Anthrolactology Podcast Season 1

Episode 4 – The COVID-19 Special Edition
July 23, 2020

Summary: In this episode of Anthrolactology, the team discusses lactation and human milk in the context of the COVID-19 pandemic. The episode was recorded in late May 2020. EA talks about the team's ongoing COVID-19 feeding study, Aunchalee talks about her ongoing leadership work in COVID 19 feeding recommendations, and Cecilia discusses the important historical framework for understanding responses within feeding frameworks.

At the end of the transcript you'll find links to blog posts and other resources mentioned in the podcast!

Our pronouns:
EA (she/her/hers); Cecilia (she/her/hers); Aunchalee (she/her/hers)

Transcript

[Music] This is Anthrolactology, a podcast about breastfeeding, science, and society

EA: Alright. We are live. Welcome, everyone, to a special edition of Anthrolactology. Who knows what month it is anymore! Anthrolactology pandemic edition with your host EA, Aunchalee Palmquist and Cecilia. I forgot my own Last name.

Cecilia: And that's where we are.

EA: So welcome, everyone. We are very excited to all be here today, having a conversation about anthropological perspectives on lactation during the COVID-19 pandemic. And this is something that, while none of us started out as COVID researchers, it has certainly been gathering some of our attention. And, I think it's really been part of the larger conversation and awareness, both in the anthropological as well as the lactation world.

Aunchalee: Yeah, so I think there are a lot of unanswered questions, a lot of controversies about different guidance and what folks are to do; and parents have lots of questions about who to listen to? What kind of questions to ask? And what to do? So, I think it's like a great opportunity for us to just chat about our perspectives and kind of what we're doing and what we're seeing. And really putting that anthropological framing on it.

And so, I guess I wanted to just before we get started with talking about COVID-19 to see, you know, how are you all doing this week? We are collectively in St. Louis and Baltimore and Elon so kind of all over.

How are you, you know? All of us are parenting and working.

How are you doing, Cecilia?

Cecilia: I'm, I'm still alive. That is really good, and yes, I started a new job. So that's really exciting, but also very busy. And yes, I'm also parenting and trying to work at the same time. And so, it's a I would say it's fairly chaotic but I am thankful that we are all healthy. I think that that's sort of really - you know it sharpens your focus on your priorities. I'm very thankful that all of us are home together. And, you know, realizing what a privilege it is to be able to do that at all and to be able to, you know, have food and shelter and have a job. I mean, these are just, they're huge. And so I think about that a lot.

Aunchalee: And yeah, EA I've been thinking about you a lot too, having such a little one at home and also breastfeeding and kind of taking care of your little one. So how have you been coping and sort of what are the things you all are thinking about?

EA: We came back Monday and all this unfolded starting Thursday of that week. You could already kind of start to see and feel it in the airport. We've been home since then. He doesn't sleep. He's gotten five teeth since the pandemic started so he has 7 teeth, learned to crawl, to pull up and he's just totally mobile. So, so my husband's an essential worker so I don't get a lot of sleep. I don't get a lot of work done. You know, I think we, we probably all miss the teachers in our lives.

Aunchalee: Yes!

EA: We're hanging in there. We are managing on you know I'm really thankful as Cecilia was saying that, you know, we're, we both still have our jobs and I've been able to be pretty much full time with him while still working on some of our projects and my collaborators have, I mean we've submitted

two grants and my collaborators done the heavy lifting on those and been in constant contact with the communities we work with in Nepal.

Aunchalee: What are they doing there?

EA: Community Action Nepal (CAN) that runs the health clinics is training the nurses on personal protective equipment, they're setting up quarantine rooms. One of the things that you do is you ritually seal the village. sounds an awful lot like stay at home if you ask me. You all know I think so highly of the CAN nurses and the community health workers and just seeing how much they're doing and learning and putting into place is phenomenal. And it shows what fantastic nurses, they are.

Aunchalee: That's great. Yeah.

EA: So how are you doing?

Aunchalee: I'm really tired. That's my standard answer now, I'm just gonna, like, own up to it. I'm exhausted. Busy yeah really busy. We have three children school age so that is - we spend, my spouse and I - spend a good time kind of trying to juggle keeping on top of that. It's really difficult. And we are kind of - I think initially we were trying to like keep on track, and be in communication and learn all the apps. And now we're just like, "okay, you do what you want to do and all right? Like, go play the rest of the day!" It's a really a lot. So yes, we need to pay teachers more and teachers are amazing and I could not do what they do.

So I went from having, you know, my one basic job teaching and being sort of this academic person and now I am homeschool teacher and leading a bunch of stuff related to the COVID 19 response. So, I feel my like my work has expanded sort of exponentially. And it's good. And it's exhausting. But we're hanging in there like like y'all said. That is, it's my reality, but it's also like we have jobs and our kids are healthy and they have each other. We have place for them to play together and they seem to be coping alright. So, all things considered good.

But I've been trying to like pay a lot more attention to my sleep hygiene and just making sure like I have what I need to help my brain to work to do all this stuff that we're being asked to do.

So, I think one of you know one of the things we talked about is maybe trying to focus on some of the work that we're seeing some of the research and advocacy around COVID-19 and infant feeding, and some of the ways in which we are being called upon to provide different kinds of perspectives on into feeding recommendations, the science that's being generated and some of the questions that we all are the three of us. And

I'm sure others who are in this space are also fielding related to COVID-19 and infant feeding. So, I think first, it would be really cool to maybe talk about the infant feeding survey that we sort of rapidly put together and maybe some preliminary insights on what we're seeing.

EA: Basically back in late March, we launched the infant feeding and COVID-19 study, and this was really predicated on my observation that in many of the online breastfeeding communities that I belong to there was suddenly a lot of concern about relactation, delaying weaning or getting formula, depending on how a woman was feeding her kid because all of a sudden you couldn't get formula and there was, I would say almost overnight dramatic increase in conversations about the immunological properties of breast milk. It was a big moment where for a lot of people their behaviors were changing and what about three or four days we were able to get the survey launched and we are wrapping up data collection. We had almost 1800 women participate. That was it was restricted to the US there the international study is still going. However, I know a group in the UK has also launched an international study and They're probably doing a better job of getting at the UK issues than we are.

Aunchalee: Yeah.

EA: We had all 50 states and Guam represented. It does have some typical biases of online studies, it tends to be very biased towards white women. About 90% of the sample is white women. The income variable is quite diverse. And we also had a large subset of healthcare workers

Aunchalee: Can you describe what were some of the questions in the survey?

EA: Sure. Thanks. So, what we were really hoping to get at with the survey is how is COVID 19 impacting infant feeding decisions. So not just breastfeeding, but also when you were going to introduce supplemental foods, when you were going to totally wean and if you're a formula feeding mother or parent how your access to formula was changing or how you perceive your access to formula changing. And what were the sources of information, people were getting. And then we of course added in some of our favorites. I was interested in some of the healthcare workers' responses. We added in questions on infant's sleep and behavioral changes related to sleep timing and the changing of when breastfeeding cessation would stop. And milk sharing. If individuals were actively seeking COVID milk or were making changes in their most sharing behavior because of concerns about COVID-19.

Aunchalee: So, we have like a subset of the initial respondents, who have agreed to provide like their email, they can receive a follow up survey that is about eight weeks from the time that they initially took it. So, we can do some

comparisons. Gathering some of this information about what's happening and the impact makes it difficult, so a survey is a good tool, but like, as you mentioned, it does have some limitations regarding like who has the time and the access to technology and information to be able to kind of participate. So even within those constraints, I think it'll be a good - there's so little data published in the peer-reviewed literature on how different kinds of emergencies, you know, population-based data and often it's really very general like: Breastfeeding? yes or no, kind of data. So, I think this survey is going to make a really important contribution to sort of how we're thinking about the effects of different kinds of emergencies, and how they're shaping perceptions of risk and insecurities around infant feeding and things that in context.

Cecilia: All three of us have been watching some of the conversations that are happening. And, fielding questions, but also listening to people's experience and just trying to support people, as they are kind of navigating these scenarios. And I think one of the points that you just made is so important that the way in which the literature is constructed.

We talked about this before, but I think it's, one of those ongoing themes that we have on the podcast and in the literature that there is a sort of split between so called wealthy settings and, the idea that those settings are somehow like above forces that can make people vulnerable when, in fact, those settings are riddled with inequalities, and people have been experiencing terrible conditions all along. And then we kind of pretend that these issues, don't really matter in those, you know, wealthy settings and is driven by narratives of privilege. And I think as the pandemic as people started realizing really the scope of what's really going on here, which is so much worse than I think initially. A lot of people anticipated.

It's all of a sudden reconfiguring that conversation. And making it much broader than it was before. And I think that's where sort of the larger comparative perspective that anthropology has is so useful because we don't you know we don't really follow that sort of exceptionalist narrative. We always deconstruct it.

Aunchalee: I am a co-author with you and another team of folks, looking at this issue of separation and I would love to hear what we have to say about separation. But really also, how like your background and thinking about breastfeeding and sleep and some of these other you know the production of knowledge around infant care has informed the way that you sort of approach this statement about separation?

Cecilia: It was definitely very much a collaborative effort, I think, driven by all of us being sort of horrified. I think all of us anticipated that guidance from different settings would look very different in response to the pandemic.

There is a long tradition and I've written about some of those issues, both in terms of sleep. And in terms of HIV in the US about sort of making up guidance, that's really quite different from many other settings kind of setting apart, you know, this idea that the US guidance is different and somehow may be superior to other settings, even if the evidence doesn't necessarily support that.

So there's a tradition of that and sort of my background and that is about the history that I talked about when you know when you interviewed me. It's really about these histories of fragmentation of different kinds of bodily processes. The idea that breastfeeding is not something that's actually really important And, you know, that is sort of this sort of extra This thing that you know is at this point accepted to be something positive, whereas you know in the past that was questionable. I think most people, there's been a cultural change around that. But there's still the sense that it's not really that important. And that it doesn't really confer value such as things like survival.

EA: And I think we've seen part of this and I mean I think this also ties in with a lot of larger contextual issues about just the way in which births and lactation have been challenged through COVID 19. I mean, there were days where I mean like, remember the New York hospitals banning partners or coaches as a couple of hospitals that have still banned doulas.

Aunchalee: Yeah, so maybe we should back up a second and just talk about the WHO guidance and then this other guidance and some of the tensions there and then maybe that could be like the lead into this statement about separation. Maybe that would be helpful for context.

Cecilia: That's a great idea. I think on. You should talk about the WHO guidance.

Aunchalee: Sure. So, the WHO guidance for the care of infants in the immediate postpartum period really is drawn from the best science that is available. And obviously, because it's an emerging infectious disease we don't have randomized control trials, necessarily, a lot of the sciences perspective or case studies clinical case studies. Who is coming at this kind of thinking about the risk to benefit. Balance in terms of possible transmission from the pregnant person to their infants. And so breastfeeding as part of that is in this immediate postpartum period, you know, what do we do to ensure the best outcome for the infant dnd based on what we know about transmission, try to mitigate transmission while preserving that relationship.

And so breastfeeding, the WHO approaches breastfeeding as *essential, integral, very important* to the health of newborns to the health of the breastfeeding parent. And the guidance really is sort of centered on that

they also integrate these things like health and human rights. So, the recommendations for intrapartum care having support during labor and delivery have been around, you know, being informed and making informed decisions about different kinds of procedures that will happen. And in the case that a birthing parent and their infant are otherwise well in the context for COVID is either suspected or confirmed the recommendations are to keep them together. Practice respiratory and hand hygiene, skin-to-skin immediately postpartum, if they have to be separated or for some reason - I mean, there are lots of, you know, all the same reasons why a birthing individual and their infant might be separated immediately after birth, hold true in this COVID 19 pandemic. So, there may be cases where there are medical reasons for separation and those cases, they are very clear about that the birthing individual needs to have mental health and psychosocial support continuity of lactation support the opportunity to nurse their baby. If the baby's well enough, or they're well enough, providing expressed human milk feedings or pasteurized donor milk. So that is like the whole package and in a sense, it's a very holistic orientation to the care, being attentive to address issues around infection prevention and control for this particular virus.

And so the other guidance that has a lot of global influence happens to come from the United States.

Cecilia: Right. And so, this is where I think your original question about how does, you know, how does their background about anthropology really matters that the guidance doesn't come from sort of neutral territory in science. It's not exempt from cultural ideologies, and so they are really reflected and how the US guidance has played out the initial guidance from the CDC had some challenging language that many people found confusing and at times, sort of contradictory. And so at and in some places it emphasized, the importance of breastfeeding.

But at the same time, it also stated that the idea of separation mothers and infants from one another, should be considered. And there was a piece about shared decision making in there, but it was sort of overlooked by most of the people who were interpreting the guidance.

And so, what we saw unfolding is various people hospitals leadership. Kind of trying to make policy all around the country based on their interpretation of the CDC guidance, which most interpreted that really it should be automatic separation.

This was not a terribly surprising thing based on what we knew about cultural ideologies and the perception that mothers - we actually talked about this, EA actually had this great line about in a previous podcast - about how there's this whole ideology of mothers presenting a risk to

their babies where the only thing that was being really considered as mothers be posing a risk of their babies, but they were not really looking very holistically, like the who guidance about, what other things do mothers provide that might actually be relevant, including of course all the proximity that's involved in breastfeeding.

And one of the things that we talked about before is that breastfeeding is this very neat adaptation that is both reliant on proximity, but also facilitates and ensures that proximity that infants human infants need. And so, that whole relationship about proximity was not really fully considered nor was the implication of the disruptions that would happen to breastfeeding once the separation was implemented.

So, the idea was that you would still be able to somehow breastfeed. But really, there was no mechanism in there for how to support breastfeeding, and it was very unclear how all of this would be implemented logistically.

And that prompted us to come together and write out in further detail. You know what exactly are these implications? We've tried to focus it particularly on breastfeeding. And one of the interesting aspects was really not thinking about the fact that we have a situation where we have really no effective treatment here. We don't have a vaccine and we're not really thinking about what about the process of breastfeeding, and the immunological relationship between the mother and the infant. That is is being overlooked.

And what about all the physiological interconnections that happen that make breastfeeding feasible? These are processes that we know about because they were disrupted before you know in all those historical processes that we talked about in the previous episode - about when childbirth got medicalized and moved to the hospital and essentially mothers and babies were separated.

So that's where a lot of those findings come from about what the implications in the context of a whole series of the literature that we talked about in terms of colonization, where basically we have forced removal of infants from their families and systematic structural violence and cultural other forms of violence that this whole idea of separation can come up.

So there's just numerous huge, enormous consequences of this kind of guidance and the special thing about the CDC in the US is that it's not only the US that ultimately has that bears the consequences. So, it's these kinds of processes and disruptions do not stay within the US, even if they're meant for the us. They actually have an influence elsewhere.

And so, we started seeing some of the Influence of the guidance elsewhere, where all of a sudden, you know, separation and policies are popping up even though the WHO has remained completely consistent.

Aunchalee: Okay, then you actually need to have, you're going to do this separation and isolation, all of the other things you need to also advocate for in that recommendation which is skilled lactation support, doula support, mental health and psychosocial support - all those things, that the WHO also recommends to support, you know, the dyad (the birthing parent and infant) in that time and that the neglect of that piece of the care package that that's wrapped up in that recommendation - that absence of that - speaks volumes about how lactation and human milk are actually valued by the people putting out these recommendations.

Cecilia: Or not valued. Right. And we're seeing that too.

I mean, I'm we're seeing, you know, examples of the industry stepping in and you know essentially marketing various products and also sort of advocating pseudo medical advice. This is an old strategy that we've seen, of course, that we've written about in our book, you know about how important this sort of medical giving advertisement,-sort of medical credibility is one of the key strategies that they use in the past to undermine breastfeeding. So, it's no surprise that it's back with a vengeance, you know, during this pandemic.

I mean, they're using the pandemic as a as a marketing opportunity which is just terrible.

Aunchalee: I just want you to also know that that the marketing opportunity is not the same thing as ensuring that families who need to have access to formula have access to it. Two different things there.

Yes, they're going to be always families who are going to need to use formula to feed infants. Whether by a medical indication, or just a choice ; that is separate from the marketing tactics and the ways that industry works in concert with scientists and medical experts to influence the kinds of decisions that people make.

So everything we have, like guidance, right, we have these different kind of big organizations putting out guidance, but then the way that it actually - like when you look on the ground at what is happening, sometimes it's aligned with different guidance and sometimes it's not. That's the other thing.

It’s like there are there practices being put into place and healthcare facilities that are not at all based in either the guidance or the science.

Cecilia: And I think you nailed it. I think that the two competing narratives. You know, the one that's sort of idealizing milk, but also motherhood and then mothers as sort of risky and dangerous and milk is polluting.

I mean, those, those narratives are getting circulated, and you know I think for me it's just like it's humbling. Because even though we study cultural ideologies, it's like I written you know so much about this and it's still humbling to watch it play out on such a grand scale, including of course in all the medical guidance. Where those beliefs already exist. That's what makes it easier for them to travel in particular ways.

That's why it was not unexpected that the US guidance. Cultural ideologies travel and they travel, you know, across the routes that became what it was, but it's still meant that we had to say, where are the lessons?

Like, did we learn any lessons here from previous guidelines? Why are we not learning these lessons about, a more nuanced more holistic way, like Aun said, that the WHO captures? Like why are we not thinking about the importance of mother child contact? Why are we not thinking about, the more complex role of breastfeeding and human milk? I mean those questions.

We thought that there was a glimmer when you know when the CDC kind of changed their guidance and started refocusing and re-emphasize the importance of breastfeeding. We were like, “Oh my goodness. It's a miracle!” And then they talked about the importance of shared decision making.

And then we got the update, just a couple of days ago that once again “strongly considers separation” and the breastfeeding guidance is completely split apart from that. So, it's just unclear how you're supposed to navigate the landscape where separation is becoming really the main recommendation. On the national level, so it makes it very difficult for people to act differently. Even if you know that there are other ways and other nations have gone down much closer to the path of the WHO.

Aunchalee: I mean, that's all, that's the really interesting thing, because if you talk to some folks who are supportive of this more stringent CDC/AAP guidance and opting to implement so stringent separation routines, the rationale is well, the United States is a unique context. We have, you know, the capacity and the materials to be able to isolate, you know, isolate both the birthing parent and their infant and after birth; they have their own teams, the PPE, the space to do this. This allows them to do it.

And yet, in other countries like Australia and Germany, other places where there. They have the same kinds of resources and structures,

they're not doing that. And they're still having, you know, they still are able to have good outcomes and still able to maintain their alignment with the WHO recommendations. So, yeah, it's interesting, and also horrific.

To hear the stories and kind of see the consequences of those recommendations, particularly in light of the fact that it seems like many healthcare providers and the health care facilities get the separation piece; and yet all of the other supportive aspects, all of the other things that have to be in place to then pick up those pieces to maintain the health and well being of the birthing parent and the infant in that context are just completely erased from the guidance. And there's not really any advocacy for how to invest in that support, and advocacy to say like, "if you do this, then you also have to make sure these pieces are in place, and you need to scale up the support and make sure that you have the skilled labor and birth support, the skilled lactation support, and maintain that continuity from discharge to community and make sure that all of their patients have access to the technology and the devices and everything you need to access telehhealth services and to do these follow ups.

Cecilia: So, it's sort of, you know, there's fragments of the language. And when they do use it, it's in two different places, which I thought, you know, was like the classic illustration of the fragmentation - pieces like here is one box and then you know breastfeeding is this other box.

Aunchalee: Apparently, yeah. I mean, initially you had that immediate postpartum guidance in one place, you know, for within the facility and then you had all the breastfeeding stuff in a separate place. They didn't match at all. Right. And there's even internal consistencies within this updated guidance to for regarding like how do you test, and if you can't test, you just assume that the baby's a PUI.

Cecilia: This is a good time for you to talk a little bit about what your role has been in terms of the advocacy piece and then we definitely want to talk about some of the scientific issues about some of the assumptions that they're making in terms of immunology and milk.

Aunchalee: EA, in a lot of these discussions, it's really coming down to the degree to which we think the virus may be passed through milk through human milk. So, what can you tell us about the state of that that science and Sort of what you know where we go from here?

EA: I mean, right now - and again, you know, the thing we're consistently seeing with companies, everything is right now because the data are so new - right now, the data are pretty consistent that they can detect viral RNA, but no actual virus in milk. And so, it doesn't look like it's transmitted by milk.

Aunchalee: Can you explain the difference between being able to detect fragments of viral RNA and human milk versus active virus or disease causing virus in milk?

EA: Apologies, if we butcher the author's names! Gros et al. did report finding viral RNA. My kind of immediate read when I read this paper was, I wonder if the mother had mastitis that might be contributing? Because we know with mastitis you get increased leak leakage into milk because the cells in the mammary gland pull apart, it can get kind of leaky and that's a massive over simplification of a very complicated biological relationship, But you can get stuff in the milk you wouldn't normally, it would be something like that.

So, there doesn't seem to be a lot of evidence. I know a couple of groups are trying to study this. But right now, there's no evidence for like milk borne transmission.

I think that's where kind of the science is right now - it's struggling with how do you actually demonstrate this, um, and how, how do you actually get at that? I mean the the transmission the observational data for transmission mother to infant isn't there.

Aunchalee: And I would think it's like super difficult like with other respiratory infections, right? Because it's respiratory, it's really hard to rule out the fact that possible mode of transmission, given the proximity of either, you know, feeding at breast or chest versus expressing breast milk.

EA: I was thinking about this the other day, because you know I'm nursing, and my kid is his hand in my mouth. I'm like, well, what does it matter if it is the milk? He's got his hand in my mouth!

Aunchalee: Yeah right.

EA: You know, I think it kind of gets that that that more complicated picture that we were talking about in this kind of fetishizing human milk as something discreet from lactation.

You know, are women a risk to their milk? Or is there actual infectious potential from milk? And nobody's really demonstrated that, but we've seen, you know, you were involved in some of the kind of public awareness and pushback about this, about like how are you putting it on the containers, on the pump? Right, the handling instructions that were coming out for handling milk in the hospital. I mean, I think it's just so complicated.

And there's some really interesting studies going on now looking for, you know, actual transmissible virus in milk. I think the data right now aren't there and it, it may change. I will personally be surprised if it changes, but I mean most of my works about metabolism or metabolic adipokines in milk, not as much, the immunology of milk but I think…

Aunchalee: But, you know, even in the case of HIV/AIDS, for example, where we know that there's the virus that can be transmitted through either breastfeeding or expressed human milk, the recommendations remain that in most place, where the risk benefit ratio is so much in favor of continuing to breastfeed, exclusively breastfeed for the first six months, because of the low risk you have. It's not just that there is virus in the milk. There's all this other stuff happening.

EA: HAMLET!

Aunchalee: Right. That helps to keep those rates of transmission low, lower than if you're mixed feeding, and then the mortality rates are lower. When you're exclusively breastfeeding, even in the context of HIV infection in places where there isn't clean water, and there's not enough formula, and babies die far sooner from, you know, unhygenic formula feeding, I mean, I think there are good lessons to learn about, like, I mean it's of what the MCN paper concludes, and kind of waht Cecilia was emphasizing - that the evidence has should be so compelling to say like, yes, really we can't support this, right

EA: And the evidence is not that compelling right now.

Aunchalee: And I think almost in in very few circumstances is it.

Cecilia: There's so many assumptions.

We're asking what threat the milk poses. But we're not really asking, are there other things that the milk does that might actually provide a benefit for that infant I think that question is simply not even really being asked. We know that there are studies that are actually investigating antibodies in the milk because milk has, you know, all these amazing properties, some of which we don't even know. How they exactly work there was like a brand new study in Nature about, you know, the ways in which breastfeeding operates in relation to viruses in the gut.

What we know is that one of the key aspects of breastfeeding as an adaptation has to do with infectious disease, and yet we're not really talking about that. I thought that was pretty shocking, and then you know the other one we haven't quite touched on yet. But I think it's important, is

that all you know in line with those cultural expectations that we talked about where the mother is the only soul potential source of harm.

There's not a consideration for where else the baby might be exposed. Right, so like when they were making these recommendations, we had all these people all these healthcare workers who didn't have, PPE, had no access to testing and have huge exposures to the virus and they would be the ones handling the baby. Like many, many more times because the babies being taken away from the parent. that part wasn't really mapped out either.

So the idea of the baby, you know, once it's removed from its mother is all of a sudden in like a complete bubble, where the virus will not come to them and that you know once they get discharged will not come to them, it's just that's, that's a very interesting cultural assumption.

I think that's coming into the guidance. That I'm still trying to process. So, there's just the assumptions here are wide ranging, and we have a lot of work to do to have a more integrated perspective. And I think bringing in an anthropological perspective into that is not an easy task.

EA: Well, and in some ways, I think a lot of what we're talking about, really gets back to the point, Aunchalee you made much earlier in our discussion. And that is, that I mean so much of this is really illustrating problems that were already incredibly prevalent in society, particularly things like health disparities and long histories of structural inequalities. And that those are, are simply being amplified.

Aunchalee: These recommendations and practices that are being implemented, particularly the ones that are really looking at separation as a way to manage infection prevention and control within healthcare facilities, disproportionately affects Black and Indigenous and families of color, in the context of a country where we have a massive critical maternal and infant mortality crisis in these communities.

So, when we have these you know conversations about the negative impacts. they're not being if they're not being experienced the same way across all communities.

And that's another really fundamental thing to realize, is that who is bearing the burden of the out the fallout and the negative consequences? And that is definitely - that perspective, that racial equity perspective, that more historical perspective, the perspective of systemic racism in the systems that come up with guidance, like *none* of that is coming into .. you don't hear any of that any of the guidance that's coming out in our country, which is a problem. And there are organizations and advocates

who are really shedding light on that and try to, you know, continuing to emphasize that we need to approach, all of this with a clear racial equity lens. But the guidance assumes that everybody is, "the same," right? And not thinking about all these unintended consequences that will be felt in differently in different communities.

I mean, even the thing about shared decision making. This is a conversation we've had several times. Like, assuming that it's, first of all putting a very large burden on people who are laboring and birthing to be able to advocate for themselves in a place where they really are disempowered, and far more so if you are a person of color, you know, already having to deal with the racism that is often in play. Within these facilities and in this sort of being tasked with, "oh, I'm going to have to advocate for myself now. And, you know, not to be treated with providers who have bias against me. And also, I don't want to be separated from my baby." Like that is, you know, we know it will happen.

There are going to be some people, some patients and birthing individuals who have more agency and more audience and are able to advocate more effectively than others for the things that they want and others will be ignored. Just like they were before the pandemic, so it's…

Cecilia: Already coming in. I mean, the whole you know the vulnerabilities in a start all the way back from-who has the privileges of becoming Who, who has a privilege to stay at home. Who are the people who are not deemed, you know, essential. Who are the people who are going to be most exposed? So the exposure is already different, and then you know the existing baseline health is already different because of all the inequities, and then you get into the, the actual vulnerabilities of that situation which like there's no way anybody's in position to negotiate these.

I mean this, yeah, I think that the shared decision making, just is really, I mean, I'm glad that the language is there, but the implementation, it's not certainly not what we're hearing, we're not hearing that kind of decision making on the ground.

Aunchalee: No, absolutely not. And then there are people in communities that are almost completely erased from any conversation which are incarcerated mothers and individuals who are pregnant; folks who are houseless; folks who are undocumented, already at greater risk. And, we had a conversation with someone who's reporting that there are some individuals who are incarcerated and pregnant and being put into like solitary confinement as a way of preventing their exposure to COVID-19.

You know the basic human rights abuses that are happening, I mean, there are lots of really important ways of thinking about and talking about

advocating through the lens of anthropology and anthropological engagement in health and human rights and other different kinds of pandemics and humanitarian crises that are really essential to understanding this different conversations we should be having around it; essentially around not just the production of knowledge and these this kind of guidance, but also how they're how it plays out and actually, starts impacting you know people in their everyday lives and in different communities.

Cecilia: You've been very busy bringing exactly that perspective to the conversation.

Aunchalee: CGBI is also part of the in Emergency Nutrition Network's (ENN) Infant Feeding in Emergencies (IFE) core group - we sit on the steering committee. So, we were you know, part of the group that puts together like the joint statement for infant feeding in emergencies that can be used at the country level to advocate for best practices to support in being a child feeding and emergencies. We're part of the Global Breastfeeding Collective - again these are organizations that operate it really high levels, trying to influence country level policies. And then in the US, we are a co-steward of the United States Breastfeeding Committee. There's a constellation, the COVID-19 and infant feeding constellation, which represents organization, as they like to say from grassroots to treetops. So, community organizations health care professional organizations public health agencies and organizations all up to federal level policy decision makers, coming together to talk about these emergent issues, like a lot of the same things we've been discussing here: how to support organizations at all levels of that social ecological model or framework for supporting lactation and safe infant feeding in this crisis. Really trying to advocate for better investment in communities, investment and telehealth, scaling up things like doulas and midwives and community health workers and lactation support persons in the community, to be able to deliver the care that so desperately needed in the wake of these practices that are disrupting lactation.

You know trying to come up with solutions for ensuring that people who need formula have the formula that they need in a way that protects them from the harmful marketing that comes from a commercial interests.

You know, I am my heart and my training, and my work is really in the community. And so, I'm continuing to think about what opportunities we have to better support lactation for population, you know, like incarcerated persons and people who are you know caught up in situations where they have to use emergency shelters or who are otherwise disenfranchised and don't have the same access to resources as others do and for whom having good solid, support for lactation and

infant feeding is actually really important for the health and well-being of themselves and also for the infant in the short term. So really, really busy. It's a lot, you know, it's a lot. And I'm not alone.

I mean, I think, I think about all of my colleagues who are in organizations. that have tirelessly been working to support Black and Indigenous communities of color before the pandemic, who are also –

Everything is on just hyperdrive. Now all the work that they're doing, all that they're giving and continue to give every day to their communities.

People are working really, really hard.

Cecilia: It's a lot. It's a but you know I think and not trying to say that it's not a valorization by any means, but you're shouldering a lot and it also shows that the contribution that you're able to make by bringing anthropological perspectives into that space is invaluable. Because really, that is not very common. I think all three of us know that it's not the kind of conversations that we often have to negotiate are dominated by people with different kind of training and the kinds of larger global perspectives and the focus on, you know, inequities and I don't think is the most common perspective is certainly not.

Aunchalee: It's not common. And it's, I mean, honestly, in some places, it's just It's not as highly valued and people don't often know what to do with it.

But I think the thing that grounds me in that work, and especially we're talking to these like very high level discussions about guidance, and what kinds of guidance should we be advocating for at the country level or at the Ministry of Health level or even at that like humanitarian organization level, my immediate perspective is always to think about, “well, how? What's that going to look like on the ground, and what is the implementation going to be like, and what are the things that we should be considering?

And I think my anthropological training was so deeply ingrained in communities, and I'm looking at, you know, yeah, we have this like strong guidance, but that doesn't - it's impossible to put into practice. So what do people do in those situations?

And really, I think, in my mind, that I'm always kind of going back and forth between that global and local that sort of production of knowledge and guidance and then how that plays out in people's lives. And that, I think that does help me to just have a different - it's just a very different way of looking at things, like you know emerging infectious diseases in different places.

And I think anthropologists typically like we tend to really understand that we have to look at the margins. We have to look at those places where people's experiences are erased, or whether or not you know, people are kind of just ignoring what's happening in a meaningful way and kind of start there.

Otherwise, even the best lead guidance is not going to cover, you know, it's not going to create equitable access to care for the people who are, you know, most in need.

EA: And often international context, looking at community ways of knowing and managing can also be so incredibly insightful.

Aunchalee: Yeah, absolutely. And it makes sense. And it's consistent with their values and what their experiences and that is going to input makes it effective and I think we're already seeing in places that had a strong Ebola response and have that experience already are having a strong - like they already have a network, and already have trained people in place to do the contact tracing, the testing, and those kinds of things, like rapidly mobilizing.

I spoke about this in a webinar earlier, like the community health worker model has been around like probably since the beginning of global health work. And it is not a perfect system, but it is such a nimble responsive system that takes care to people that would be perfect to implement and you know it's a really great tool in any kind of disaster emergency, right, particularly in a place where you have, you know, shelter-in-place orders and people can't get to the care. Give them PPE and help them take the care, you know and do the things that they need to do in their communities. And you train people from within the communities to be these community health workers and then you have like the sustainability programs.

There's so much wrong with our healthcare, you know, we don't have universal health care if you have to pay like inordinate amounts of money to get a COVID-19 test or like you know, worried about how they're going to pay for their health care, like it's ridiculous that we're in the middle of a global health pandemic -people shouldn't be worrying about how they're going to pay for their medical bill. And yet that is their reality.

Cecilia: It's how you do things

Aunchalee: We could do things so much better and in other places that are well prepared.

Cecilia: Better cheaper and learn from

Aunchalee: interactively exactly I mean it's it's not
Cecilia: Yeah, it doesn't have to…

Aunchalee: be that hard.

Cecilia: Like this. I think that that's like one of the hardest things to watch and you know I think both of your points like the erasure of any indigenous knowledge that might exist. You know, like that doesn't enter into the conversation. It has to be all top down, it has to come from, particular kinds of experts forget how people have survived really horrible conditions, many parts of the world. And then, not learning from those models of healthcare that are tuned into communities. It is shocking. The arrogance, the condescension of some of the people who believe that it's impossible. You know, this sort of like I'm gonna throw my hands up in the air and I'm just gonna be like, what's cool, you know, we're just gonna let you know a few million people die like no I mean I don't think that's an acceptable response. It's morally untenable response.

Aunchalee: Yeah. That says a lot about who, you know - some people care about who lives and who dies, you know Or, some people care more about some people living and they don't care about other people, I guess.

Cecilia: Oh, absolutely.

Aunchalee: Yeah, and even like the Hawaii State Commission on the Status of Women put together this like feminist recovery plan for COVID-19 and it's just beautiful. It was led by Native Hawaiian women and it was very intersectional feminist approach, kind of weaving together building the strength of the economy through gender equity through health and well-being through environmental stewardship, like this very holistic integrated, very forward-thinking approach. And even their definition of feminist is very inclusive and it's just like within you know within the first weeks of the epidemic already having this time. I think we need, we have the lessons learned here it's like, "this is what we need to do." We can't just be focusing on these different things piecemeal, and we have to really be invested in the health and well-being of women who are supporting communities and families and the economy and all of these ways that have been disenfranchised. Like, I think really I, you know, being able to elevate and amplify those kinds of movements, thinking about, you know, indigenous culture and just this perspective on community that is so essential. That is what's going to be the way that we move forward and we have any semblance of, you know, recovery or resilience.

Cecilia: I feel like that's a great ending point for our discussion today.

[*Music*]

You've been listening to Anthrolactology. It's a podcast about breastfeeding, science, and society!

Anthrolactology is hosted by me, Aunchalee Palmquist, EA, and Cecilia.

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[*Music*]

-END-

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Community Action Nepal (CAN) https://www.canepal.org.uk/

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Johns Hopkins Nursing blog post about the MCN article:
https://magazine.nursing.jhu.edu/2020/06/mother-infant-contact-and-breastfeeding-should-remain-top-priorities-during-covid-19/

Tomori's ILCA webinar presentation:
https://ilca.informz.net/ilca/pages/COVID_19_Webinar?fbclid=IwAR08qJoE3NLV9DOFqVoMH9YWnkg1AcbCNx0E2iWkWW9nzyK4pV8fSW7Mozw

Links to updated AAP guidance (as of 7/23/2020):
https://services.aap.org/en/pages/2019-novel-coronavirus-COVID-19-infections/clinical-guidance/faqs-management-of-infants-born-to-COVID-19-mothers/