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 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
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.

despite 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 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 there are 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.