Testimony submitted via email.

HB 2503/2504

Written Testimony:

My name is Dr. Marion Rice,Ed.D., IBCLC. I am an International Board Certified Lactation Consultant and the former Executive Director of the Breastfeeding Coaltiion of Oregon. A state coalition with the United States Breastfeeding Committee charged with support, promotion and protection of breastfeeding across Oregon.

While I deeply believe in supporting the inclusion of lactation care as a key component of supporting lifelong health, I have concerns as to the impact of this bill on the landscape of lactation services in Oregon. I have some concern about HB2503 and HB2504, that the proposed bills have not been developed through an equity-based approach and may further exacerbate inequities that exist in the lactation support provider landscape in Oregon that may in fact adversely effect lactation care and support for families.

I am further concerned that Bill 2504 centers control for determining Peer Lactation Support Providers within WIC. The WIC Peer Support Provider Program was modeled after Nursing Mothers Counsel of Oregon Peer Support Program in the first place. I have concerns as to how this bill may impact the important work of Nursing Mothers Counsel of Oregon to train Peer Support Professionals and other organizations such as Doulas Caribe or International Center for Traditional Childbearing that train Doulas and may also engage in training Breastfeeding Peer Support Providers.

I would like to recommend that the committee not advance these bills at this time, take a step back and put in place a process for advancing this work through an equity based approach. I highly recommend guidance from the statement released by the National First Food Racial Equity Cohort, which I have also pasted below. I am a member of the National Racial Equity First Food Cohort residing in Oregon.

The key components of that guidance are:

- Engage diverse stakeholders (especially target populations) in conducting a community-based assessment.
- Collect both quantitative and qualitative data to identify the problems and solutions.
- Use a racial equity framework in the development and implementation of interventions.
- Conduct an evaluation of interventions and policies being considered.

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You may access the full statement here:

http://www.centerforsocialinclusion.org/national-first-food-cohort-addresses-the-value-of-peer-and-community-based-breastfeeding-support/

Sincerely,

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This post was authored by the National First Food Racial Equity Cohort. To learn more about the cohort, click here.

All children and families deserve the best possible chance to be strong, healthy, and happy throughout the course of their lives. Breast milk and breastfeeding are among the first building blocks to ensure this is possible; many in healthcare and public health have researched and documented the health benefits to breastfeeding. Unfortunately, women and babies of color are the least likely to have access to critical support and care to make breastfeeding a reality in their homes and communities. As discussed in Center for Social Inclusion's report, *Removing Barriers to Breastfeeding*, overlapping structural inequities in housing, healthcare, and employment (to name a few) have led to disproportionate rates of breastfeeding among women of color. Studies from 2006, 2014, and 2016 have noted that in-hospital healthcare providers are less likely to discuss breastfeeding options or services with African American women, and maternity care practices supportive of breastfeeding are limited in communities with higher African American populations.

The goal of the First Food Racial Equity Cohort is to provide a stronger racial equity analysis for field of breastfeeding as well as child and maternal health, more broadly. As we learn more about what resources are needed to improve breastfeeding rates in communities of color, we seek to bring in a systems based root cause analysis to new and developing ideas. The emerging notion of licensure—that the activities of persons engaged in lactation care and services should be regulated or professional licensed—is a key racial equity issue in the birth and breastfeeding field. We find no evidence to suggest that licensure will help achieve more support or access to care for all communities, particularly for communities of color. To date, a limited number of research studies have been conducted in the area of professionalized lactation support, and more research is needed to ascertain the impact of licensure on breastfeeding rates and community support. However, a mounting body of evidence suggests that community and peer support is the most effective and powerful means of breastfeeding support for women and communities of color. In areas with limited lactation services, we have found that breastfeeding peer counselors (BPC), certified lactation counselors (CLC), and certified lactation educators (CLE) are usually the people interfacing with and providing support to mothers and families during the antepartum and postpartum periods. Breastfeeding mothers are typically referred to International Board Certified Lactation Consultants (IBCLCs) if issues are outside of the scope of the peer/CLCs, which tends to be a small percentage.

There remains a high level of disparity across the board between race and location in regards to breastfeeding initiation, duration, and exclusivity rates. **Given the limited accessibility of lactation services in communities of color and other under-resourced communities, all types of breastfeeding support providers must be seen as valuable contributors in the field of lactation.** Each type of supporter provides a unique level of support that improves breastfeeding initiation, duration, and exclusivity. No supporter should be excluded from compensation from insurers or other systems, because of their scope of work. Per Health and Human Services (HHS) guidelines, all lactation supporters are able to provide care and be compensated as long as they work within the scope of work defined by their certification or credential. According to the CDC *Guide to Strategies to Support Breastfeeding Mothers and Babies*, a systematic review of peer support programs has found them to be effective in increasing the initiation, duration, and exclusivity of breastfeeding. Multi-faceted interventions, with peer support as one of the main components, have also been found to be effective in increasing breastfeeding initiation and duration (CDC, 2013). **With this in mind, the current call for IBCLC licensure as the sole entity that can provide lactation support and care for compensation creates a barrier that may prevent mothers from having access to other valuable lactation supporters who are more readily available in their community.**

Currently there is no available demographic data on the race, ethnicity, age, spoken language, etc. of IBCLCs, CLCs, and Breastfeeding Peer Counselors that are available throughout the country. However, it is widely understood that since the inception of the IBCLC credential, White IBCLCs disproportionately outnumber IBCLCs of Color. Many throughout the lactation field have noted and addressed barriers to entrance into the profession; CSI appreciates the leading organizations that are actively addressing ways to decrease these barriers and improve access to IBCLCs in communities of Color.

In response to the CSI's report *Removing Barriers to Breastfeeding*, USLCA submitted a letter in which they stated: "Creating more jobs for IBCLCs will, in turn, spur entry into the profession." Although this may be true in the future, it is imperative to note that it will take years to begin to see an increase of People of Color as IBCLCs—simply due to the didactic, clinical, financial, and mentoring requirements it takes to acquire the credential. Thus, this exclusion of other supporters would only exacerbate the inequities that negatively impact communities of color and the continued concerns for public health. In addition guidance from HHS and USLCA, the Surgeon General's Call to Action to Support Breastfeeding further outlines the need for both mother-to-mother peer support as well as community based support for breastfeeding.

The First Food Racial Equity Cohort recommends that all states and insurers adhere to the HHS guidelines and the Surgeon General's Call to Action to ensure that all mothers are provided with the level of care they want and need in order to achieve their breastfeeding goals.

Inequitable pay for peer counselors and low reimbursement rates, such as Rhode Island Medicaid reimbursement rates, are unacceptable. Currently, a Georgia Bill on licensure excludes certain providers, such as lactation support providers—thereby producing a negative impact for communities of color, who clearly benefit most from community and peer support.

The First Food Racial Equity Cohort, centered on making racial equity a reality in breastfeeding, would like to make the following recommendations with an equity-based approach:

- Engage diverse stakeholders (especially target populations) in conducting a community-based assessment.
- Collect both quantitative and qualitative data to identify the problems and solutions.
- Use a racial equity framework in the development and implementation of interventions.
- Conduct an evaluation of interventions and policies being considered.

Additionally, the cohort strongly recommends that states use a Racial Equity Impact Assessment to address who will be impacted most by licensure policy. This analysis will allow key stakeholders to explore who will benefit or be burdened by the policy, and who can co-create strategies and policies with stakeholders. Stakeholders must include, but are not limited to, all providers of breastfeeding support, families, community leaders, policy makers, etc. The engagement process must ensure that there is equitable representation, especially of the community that is mostly impacted by disparities and inequities. It will be essential to include Equity-focused Evaluations, and to report outcomes to all stakeholders. Currently the CDC Breastfeeding Report Card tracks the number of IBCLCs, CLCs, and La Leche League Groups/Leaders that are available for Mother-to-Mother support. Other types of peer support such as Community-Based Breastfeeding Peer Counselors, WIC peer counselors, community-based support groups, and others, are not included in the CDC Breastfeeding Report Card, and we strongly recommend to the CDC to include these valued providers of breastfeeding support. There is a gap in lactation support (of all kinds) in communities of color, as well as a lack of community-of-color representation among more professionalized breastfeeding support providers; we encourage states to gather data on current available lactation support and to take into consideration how policies will impact support for underserved communities.

The field needs to invest in long-term funding that can capture long-term outcomes and prioritize community-based approaches—with equitable surveillance strategies for outcomes—in underserved communities, communities with the highest disparities, and communities of color. In addition, we need to explore what systems and policy changes can be made to address equity—such as social determinants of health, paid family leave, living wage, student and workers rights, maternity care practices, and inequitable service delivery and supports in health care system.

Decisions about licensure have the opportunity to either exacerbate the very gaps we see or move toward closing these gaps. Equity in breastfeeding can be achieved by creating more opportunities for women of color to not only breastfeed but also by providing effective, culturally-centered support that communities of color so desperately need.

This post was authored by the National First Food Racial Equity Cohort.