion of the birth certificate form for home births our team has used birth certificate data for a couple different analyses a publication in may 2021 reported on racial and ethnic disparities in breastfeeding initiation using 2019 birth certificate data the figure on this slide shows the largest disparity in breastfeeding initiation between maternal racial and ethnic groups by percentage point differences in 48 states and in the District of Columbia the magnitude of disparity varied across the nation these data also indicated that the specific racial and ethnic group with the highest and lowest rates varied between states that analysis also indicated that

states with higher breastfeeding

initiation rates have the lowest disparity between

racial and ethnic groups here the light blue bars

show the overall breastfeeding initiation

rates within a state and the dark blue bars

show the disparity within the state which is

defined here as the difference in breastfeeding

initiation rates between ethnic and racial

groups with the highest and lowest rates

for example Oregon is the first state on the left

Oregon has the highest breastfeeding rate and low

disparity West Virginia on the far right has the

lowest breastfeeding rate and higher disparity

another publication in June 2019 described the

receipt of breast milk by gestational age in

the United States using 2017 birth certificate

data this was one of the first times that we

were able to look at breastfeeding initiation

by gestational age and we were able to focus on

some of our nation's most vulnerable infants this

report indicated that the prevalence of infants

receiving any breast milk was 48 overall

and this number varied by gestational age

disparities and receipt of breast milk by several

socio-demographic factors including maternal race

and ethnicity were noted across gestational age

groups this slide highlights differences between

NIS which are the data that we release every year

on our website and the Breastfeeding Report Card

and birth certificate data when looking at

breastfeeding rates NIS on the left provides

data on breastfeeding initiation duration and

exclusivity whereas first certificate data on

the right only include breastfeeding initiation data the most recent NIS data are for births occurring in 2018 whereas the most recent birth certificate data are for 2020 births. NIS provides data at the national and state level whereas birth certificate data have data at the county level birth certificate data do not include California. California did not report this variable to CDC and birth certificate data also do not include Michigan which asked the question a little differently and resulted in data that were not comparable breastfeeding initiation data for California and Michigan will be available for 2021 data and finally birth certificate data can allow analyses for gestational age and disparities due to the larger sample size within this data set.

This slide shows you a resource for county

breastfeeding initiation data this was

recently published on our website

last fall the link is on the slide

the darkest blue on this map indicates the

category of lowest breastfeeding initiation

rates and the lightest blue indicates the category

of the highest breastfeeding initiation rates

the hashed lines indicate states

or territories where data were not

available and gray areas indicate data that

were not shown for confidentiality reasons.

Overall birth certificate breastfeeding initiation

rates ranged from 22 percent to 100 percent

across 3001 counties and county equivalents in

48 states in the District of Columbia we also

presented rates for the territories of Guam and

the commonwealth of the northern Mary islands

and for 78 county equivalents in Puerto Rico.

these rates demonstrate wide variation
within states and across the nation.

You can also select a state or territory
to get more detailed information.

This is an example of the map and the first
few rows of a table presented for a state

the breastfeeding initiation rate is presented for
the state overall and for each county in a table.

These tables of breastfeeding initiation rates by
counties are available for download as a csv file.

you can also sort the table here by location name
number of infants or breastfeeding initiation rate.

Note that data for some counties are not
shown or the actual rate is not displayed

to prevent identification of individuals

these data can be used by many people

and organizations to identify local rates of
breastfeeding initiation to reveal disparities

by location to inform programmatic efforts and
to tailor local interventions more effectively.

This concludes my presentation next
I'll pass it over to Harumi Reis Riley.

Thank you Jasmine and thanks for having me here
to share a bit about the blueprint and what it

says about local level breastfeeding data. So
here are my acknowledgements. Uh the blueprint

project is funded by CDC DNPAO so thank you
but the views within the blueprint does not

necessarily represent those of CDC. I also
want to acknowledge that the content of the

in the blueprint is a result of at least 100
professionals in the field here's a bit about

us. NACCHO is the National Association of County and City Health Officials. Within NACCHO the chest breastfeeding program falls under the maternal child and adolescent health portfolio and exists since 2014. We have tons of resources developed through these past eight years and most recently we launched the Continuity of Care Breastfeeding Support Blueprint that I'll talk about today. I also wanted to add a plug here for the NACCHO's Public Health Informatics team. I'm going to talk about gaps on local level breastfeeding data but through their work I understand these gaps exist across many local public health programs so local professionals rely on data systems to assess community health identify population needs and create effective policy and programs

and although most data collection happens

at the local level this data is not easily

accessible by local agencies. Usually the health

data is fed from local to state to federal level

so NACCHO informatics work to identify solutions

within local health IT infrastructure to ensure

that the data collect is collected and can be

disseminated at the local level by looking at uh

interoperability of systems and security of data

sharing. So next slide you'll see a snapshot of

the blueprint the blueprint goal is to ensure that

lactation services are accessible coordinated and

that all community spaces are consistently

supportive. The blueprint was developed in

partnership with the U.S. Breastfeeding Committee

and their Continuity of Care Constellation. The

blueprint includes seven recommendations divided

in two themes. Uh improvements in community

infrastructure structure and capacity building
of the local lactation workforce. Uh the blueprint

focuses only on actions that can be taken at the
local level we launched the blueprint last August

and you can download the blueprint from the
continuity of care resource repository website

and you see the link there in the slide. And next
slide you see the blueprint recommendations. Today

we'll focus only on recommendation one and four
because there are the specific ones that discuss

local breastfeeding data and the rationale for
those recommendations is that community data

can tell the story of where continuity of care
gaps exist and equitably support specifically

specific continuity of care models that uh enable
families to meet their infant feeding goals.

But as you're going to see the availability of communal level breastfeeding data especially

data that is stratified by race and ethnicity and income is very limited. And through the blueprint

meetings we heard many challenges in accessing local level data. The frustration was even more

evident when we divided two subgroups and then the postpartum subgroups like the three-month

milestone in babe babies over six months because continuation data is almost inexistent by then.

So without this local disaggregated data it's really hard to even state that sub-optimal

breastfeeding is actually an issue in the community. How we're going to say that there's

a problem if there's no data to tell the story and how is anyone going to show impact of lactation

support implementations if there is no data to
show increasing rates and decreasing disparities.

So in that slide the recommendation four states
to develop a community driven database to track

infant feeding consistently. Uh strategy 4.1
talks about assessing existing local data.

One of the most known breastfeeding data that is
consistently collected in communities is through

the local WIC agency. However we've heard over and
over and over again that this data is not easily

accessible by other community agencies and also
WIC data reflects only a subset of the community.

But anyways other breastfeeding data that is being
potentially collected at the local level are those

through the home visiting programs like Healthy
Start Nurse Family Partnership, Early Head Start

data from Baby Cafes and also probably by

some of some federal quite qualified health

centers and other individual providers probably
through their electronic health records systems.

But the type of data collected by each may not
align with each other and usually systems do not

talk to each other which makes very difficult to
safely share data. So this recommendation speaks

to the need to improve into interoperability
across health systems to allow exchange of

information effectively. In the next slide you see
we're going to start talking about um strategies

for this recommendation to establish
a streamlined community database.

You see that in this recommendation a lot of
the language is borrowed by the collective

impact framework and public health informatics but
this recommendation is really the shortest in all

the blueprints and because currently there's

not a whole lot of examples best practices

or useful tools in the field but we are hopeful

that there will be more communities addressing

this critical gap in continuity of care. And also

if you are doing some work on this area please

let us know. I'll show briefly some of the few

community examples that we know. I know some of

them are here in this call today so please help me

out. Tell your story in the chat box. But hopefully

we can get everybody to come back and present on

our recommendation for webinar later on this fall.

We have REACH recipient in Nebraska.

They have been using the collective

impact framework and they use the

shared measurement systems concept

which means that partners are consistently
collecting data and measuring results. And then

the Partnership for Health Lincoln serves
as a backbone organization to manage this data.

so they collect and compile different sources
of breastfeeding data that includes both of

their local hospitals vital records data for
breastfeeding intention and data from both of

their local WIC offices. And they use those to
identify trends in breastfeeding duration. They

do even more in other program areas where there is
an actual standardized indicator. For example they

collect a lot of A1C data which is the indicator
that measure average blood glucose and informs

diabetes management. So this data is pulled from
their three largest safety net clinics in Lincoln

so they have a very good idea on how diabetes

control is progressing in their county and they

can tell if diabetes prevention activities are
in fact being affected. And then the next example

comes from Erie county in New York. This data is a
bit old they plan to develop this county-wide data

dashboard and repository to track their county
breastfeeding rates. So first they establish the

core set of data of breastfeeding data and
the data format for each partner to collect

and report among hospitals pediatricians family
physicians WIC offices so each partner would have

the ability to query in real-time aggregated rates
among all reporting entities. They also wanted to

have a storage of data for future research and
evaluation purposes but I've heard they were not

yet successful in engaging and encouraging their
medical practices to use existing resources within

their electronic health records to track rates.
But their plan is pretty cool right. But of course

this idea for a local breastfeeding dashboard did
not come overnight out of the blue right. This was

just one more step within the comprehensive
breastfeeding program that you see here. Next

uh here you see that they had previously formally
incorporated breastfeeding measures and services

into their community health improvement plan and
through that they had their own strategic plan for

breastfeeding and a comprehensive process map for
the county as you see here. So this is to say that

data related activities requires intentional
planning to strategically like identify

what when who to collect this data. And then
in the next slide we're going to move on to uh

recommendation one and Erie county is the perfect

segue because of strategy 1.2 uh to integrate

breastfeeding indicators and goals into community

health improvement plans like here he did

uh we did a whole 90-minute webinar recently

just on that recommendation. So you can see

the recording link there we're going to change

the chat box too. There's a lot of strategies

under this recommendation but today I really

just wanted to talk about the data related

strategy 1.1 of conducting a local lactation

landscape assessment which is a little different

from the recommendation four that I just talked

because it involves more than collecting just

the quantitative data. So next for this strategy

I'll share a bit of our identifying care gaps

uh project. So this was a grand project focusing

solely understanding the community. So we funded

eight community partnerships to conduct communal lactation assessments. So next you can see that

we based their assessment framework on CHA CHIPs Mobilizing Action through Planning and Partnership

or MAPP that has been used for decades to develop community health assessments and improvement plans.

So we tailored MAPP best practices to include those three-part assessments. First you can you

see their community status assessments that quantitatively describe the community and you

see some of the samples of data that could be collected here. The second part is the community

partners assessment to understand the individual and collective capacity of partners to address the

root causes of breastfeeding inequities by looking critically within their own systems and processes.

And finally third and critical part is the

community context assessment to learn through

the lens of those with lived experience and dig

further into historical and structural routes of

inequities within the community and of course

also learn the community strengths desires

and because we know that the solutions should

disparities lies within communities members

wisdom right. So in the next slide you're going to

see all of eight grantees. They all did a great job.

Um I'll just highlight the four

here the pictures because of some

something very unique they shared with us and we

don't have a lot of time. So first here you see

the Center for African American Health in the green

box. One of their focus was understanding barriers

to career advancements for Black lactation support providers and Black families experience navigating lactation support. So their results show the families experience modern medical racism and very limited opportunities for newly Black lactation support providers across the Denver region.

Second here you see the east Saint Louis Health Department. One cool thing that they did was collect data from over 150 local businesses about their breastfeeding friendly practices and with these results they know exactly where to focus future efforts right. Third we have Coahoma Diaper Bank in the Mississippi Delta and they partnered with the Center for Health Equity Education and Research here. So they did a comprehensive assessment of existing community breastfeeding data and then they found a large data gap

in breastfeeding durations and exclusivity

and many difficulties accessing existing
breastfeeding data from the state.

They also identified other data sources
from Baby Cafe and the CHAMPS hospital

initiative but only CHAMPS gathered data by race
and ethnicity which is crucial for understanding

current community disparities and advancing
health equity. And finally here last you see the

breastfeeding coalition that by the way this
coalition was created because of the availability

of incredibly disaggregated data that is made
available by the Minnesota Department of Health.

Through this data they were able to identify that
Hmong families had the lowest breastfeeding rates

in many different counties so they formed the
Hmong Breastfeeding Coalition and through this

project they were able to understand some of their continuity of care gaps and found the

Hmong driven organizations offered no lactation services or referrals and the most organizations

providing lactation support do not offer any culturally responsive services for Hmong families.

They also did a very cool um culturally attuned community contacts assessment which was a video

storytelling collection initiative since the Hmong culture is rooted in oral storytelling to preserve

language and traditions. So you can find all their recommendations under recommendation one on the

blueprint website. And then next I just wanted to conclude these examples with a beautiful sample of

disaggregated county level data from the Minnesota Department of Health that I just talked about. They

do such a great job compiling data from WIC from birth certificates and hospitals and make the data very accessible to anyone that requests it. I was very impressed uh impressed with the how much they were able to disaggregate their WIC data by cultural identity like you see in this table here.

Uh you see Black families from at least six culturally cultural identities instead of lumping all Black infants together as if they were one monolithic group. Very impressive right.

And on the smaller screenshot you see another graphic of county level breastfeeding data duration data. So this only reflects WIC participants but still I think this is one of the most uh most disaggregated duration that we have seen through the past year um and very accessible.

And then just to conclude I wanted to tell you

about the current happenings within the blueprint.

We're currently funding 10 organizations

to implement the blueprint recommendations

and we are also running our blueprint webinar

series and I would like to invite you all here

to the recommendation 3 webinar on May 24. And

then in the fall we hope to bring all these

organizations highlighted here today to discuss

their project more in depth for webinar and

data so stay tuned. Thank you so much and thank

you CDC for all the technical support provided

during this webinar. It's my pleasure now to

turn it over to Tanya Lang and Cindy Young who

have been doing great work in this field. Tanya.

Thank you Harumi and thank you so much for the

opportunity to present today again I'm Tanya

Lang and I'm one of the co-founders of the

collaborative. Um I identify as Chinese-American

and I was born in the U.S. and I also speak two

dialects of Chinese. And I'm going to hand it

over to Cindy. Hi everyone I'm Cindy Young

and I'm also a co-founder of the collaborative

and I identify as Japanese and Korean-American

and I also speak a little bit of Japanese as well.

Today I wanted to go over quickly our or overview

of what we're going to talk about. We're going

to be talking about the diversity of our Asian

American Native Hawaiian and Pacific Islander

communities we're going to be talking a little bit

about the current AANHPI chest and breastfeeding

data and limitations. We're going to be talking

about the model minority myth and the framing of

our data. And finally we're going to be talking a

little bit about the lactation landscape analysis that we're doing within the collaborative.

Finally we're going to be talking about the formation of the collaborative and how we

came together. So let's start by defining our population. Uh what do we mean when we say

Asian American Native Hawaiian and Pacific Islander. So AANHPI is an umbrella term used

to describe many different cultures and distinct languages that represent almost half the globe.

The continent of Asia alone has over 48 countries and the Pacific Islands cover a

geographic region that spans a distance broader than the United States and includes dozens of

distinct cultures. So with this incredible ethnic diversity comes also a vast number of languages

spoken. Uh let's take a closer look at the Pacific Islands or Pasifika which is what I'm told is the preferred term. So Pasifika is further divided into Micronesia Melanesia and Polynesia and here are some of the islands listed within each. I just want to note that the immigration and political status is different for residents of each island which determines whether one can live or work in the U.S. and access services and you may even see differences within each family.

So where do most AANHPI people live in the United States. California actually has the highest number of people who identify as Asian and the second highest number identifying as native Hawaiian or Pacific Islander. AANHPIs are a large part of the population California and that's why it's so important to understand the needs of our

communities. Okay so let's talk a little bit about

data. Dr Nakayama already discussed the May 2021

CDC MMWR report on racial and ethnic disparities

in breastfeeding initiation and that report found

pretty high initiation rates for Asian mothers.

In fact the prevalence of breastfeeding

initiation was highest among Asians in 36 states

nationally the largest racial ethnic

disparity in breastfeeding initiation

was 16.7 percentage points so what

that meant was that it was a higher

it was um higher for Asian mothers than for Black

mothers um and as she mentioned uh California did

not report its data. And remember I always said

that California is a state where 30 percent

of the US AANHPI population resides and that's the

largest in the nation so making broad statements

about high initiation rates in Asian and Native

Hawaiian or other Pacific Islander communities

without data from California really misses a

large proportion of AANHPIs and their experiences

and doesn't really present a full picture

of breastfeeding in our communities.

Also the data in the report only captures any

breastfeeding rather than exclusive rates and

again any breastfeeding can represent as little as

one feeding so um just want to put out there that

we really need to be careful about how we frame

our data. So let's take a closer look at California.

Um so the in-hospital breastfeeding data

are taken from the newborn screening program

and the exclusive breastfeeding data at one

month and five or three months are taken from the

Maternal Infant Health Assessment or MIHA so data from the newborn screen show high initiation rates for Asians and Pacific Islanders. But when we look at exclusive breastfeeding we see much lower rates for AANHPIs which are both of which are lower than the California average and by one month you see exclusivity drops. The one month exclusive rate for Asians and Pacific Islanders is the lowest among all ethnic groups and the three month exclusive rate is the second lowest.

So just wanted to note also that the newborn screening data are broken out into Asian and Pacific Islander into two categories and you see a difference between the Asian and Pacific Islander groups in initiation but the MIHA data combine Asian and Pacific Islander into one category. So are there differences in duration between Asian

and Pacific Islanders that are being masked by

aggregated data. We don't really know. Um also MIHA is administered only in English and Spanish.

Almost half of those identified as linguistically isolated in California are AANHPI

meaning they self-identify as speaking English less than well and as we know language barriers

can negatively impact the quality of care in hospital and clinic settings

we're probably missing a significant portion of the AANHPIs in this survey.

So let's take a look at my home in Alameda county which is in the San Francisco bay area in

California. Here we see high initiation rates and lower rates for initial exclusive breastfeeding.

Pacific Islanders have the lowest in-hospital exclusive breastfeeding rates as you can see

but by one month exclusivity drops to 37 percent for Asian and Pacific Islanders and continues to decrease at three months to 32.7 percent. Again the one-month exclusive breastfeeding rate for Asians and Pacific Islanders is lowest among all ethnic groups and the three-month exclusive rate is the second lowest. In Los Angeles county we see slightly lower initiation rates but the initial exclusive breastfeeding rate is much lower than what we saw for Alameda county and California overall. Here we see that Asians have the lowest in-hospital exclusivity rates of all groups and it gets even worse by one month exclusivity drops to 31.6 for Asians and Pacific Islanders and continues to decrease to 18.2 percent by three months. So Asians and Pacific Islanders have the

lowest exclusive breastfeeding rates of all ethnic groups at one month and three months. And I don't know about you but I find these numbers to be alarming and again why are we focusing so much on supplementation and exclusivity rates. Uh remember any breastfeeding can represent as little as one feeding and while any amount of human milk feeding is of course good and should be celebrated we know that the greatest health benefits for both mom and baby come from exclusive breast or chest feeding and that is why it's important to focus not just on the initiation rates. So to sum up AANHPI is an umbrella term used to refer to many heterogeneous groups that differ in culture language ancestry and religion however this is not how AANHPI are necessarily perceived. In our country Asian Americans are often stereotyped as a model

minority. So a polite you know law abiding group

who's successful due to inborn talent and
kind of pull yourselves up by your bootstraps

immigrant mentality. Asians as a group are
thought to succeed just as well as whites

but at the same time Asians are also viewed as
perpetual foreigners. So however the myth ignores

the diversity of our communities and considers
Asian Americans as a monolith that is generally

invisible in our society while also masking racism
against our communities. Um the rampant racism

against AANHPIs during the COVID-19 pandemic
is just one example and more recently on March

uh March 16th we acknowledged the one-year
anniversary of the murders of eight people

including eight Asian women massage workers
at spas in metro Atlanta. Um the model minority

myth also completely ignores Pasifika peoples. Uh
the perceived success of Asians is often used to

divide communities of color which ultimately
harms the goal of achieving racial justice

in our community. So from the current data
we see high initiation rates to breastfeed

um and high intention. We also see high rates of
formula supplementation. So why is that is that

related to racism or unfair or harsh treatment or
linguistic isolation. When we look at national data

it appears that we're doing great but that's
not necessarily reflected in the local data

for all health indicators are not regularly
collected for our communities and even if we have

data for Asians often data for Pacific Islanders
is not available and we're often told that there

are too few numbers and we're too few in numbers

to break out the data in its own category.

um but that's um that's a problem with

data collection can be solved by things

like over sampling of certain populations. Um

unfortunately what little data we have on Asian

Pacific Islanders are often combined together into

one category and do not paint an accurate picture

of the health of our communities. The model

minority myth combined with the aggregated data

paints a much more positive picture of the health

and well-being of our communities and what we know

is true. Um and as we saw in the MMWR report the

problematic data framing of data has implications.

Um data often drives programmatic priorities

and funding opportunities so what little data

we have suggest that our communities are doing

well when looking at most health indicators.

Um so that leads to a vicious cycle of fewer
allocation of attention and resources to

our communities and then not seeking out more
data because there's no apparent need to do so

and then not having the data
to show any community needs.

I'm going to hand it over to Cindy. All right
now I'm going to talk a little bit about some

of the work that we've been doing within the
collaborative. So we've been doing our lactation

landscape analysis and our landscape analysis
began back in June of 2021 and it's the largest

AANHPI lactation community needs assessment in
the nation and we wanted to really add to the body

of knowledge about chest and breastfeeding
and human milk feeding in our communities

and the resources available or the lack thereof to support our communities. So our landscape analysis has been divided into three parts. We have our national resource mapping survey which I'll talk about in a second. We have our community context assessment which includes a provider survey and a parent survey and Tanya is going to be talking about that. And then also we really wanted to focus on advocating for disaggregated data. That was a really important piece for us because it illustrates the diversity within the AANHPI umbrella and presents a more accurate picture of chest and breastfeeding with our within our communities. As Tanya mentioned data for all health indicators are not always collected for AANHPI and furthermore most data

are aggregated under the general Asian American
and Pacific Islander umbrella and so that's um

the main reason why we wanted to really advocate
for disaggregating it. And I also wanted to mention

that this project that we were working
on as a collaborative was not funded

and we all decided that we wanted to do
this work and we volunteered to do it. Um

Breastfeed LA shout out to them. They were able to
provide some in-kind support through their staff

and others all volunteered their time for the
work that we were doing so we're really grateful

for all of the folks who worked on it so thank
you to the collaborative members who couldn't

be here with us today our extended family.
We consider them our family members. Um so

first let's talk a little bit about the National

Resource Mapping Survey. The goal of that was to

really create a national list of AANHPI lactation

support professionals and educational resources

for AANHPI families and this piece was led by

one of our students Danielle Tropea and was who

developed a landscape assessment tool to gather

resources nationwide. We launched the survey back

in October of 2021 and kept it open from October

to December and we sought input from lactation

support people who either identified as AANHPI

or worked with predominantly AANHPI communities.

We promoted the survey through many of our partner

organizations including USBC NACCHO the California

Breastfeeding Coalition California WIC National

WIC and so far we've received 60 responses

which tells us several things that either um

there aren't very many resources out there

which we suspect is probably true um or we're just not getting um it out to the um the right

people. So we have decided to reopen our survey and we are continuing to gather um resources

and we're hoping that we can further um add to the listings and make it as robust as possible.

And we plan to share the list um when we have a good amount um on a website where people can

access it for free. And so I want to share with all of you the link. Here there's a QR code. So if

you'd like to take the survey or know of someone who can and is eligible to take the survey please

share with um for with them and there's also a URL as well that you can share with folks.

All right I'm going to turn it back to Tanya who's going to talk about the provider survey.

Um so our community contacts assessment was led by another student Sophia Tan and included a survey

and focus group of AANHPI healthcare providers and key informants who serve primarily AANHPI families

and also a survey for AANHPI postpartum parents. So the survey for parents is currently in progress

but for this provider survey and focus group we partnered with Asian Health Services which is

which is an FQHC based in Oakland California. Um and that's the main side of our community context

assessment. So uh providers and staff at AHS um completed a survey and participated in a focus

group discussion. Um some of the findings that came out um from the survey and the focus group

is that um there was definitely a need for more educational materials in AANHPI languages more

staff training and lactation and also how

to incorporate cultural practices in chest

and breastfeeding support and also a resource

directory of lactation support professionals

which we are working on with that national um

resource mapping survey and some of the important

points that came out of that focus group is that

um the family in the household extended family

members in the household have a heavy influence

on whether parents will breast or chest feed.

They we had providers tell us straight up you know

I can tell immediately who's going to breastfeed

depending on how supportive other family members

are in the house. They also wanted to know

where to access in language educational materials

and needed a defined referral process and where to

send patients for more complex lactation support

and also realize that the need to make some more

workflow changes to improve communication um so

minor things like um the comprehensive perinatal

health workers now include their teaching notes

in both the parent and the child's chart so that

pediatricians actually know what happened and what

kind of education the lactating parent received.

and I'll hand it back over to Cindy to talk

about how the collaborative formed. So many of

you are probably wondering so how did you all

come together. Um so it's kind of a nice a very uh

great story I like to share. Um so the

Lactation Collaborative of California

AANHPI lactation collaborative um evolved from a

joint effort between the Asian Pacific Islander

Breastfeeding Task Force of Los Angeles. So

that's an organization that I was working with

and the Asian Southeast Asian and Pacific

Islander Task Force of Alameda County and

that's an organization that Tanya is affiliated

with and we thought you know the north and the

south of California we should all really be

working together and so we decided to write for

a grant um that NACCHO was offering um and it was

the conducting communities assessment to improve

the chest breastfeeding landscape in historically

oppressed communities. And we heard about a lot of

the grant recipients. They're really great and much

deserving of the funding. We unfortunately didn't

get the funding but we put together a really

great work plan um that included the landscape

analysis and the parent and provider surveys

and the disaggregating of the data and we said

we still want to do this is really great

work. It's important work. It's not being done.

Let's do it. And so we were able. It was just very

fortuitous. The group came together we had some

students that needed um to do some hours for

their um master's degree um we had some elders

um who were in the community who really wanted to

give back to the community and had some time and

said you know we can work on this as well. And

we're like great let's do this. So we decided

to put that work plan to work and we were able

to accomplish a lot of that work plan unfunded.

So one of the goals of the collaborative is to

create a bridge between mainstream lactation

public health organizations. And the AANHPI

community the collaborative recognizes that many

barriers to breast and chest feeding that exist

in our AANHPI community which include limited

breast and chest feeding data lack of culturally
humble and language-appropriate lactation support

systemic racism and healthcare and implicit bias
among healthcare staff who continue to perpetuate

myths such as AANHPI women don't breastfeed. And
so we're here to dispel those myths and bring

attention and resources to our community who are
often left out of important health conversations.

And our collaborative really
fosters connections between

our AANHPI individuals groups and organizations
who provide lactation education and support.

And like I said before we are really a north and
south California statewide partnership that also

conducts outreach to other AANHPI groups and
to mainstream state and national organizations.

One thing that really makes us special is that

we really place a high priority on mentoring our

AANHPI students and young professionals including

supporting those who wish to become IBCLCs.

And our collaborative recognizes that there

are many um additional uh barriers to building

capacity within our communities and we believe

in providing additional support and uplifting

our emerging leaders. And so we're always giving

them opportunity to lead to speak at public um you

know events and really put them in the spotlight

because we feel that that's important. And another

piece that we have included and that we care

deeply about is that we incorporate the wisdom

of our elders and ensuring that um their voice is

heard as well. Um so it's a really great um sort of

generational organization that encompasses all. Um the collaborative is also supported by allies from

LA and the Alameda County Breastfeeding Coalition and we've also forged strong partnerships with

other community organizations and stakeholders. And that pandemic has really allowed us to form

a really close relationship. Um you know all these zoom meetings probably were not a thing until the

pandemic. And so we're that maybe a silver lining that occurred uh from the pandemic is that we were

able to really um connect and work together. And um we strongly believe that the successes that are

you know within our collaborative are a result of our strong roots in our AANHPI communities.

And our collaborative is also unique in that our efforts are completely organized and driven by

our AANHPI community members with support from our

allies within the lactation field. And our while

our member um while one member may take the lead
on a specific project our group norm is to include

input from everyone in the group. And we strive to
make sure everyone's voice is heard. So we always

kind of joke around we bring our family with us
when we when we do um you know presentations when

we um we work on different projects because we
feel that everyone's voice is really important.

All right. Um so now you're wondering um what
can we do you know. What how can we lift uplift

the AANHPI community. How can we work with AANHPIs.
Um so some of the things that we would um uh call

you to do is to look at the data where you are. Get
to know your communities and who your clients are.

And if you don't know ask. Questions are great. Um
reframing cultural traditions as assets versus

something that you need to you know work around

or work against. Uh support AANHPI organizations.

Include us at the table. Um bring in young

professionals and include the wisdom of our elders

in all conversations. And ensure education provided

to the community is culturally congruent not just

regular information that's been translated into

another language. It specifically needs to be

tailored to the needs of our community. Um I know

we're kind of coming up on time here so I want to

thank all of you for letting us um share about

the work that we've been doing and if you have

any other questions about the AANHPI Lactation

Collaborative of California welcome to reach

out to Tanya or myself. Our contact information is

listed here. And um like I said thank you so much

and I turn the time back over to Janelle. Thank you. Thanks for all these wonderful presentations this afternoon. We have just a couple minutes for a few questions and answers. We want to remind our participants as well that the seminar is recorded and will be uploaded on the DNPAO webpage with some links so you can come back to there for some resources. So Jasmine if I could turn it back to you we've got some good questions about plans for repeating uh your analysis. Great.

That's a question we get asked very often. We don't have any firm plans but we would like to repeat something like this in the future. We've received very positive feedback. It sounds like people really like having this data. They would like to have this done in the future to compare trends across time. We would like to include

California and Michigan which means that we

would need to wait for the 2021 data. And we
also want 2022 data so that we can aggregate the

two years and have enough of a sample size
to look at county level initiation rates.

Thank you. So we're halfway there. Um Harumi the
next question is for you. The question is how

can we access local WIC breastfeeding disparities
data? Yeah as I mentioned uh local data is usually

any local data is usually fed to state
and then probably USDA here on a week so

but we heard that I would start with your state
health department but we heard across the country

different levels of accessibility. Uh some make
it very easy to access and some even I heard one

require a fee um so it really depends on your
state but I would start with the state. But then

you know REACH Nebraska they compile the local WIC data at the local level and they

make that accessible too. So I think it really depends on your state and your community.

Thank you. And then Cindy and Tanya.
I'll turn a question over to you.

Given the diversity of Asian American Native Hawaiian Pacific Islander communities,

how does language affect the ability to collect accurate data?

Well as we had talked about earlier you know oftentimes surveys that are done to collect

more data aren't necessarily translated into AANHPI languages. Um at best we see that um

you know a survey um might be translated into Spanish or even a lot of educational materials

you know that was something that we heard loud

and clear from providers who were serving our

communities. Um there just are not enough in

language resources for our families and um

it's and it's not a simple thing either because

again given the diversity of our communities

um think about how many languages that represents

you know um even you know on Chinese. And even for

Chinese there's not really you know just Chinese

there's you know if you're translating materials

is it in traditional Chinese or simplified

Chinese or if there's anything um that need to

be translated into another spoken language there

are many dialects so that's just for Chinese.

Yeah so just to add to what Tanya was saying so

we are missing a big portion of our community

by limiting the languages that the surveys

are offered in and so that's something that

we definitely are you know advocating for is

to expand the number of languages that surveys

are um offered in so that we can capture

more of particularly the folks that are

monolingual or you know um English is not

their first language um communities so

that's something we're hoping to work on as

part of the advocacy work that we're doing.

Thank you. Well we are coming to the end of

our hour today. I really want to thank all

our speakers for joining us. We had a great turnout

which I'm so pleased really showing the interest

across the country and how communities can

better support breastfeeding. So thank you

again to all of our speakers. Thank you to all

of our participants for joining us for this

first seminar series in 2022 and we look forward

to seeing you at the next one. Thank you all.