THUNDER BAY AND DISTRICT

2025 LACTATION SERVICES SCAN REPORT

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Land Acknowledgment

We respectfully acknowledge and are grateful to live and work on the traditional lands of First Nations within the Robinson-Superior Treaty of 1850, Treaty 9 and Treaty 3 areas. We also acknowledge the contribution that the Metis have had areas across theses lands.

Statement on Inclusive Language

We acknowledge that not all individuals who become pregnant, give birth or lactate identify as female and that some may identify as non-binary, transgender or gender-diverse. To reflect this diversity and promote respectful, inclusive care, we aim to use desexed or gender-inclusive language in our written materials such as referring to a "lactating person" rather than "mother"and use "breastfeeding" and "chestfeeding" interchangeably where appropriate. However, in some contexts, sex-specific language may be used to ensure clarity or align with the language of clinical guidelines and research. In such cases, we emphasize that our intent is always to be inclusive of all individuals who breastfeed, chestfeed or provide human milk to their children.

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Abstract

Lactation support is a critical component of maternal and infant health promotion, yet access to such services remains uneven across geographic regions. This qualitative scan explores the available services and perceived gaps in lactation related services across the City of Thunder Bay, the surrounding District and a nearby community in Northwestern Ontario through semi-structured interviews with 20 service providers.

Findings reveal clear disparities in service access between the City of Thunder Bay and the surrounding District, with District programs facing more pronounced challenges related to staffing, resources, transportation and cultural sensitivity. The City of Thunder Bay services demonstrate greater service diversity and integration. However, both settings demonstrated inconsistent approaches to public health promotion and client engagement. Importantly, the study identified the need for more culturally appropriate and community informed approaches, particularly in working with Indigenous families.

The scan concludes with region specific recommendations emphasizing the role of public health in improving coordination across systems to ensure seamless service delivery and ensuring equitable, culturally safe lactation support. These insights can inform future program planning, cross-sector collaboration and policy development aimed at reducing service inequities and improving breastfeeding/chestfeeding outcomes across the City of Thunder Bay and District in Northwestern Ontario.

Background and Public Health Relevance

Lactation support plays a critical role in public health by promoting breastfeeding/chestfeeding, both of which have well-documented benefits for infant and maternal health. These include improved nutrition, enhanced immunity for infants and reduced risk of chronic diseases for both the parent and child (World Health Organization [WHO], n.d.). However, access to comprehensive lactation services is not always equitable or consistent across geographic regions, particularly in rural or underserved areas. Understanding the current landscape of lactation services is therefore essential for addressing service gaps and supporting optimal health outcomes.

Literature Review

Below is a brief overview of the literature's relevance to the current scan. The complete literature review can be found in Appendix A.

Introduction

Breastfeeding/chestfeeding is widely recognized as an essential part in supporting infant and maternal health. According to the World Health Organization (WHO), exclusive breastfeeding for the first six months is recommended due to its improved health, cognitive, emotional and economic outcomes (World Health Organization [WHO], n.d.). Despite these clear advantages, breastfeeding rates in Canada remain suboptimal, especially in underserved communities. Public health services have a critical role in health promotion, addressing these barriers and encouraging breastfeeding through a wide range of support, from prenatal education and baby-friendly initiatives (BFI) to feeding assessments, postnatal support and peer counseling programs. By offering consistent, evidence-based guidance, public awareness of positive health outcomes and hands-on assistance, public health agencies can help ensure lactating individuals feel supported throughout their breastfeeding/chestfeeding journey (Public Health Agency of Canada, 2014; 2019).

Gaps and Limitations in the Literature

- Most studies focus on clinical or hospital-based care, not community-based programs or public health units
- Limited research exists on how services are delivered in rural/remote areas like Northwestern Ontario
- Few studies explore how well public health agencies and community organizations collaborate to deliver lactation support
- Majority of studies are conducted on client perspectives, not health care providers

Relevance to the Current Scan

This literature review supports the need for qualitative, community-focused research that centres the voices of public health and community service providers. The Lactation Scan project fills this gap by exploring the local delivery of lactation support across Thunder Bay and District, highlighting where public health can better bridge existing service gaps in this region.

Purpose of the Scan

The Lactation Scan was conducted to assess the availability, accessibility and types of lactation-related services in the City of Thunder Bay and the surrounding District. Services considered under the umbrella term “lactation” included direct support (e.g., lactation consultants), education and adjunct services (e.g., massage therapy). The scan aims to

identify both existing strengths and areas for improvement within the current service landscape.

The Thunder Bay District Health Unit serves a large geographic region in Northwestern Ontario, encompassing the City of Thunder Bay as its largest urban centre in addition to 14 other municipalities, 25 First Nations and unorganized communities and rural areas across the Thunder Bay District (Thunder Bay District Health Unit, 2024). For the purposes of this scan, "Thunder Bay" refers specifically to the City of Thunder Bay, while "the District" refers to the remainder of the Thunder Bay District, excluding the city. When referring to both, "Thunder Bay and District" will be used. Throughout this scan, we will differentiate between urban and rural services. The City of Thunder Bay will represent the "urban" category, while the District will represent the "rural" category. When referring to services that operate in both the City of Thunder Bay and the District, the term "combined" will be used. Services operating outside of the Thunder Bay and District catchment will be included in either the "combined" or "outside region" category.

Research Objectives

The specific objectives of the Lactation Scan were:

- To identify and describe the types of lactation related services currently available in Thunder Bay and District
- To understand perceived gaps in services from the perspective of service providers
- To explore opportunities for collaboration and enhancement of lactation support in Thunder Bay and District
- To inform the Thunder Bay District Health Unit's role in the broader landscape of lactation services across Thunder Bay and District

Scope of the Scan

This Lactation Scan was conducted within the geographic boundaries of Thunder Bay and District, with one additional participant from a Northwestern Ontario community outside the region due to their community members accessing lactation services within Thunder Bay and District and a collaboration among community partners and healthcare providers. The Lactation Scan focused on services who provide, support or refer to lactation services, including healthcare providers, public health professionals, community organizations and allied health practitioners. Data collection included participants from both urban and rural areas to ensure diverse representation of service experience and needs, including organizations from public health, primary care, acute care, allied service providers, early years organizations, Indigenous communities and the violence against women sector.

Design and Rationale

This scan used a qualitative research design, specifically semi-structured interviews, to gather rich, contextual information about local and regional lactation services. This approach was chosen to allow flexibility in exploring participants' knowledge, experiences and insights about available services and unmet needs.

Participant Recruitment and Sample

A combination of purposive and snowball sampling strategies were used to recruit participants. Initial outreach was conducted via email to known service providers and organizations, with a request to forward the invitation to other relevant contacts. The recruitment materials included an information sheet about the scan and a list of interview questions to help participants understand the purpose and scope of the scan.

Between February and May of 2025, there were 20 interviews conducted with a range of participants, including public health staff, healthcare providers (e.g., nurses, midwives, physicians, dietitians, massage therapists, lactation consultants), health care leaders (e.g., managers, coordinators) and representatives from community organizations. Participants were geographically distributed across Thunder Bay and District, with one additional participant from a Northwestern Ontario community outside the region, ensuring input from both urban and rural areas was obtained.

Ethical Considerations

Prior to data collection, the team completed the Public Health Ontario (PHO) Risk Screening Tool, which determined the project to be "1 – Likely Low Risk. Additional Information May Be Required." Participants were informed of the voluntary nature of the scan, the purpose of the interview and how their information would be used. Verbal consent was obtained before each interview. Confidentiality was maintained throughout the project by securely storing data and de-identifying participant information in any reporting (Public Health Ontario, 2024).

Data Collection Methods

Interviews were conducted by phone or via Microsoft Teams, depending on participant preference. Audio was recorded using digital recorders. All recordings and transcripts were securely stored in a confidential folder accessible only to the project team. Verbal consent to audio recording was obtained from all participants.

Data Analysis Approach

The interview data was analyzed using thematic analysis guided by Braun and Clarke's (2006) six-phase framework, which provides a systematic approach for identifying, analyzing and reporting patterns within qualitative data. After the interviews were transcribed verbatim, the research team familiarized themselves with the data through repeated readings. Initial codes were generated inductively (emerging from the data). The team then collaboratively searched for themes by organizing codes into broader categories, reviewed and refined these themes for consistency and relevance and defined the final themes that best captured key findings across the 20 interviews. The top 3–5 themes were selected based on frequency, depth and their significance in addressing the research questions. This approach ensured a detailed and credible representation of the current landscape of lactation services in Thunder Bay and District (Braun & Clarke, 2006).

Findings

This section presents key themes that emerged from 20 semi-structured interviews conducted across the Thunder Bay and District, with one additional participant from a Northwestern Ontario community outside the region. To highlight geographic variation, findings may be presented with distinctions between urban, rural, combined and outside region services.

Current Services Offered

Participants identified a variety of lactation-related services, including clinical care, education and adjunct supports such as infant massage and feeding assessments. These services vary by region and are presented in two sections: service availability and specific service elements. This regional variation is further illustrated by the emerging themes outlined in Table 1. and Table 2.

Table 1. Lactation Services Available

Thunder Bay Services		
Prenatal Classes (Drop In)	Prenatal Packages and Handouts	Baby Friendly Initiative Course
Online Prenatal Class	Hand Expression Education Classes	Prenatal Cooking Programs
Pumping Consultation	Feeding My Newborn Classes	Caring for My Newborn Classes
Lactation Clinic - IBCLC	Lactation Home Visiting	Bottle Refusal Education
Lactation Cultural Awareness and Traditional Teachings	Postnatal Follow Up in Clinic and Home Visiting	Medical Evaluation of Breastfeeding in Clinic
Lactation Classes (Drop In)	Infant Nutrition/Lactation Presentations	Lactation Peer Support Groups
Well Baby Clinic and Home Visiting	Infant Massage and Movement	Feeding Positioning Assessments
The District Services		
Prenatal Clinic and Home Visiting	Prenatal Packages and Handouts	Online Prenatal Class
Well Baby Clinic and Home Visiting	Lactation Clinic - Indigenous IBCLC	Breastfeeding/Lactation Referrals
Postnatal Follow Up in Clinic and Home Visiting	Lactation Cultural Awareness and Traditional Teachings	
Outside Region Services		
Breastfeeding Education/Resources	Baby Friendly Initiative Course	Breastfeeding Peer Support Groups
Breastfeeding Champions	Lactation Support - IBCLC	Lactation Cultural Awareness and Traditional Teachings

Table 1. summarizes the range of services described across regions, offering insight into broader themes related to access, comprehensiveness and cultural safety.

The following findings and emerging themes are drawn from data in Table 1.

Theme 1: Greater Variety and Specialization of Services in Urban Areas

Thunder Bay programs offer the widest range of lactation services, including specialized classes and services (e.g., Feeding My Newborn, Infant Massage and Movement), clinical supports (e.g., IBCLC-led clinics, pumping consultations, medical breastfeeding evaluations) and peer-led interventions. The inclusion of programs like bottle refusal education and hand expression classes points to a higher level of service specialization that have not been reported as available in rural settings. This variety likely reflects on greater resources, higher staffing levels and more organizations concentrated in urban regions like Thunder Bay.

While no direct quotations are available due to the closed-ended nature of the question (participants responded with the lactation services they provide), the majority of responses aligned with the above theme.

Theme 2: Broad Programs and Services Offered in Rural Areas

The District programs focus on essential and more generalized prenatal and postnatal services such as prenatal packages, pre and postnatal home visiting and clinic follow-up rather than lactation specific services. The presence of a new Indigenous IBCLC-led lactation clinic in a rural setting is significant and reflects growing efforts toward culturally aligned care. However, the limited number of available services in the District compared to Thunder Bay highlights ongoing issues of resource constraints and access disparities. Notably, group classes and drop-in supports are lacking in the District, potentially impacting peer connection and sustained engagement.

"For us I would say… we don't necessarily have a program for it [lactation services]." (Participant 6)

"We do what we can in terms of lactation education but it's pretty limited. It's whatever our rural staff is able to support." (Participant 9)

"We don't have a specific lactation consultant or anything here so we just do prenatal visits, myself and the dietitian." (Participant 10)

"There's no formal program within our…team around breast or chestfeeding" (Participant 13)

"I am an Indigenous Lactation Counselor. I just received that certification earlier this year… I haven't had a chance to really use it … I did try to get a new mom support group going on." (Participant 15)

Theme 3: Emphasis on Cultural Safety and Indigenous Support Across Regions

All settings include some culturally focused lactation services, such as Lactation Cultural Awareness and Traditional Teachings and Indigenous IBCLC supports. These services appear in both Thunder Bay and District and the outside region, suggesting an encouraging trend toward equitable and culturally responsive care for the Indigenous population in both urban and rural communities. The presence of culturally focused lactation services underscores the importance of not only clinical lactation support but also the cultural context in which infant feeding takes place.

"We use a culturally sensitive lens when delivering all of our programming." (Participant 12)

"Our program is very focused on culturally based teachings." (Participant 14)

"I am ensuring that our services are approachable and really tailored to community needs and culturally appropriate, culturally relevant care, inclusive of traditional practices. I think that is what is most helpful, that we have built a level of trust and the community workers know they can come to us." (Participant 20)

Theme 4: Peer Support and Education Vary Widely by Region

Thunder Bay and the outside region include peer support groups and initiatives such as breastfeeding champions, while the District lacks these services. Peer-led programs are important for maternal mental health, empowerment and continuity of care (McLeish & McCourt, 2023). Their absence in the District highlights a gap in social and emotional support for new parents that may need to be addressed in future program development.

"I think groups would be a nice way to connect people together as a community but also it's an easy way to share information and correct any misinformation." (Participant 8)

"Something more formalized in terms of feeding support groups in town so people don't feel like they're doing it alone and they can share how hard it is and the challenges that they have, because sometimes I still think that parents feel alone in feeding." (Participant 13)

Theme 5: Standardized Tools, But Uneven Delivery

Certain services and tools such as prenatal packages, breastfeeding education handouts/kits and online prenatal classes are found in both Thunder Bay and District, suggesting that there is some standardization of educational tools. However, these tools alone may not be sufficient to meet the broader support needs of breastfeeding caregivers, when hands-on, in-person support is required, especially in rural or remote areas where service diversity is limited.

"I would like to see something that's local, where we can refer people for lactation consultation." (Participant 9)

"We only serve urban Indigenous … occasionally I think we've had some clients come from different reserves but they usually have a home base in Thunder Bay somehow, they are coming here visiting family or for other appointments." (Participant 12)

Summary of Lactation Services Available

Overall, the data illustrates how urban programs tend to offer broader, more specialized and peer-integrated lactation services, while rural programs provide core care with a focus on accessibility and cultural safety. Outside region offerings reflect a mix of cultural responsiveness and advocacy-based models. These differences point to regional inequities, but also opportunities for cross setting learning and innovation, particularly around community-based and culturally safe care.

Specific Service Elements

This next section is a continuation of current services available, expanding on the service elements provided. The following themes are drawn from data in Table 2.

While no direct quotations are available due to the closed-ended nature of the question (participants responded with 'yes' or 'no' to whether the service element was present), majority of responses aligned with the following themes;

Table 2. Comparison of Lactation Service Elements Reported

Service Elements	Yes - Thunder Bay Specific (n = 10, %)	Yes - District Specific (n = 6, %)	Yes - Thunder Bay and District (n = 3, %)	Yes - Outside Region (n = 1, %)
Promote Education/Knowledge	9 (90%)	6 (100%)	3 (100%)	1 (100%)
Skill Building	8 (80%)	5 (83.3%)	3 (100%)	1 (100%)
Contributing to Education/Skill Building of other Professionals	5 (50%)	1 (16.6%)	2 (66.6%)	1 (100%)
Policy, Procedure or Protocol Development	3 (30%)	2 (33.3%)	2 (66.6%)	0 (0%)
Participation or Organization of Community Events	8 (80%)	1 (16.6%)	2 (66.6%)	1 (100%)
Advocacy Work	8 (80%)	3 (50%)	3 (100%)	1 (100%)
Screening and Assessment	7 (70%)	5 (83.3%)	2 (66.6%)	0 (0%)
Referrals	10 (100%)	6 (100%)	3 (100%)	1 (100%)
Direct Client Counselling	8 (80%)	4 (66.6 %)	3 (100%)	1 (100%)
Peer Support	5 (50%)	1 (16.6%)	3 (100%)	0 (0%)
Drop In or Informal Group	6 (60%)	1 (16.6%)	2 (66.6%)	1 (100%)
Home Visits	4 (40%)	3 (50%)	3 (100%)	0 (0%)

Table 2. The availability of various lactation support elements was assessed across four categories of service areas: Thunder Bay Specific (n=10), the District Specific (n=6), Programs serving both Thunder Bay and District (n=3), and an Outside Region (n=1). The findings demonstrate both similarities and variability in the types of services offered across these regions.

Theme 1: Education and Referrals as Core Practices

Across all regions and services, education/knowledge promotion and referrals were reported as universally provided services. Every participant (100%) in the District specific, Thunder Bay and District and the outside region, and nearly all (90%) Thunder Bay specific participants, indicated offering these components. This consistency suggests that education forms a foundational core of lactation support, while referral services play a key role in facilitating successful connections and resources across geographic settings and programs.

Theme 2: Limited Service Scope in District

Participants from the District specific services reported providing significantly fewer service components compared to participants from Thunder Bay specific and the Thunder Bay and District combined services. For example, only 16.6% of the District specific participants offered peer support or drop-in groups, compared to 50–100% in urban and other regions. Similarly, the District specific participants showed lower involvement in advocacy work (50%), policy development (33.3%) and community event participation (16.6%). These findings suggest geographic inequities in the availability and range of lactation services.

Theme 3: Peer and Community-Based Support Is Unevenly Distributed

Services that facilitate informal support or peer-led engagement such as peer support groups or drop-in services were common in Thunder Bay specific services (50–60%) and the agencies that served Thunder Bay and District (66.6%) but these peer and community-based supports are rare in the District specific settings. This may indicate that the District clients have fewer opportunities for community building or ongoing informal support, which are often key components of maternal and lactation care (McLeish & McCourt, 2023).

Theme 4: Structural and System-Level Involvement Varies

Engagement in activities such as policy development and contributing to the education of other professionals was inconsistent across regions. These functions were more commonly reported by Thunder Bay specific agencies and Thunder Bay and District combined participants and almost absent when reported by the District specific participants. This may reflect structural or organizational constraints limiting rural providers' participation in systems-level work.

Summary of Lactation Services Elements

Overall, the data reveals clear geographic differences in the scope and nature of lactation services. While education and referrals are consistently offered across all settings, other service elements such as peer support and community engagement are less evenly distributed, with rural programs reporting more limited offerings. These disparities suggest potential gaps in access and comprehensiveness of care for clients in rural areas.

Access and Cost

Participants further elaborated on the lactation related services they provide, discussing how they are accessed and associated costs, as well as the format, mode and location of service delivery. These characteristics varied by region and are further illustrated in Table 3. and through emerging themes.

Table 3. Overview of Lactation Support Services by Region

Organization Region	Delivery Format	Mode of Service	Location of Services	Cost of Service
Thunder Bay	One-One; Group	In-Person; Virtual; Phone; Email	Ontario Early On; Hospital; Community Facility; Family Health Clinic, Health Unit; Indigenous Organization, Schools, Home	None; $20-$30 for groups; $75-$400 private sessions/packages
The District	One-One; Group	In-Person; Virtual; Phone	Ontario Early On; Hospital; Community Facility; Family Health Clinic, Health Unit; Indigenous Organization; Day Care, Home	None
Thunder Bay District	One-One; Group	In-Person; Virtual; Phone; Email	Clinic/Family Health; Community Facility; Indigenous Organization; Home	None
Outside Region	Group	In-Person; Virtual; Phone; Email	Community Facility; Clinics, Family Health Clinic; Indigenous Organization; Home; Hostile	None

Table 3. summarizes the characteristics of lactation support programs across Thunder Bay, the District, the Thunder Bay District and outside region, for an expanded version of the table please refer to Appendix B.

Theme 1: In-Person Lactation Support Remains Key While Virtual Access Varies

Across all regions and services, in-person lactation support remains a consistent and foundational component of care, with 100% of programs offering in-person lactation services. This hands-on approach is especially valued in situations requiring practical and immediate assistance with breastfeeding and infant feeding challenges. Thunder Bay participants reported the broadest range of delivery formats, including one-on-one appointments, group education sessions, phone appointments, email follow-up and video-based lactation services. Many Thunder Bay participants combined these formats, allowing for tailored service plans that better align with families' schedules, learning preference and comfort levels. In contrast, The District specific agencies and some Thunder Bay and District combined participants reported more limited delivery options. While virtual and other remote communication methods are increasingly adopted by Thunder Bay specific and the Thunder Bay and District combined participants (with 70–100% offering these options), the District specific participants reported relying more heavily on in-person visits and some phone contact, with limited to no use of email or video. This uneven access is influenced not only by provider resources but also by client barriers, such as lack of reliable internet and limited access to technology or devices. These disparities highlight ongoing regional gaps in lactation service delivery.

"I just think when people are really struggling to feed, it's that hands-on support that they need. So I would love to see lactation consultants in the district, or traveling lactation consultants." (Participant 13)

"We just completed our [name of report] survey that really indicated that people prefer face to face, hands on resources versus virtual." (Participant 20)

"Not all of our families have access to a device that they can use to see things on social media, or maybe they don't have a phone, a phone number or the numbers changing often, so it can be kind of hard for us to get in touch with them, to let them know about the services that we have going on." (Participant 14)

"We do have a handful of people who don't come either and we have a hard time reaching… just not having phones, not having access to emails, transportation to the clinic, those would be the big barriers for those individuals." (Participant 19)

Theme 2: Fee-Based Models Are Concentrated in Urban Programs

Only Thunder Bay participants reported charging fees for lactation support services, with private sessions and packages ranging from \$75–\$400 and group classes between \$20–\$30 per participant. No District specific participants reported any costs to clients. This regional discrepancy suggests that urban areas like Thunder Bay may have more private or hybrid funding models, likely reflecting differences in clientele demographics, service infrastructure and provider availability. Conversely, the District appears to prioritize cost-free access, possibly as a measure to increase equity in lower-resource or geographically isolated settings.

While no direct quotations are available due to the closed-ended nature of the question (participants responded with 'yes' or 'no' to whether services had a cost), the majority of responses aligned with the above theme.

Theme 3: Service Location Diversity Is Greatest in Urban Settings

Thunder Bay participants reported a wide range of places to offer services, including hospitals, homes, clinics, early years centres, schools, Indigenous organizations and community centres. The District programs used fewer locations, but they were more connected to the local community such as clinics, hospitals, homes and Indigenous organizations. Thunder Bay and District services combined both approaches and the program outside the region took place in less typical places, such as shelters or housing services. These findings suggest that Thunder Bay lactation services have more resources and partnerships, which likely help them reach more people and make services highly visible.

"It's actually a collaborative program developed with us and… [named two organizations]." (Participant 1)

"In terms of community programming we have a partnership with … [named three organizations] … and we did start a partnership with … [named two other organizations]." (Participant 12)

"One of my priorities would be… collaborating with the partners in the area to do, maybe programs, groups and home visits with their teams." (Participant 19)

Theme 4: Home-Based Services Support Accessibility in All Regions

Home visits or home-based services were reported as available by 55% of participants, suggesting that this type

of service is an important strategy for improving access especially for postpartum families. Their consistent use across both Thunder Bay and District reflects an awareness of common barriers such as lack of transportation, childcare responsibilities and equitable access. For many families, traveling to appointments can be challenging due to the high cost associated, limited public transit options and expensive or limited parking at clinics and hospitals. Home-based care helps reduce these burdens, making it easier for families to receive support during the postpartum period. This approach promotes more equitable access, particularly for those with fewer financial or logistical resources.

"Sometimes people with a new baby are overwhelmed and they can't leave their other kids. They don't have childcare. It's just difficult to have many appointments and leave their home." (Participant 7)

"That's going to be a big part of this program is offering those services [home-based services], because I find if we rely on people coming to see us from like a poster, it's not going to be as successful as if … especially when moms have midwives … they're already getting those home visits, so to make them leave the house every time is … all right". (Participant 11)

"But the cost for parking can be a bit tricky for some people to manage. So I would say the main barriers would be the availability of appointments and the costs associated with attending appointments." (Participant 12)

Theme 5: Group Services Are Less Common in Rural Settings

While group formats for lactation support (e.g., breastfeeding classes, drop-in sessions or peer support groups) were consistently reported in Thunder Bay specific agencies and Thunder Bay and District combined programs (80–100%), they were noticeably less reported by the District specific participants. Only one District participant indicated offering group-based lactation services, with most relying solely on one-on-one breastfeeding support. This disparity may result from lower population density, transportation challenges or limited staffing, which can make it difficult to sustain regular group activities. The absence of group options in the District may restrict opportunities for peer support, social connection and shared learning during the postpartum period.

While no direct quotations are available due to the closed-ended nature of the question (participants responded to whether services were delivered in-person, online, by phone or in some other way), the majority of responses aligned with the above theme.

Summary of Access and Cost

In summary, the data highlights notable regional differences in how lactation services are accessed and delivered. While in-person care and home-based visits remain important across all settings, urban areas such as Thunder Bay demonstrate greater flexibility in delivery formats, service locations and funding models including the use of virtual tools and fee-based services. In contrast, rural and District specific programs offer fewer service options, often constrained by resources, technology access and staffing limitations. These disparities affect not only how families engage with lactation support but also their opportunities for community connection, particularly where group services are scarce. Overall, the findings point to ongoing geographic inequalities affecting access to lactation services.

Intended Audience and Reach

In addition to examining how services are delivered, participants also spoke to who these services are intended to support. Understanding the target populations for lactation services provides insight into program priorities, the reach of current offerings and how well they align with the community and district needs. The intended audience and effective strategies for reach vary by region and are further analyzed in Table 4. and through the surfacing themes.

Table 4. Intended Audience Served

Intended Audience	Yes - Thunder Bay Specific (n = 10, %)	Yes - District Specific (n = 6, %)	Yes - Thunder Bay and District (n = 3, %)	Yes - Outside Region (n = 1, %)
Preconception	3 (30%)	2 (33.3%)	2 (66.6%)	1 (100%)
Prenatal	7 (70%)	6 (100%)	2 (66.6%)	1 (100%)
Postnatal	9 (90%)	5 (83.3%)	3 (100%)	1 (100%)
Newborns	5 (50%)	1 (16.6%)	1 (33.3%)	0 (0%)
Children 0-6	4 (40%)	0 (0%)	1 (33.3%)	0 (0%)
Family Supporting Breastfeeding	4 (40%)	2 (33.3%)	3 (100%)	1 (100%)

Table 4. illustrates the distribution of intended audiences for various lactation services across four categories of service areas: Thunder Bay Specific (n=10), the District Specific (n=6), Programs serving both Thunder Bay and District (n=3), and Outside Region (n=1). The percentages represent the proportion of respondents (n) within each category who explicitly identified a specific population group as an intended audience for their services. The absence of a group does not mean they are not being served, only that they were not named as a primary audience during data collection.

Intended Audience

Across the data, the most commonly identified intended audiences were individuals in the prenatal and postnatal stages, highlighting a strong focus on supporting people during pregnancy and the early postpartum period. Preconception care was also noted, though less consistently across regions. While newborns and children aged 0–6 were less frequently named as primary audiences, they still appeared in several responses, particularly in agencies that serve Thunder Bay and District and outside the region. Family members who support breastfeeding individuals were also identified in multiple contexts, suggesting attention to those who may be indirectly involved in infant feeding. Overall, the data reflects a primary emphasis on maternal and early child health, with some variation based on geographic context.

Effective Strategies for Reaching the Intended Audience

When participants were asked how they reach their intended audiences for lactation services, a variety of strategies emerged. While some approaches such as word of mouth and referrals were mentioned across both urban and rural interviews, some differences remained. This section presents four key themes and explores how they were expressed differently across urban and rural settings: connections and networking, word of mouth, referrals and social media use.

Theme 1: Connections and Networking (Urban)

Thunder Bay participants frequently spoke about the value of inter-organizational partnerships. Being part of coalitions (e.g., perinatal networks) and maintaining relationships with hospitals, public health units and community programs (e.g., early years centres) were described as imperative for visibility and service integration. Having connections with various organizations has reportedly helped programs reach different demographic groups than their intended audience.

"We reach the intended audience a lot through our kind of network and connections with other organizations... the perinatal coalition is a big one…We do have a collaboration with [named organization] … but we have noticed that it is a different demographic than we tend to get at some of the other groups. That's a good site to do different outreach at and try to connect with families." (Participant 1)

"[this organization], especially with this age group, has a pretty well-established presence in the community and with different organizations." (Participant 2)

"I have a good rapport with the providers who are also seeing these young families so they are aware and inclined to connect them with me if they feel it would be useful." (Participant 7)

"I was lucky when I was working as a [states role], I did make lots of connections with our allied health professionals…and then having the connection with our midwifery clinics." (Participant 8)

Theme 2: Word of Mouth (Combined)

Word of mouth was a consistent theme, often linked to increased attendance at clinics and support groups in both the Thunder Bay and District settings. Participants noted that families with positive experiences often shared them within their social circles, helping to organically expand service reach. Additionally, healthcare providers who actively promote their services to the public and to other providers tend to see higher attendance and engagement.

"We've heard just positive things and overall have had an increase in our numbers coming to the clinic." (Participant 3)

"I would say mention it in every appointment, every visit, just to let them know that it [our service] is there and it is offered to people." (Participant 6)

"I'm often surprised by the number of people who say my friend came and said it was really useful to her". (Participant 7)

"I pretty much cold called multiple clinics, multiple professionals to meet with them just to discuss their services, if we could ever collaboratively treat. Honestly, I think it was just me pounding pavement that I think helped in the long run". (Participant 8)

Theme 3: Referrals and Service Integration (Combined)

Formal referrals, particularly those from healthcare providers were described as playing a key role in connecting families to lactation services. Participants across all regions noted that referrals were a common method for client engagement. Referral processes that were well-integrated and functioning smoothly, contributing to strong service uptake. Thunder Bay specific and Thunder Bay and District serving agencies often had clearer referral pathways and more structured follow-up than the District specific services.

"That 48-hour phone call if people are needing breastfeeding support… usually leads into a referral for our clinical services." (Participant 3)

"A lot of my clients come to me…by referral from other providers." (Participant 5)

"I would say probably 80-90% of my clientele is external referrals that I'm getting from providers." (Participant 8)

"It's referrals from other professionals." (Participant 16)

The District specific participants and some servicing Thunder Bay and District reported that rather than relying on formal referral systems, lactation services can be integrated into routine care especially during prenatal checkups, well-baby visits or hospital stays.

"When people are already here in the clinic for appointments and they have breastfeeding concerns, one of us is available. They [clinic staff] can just come and grab us really quickly. We can sit down, have an appointment with them. That flexibility of being available when someone has a specific concern, rather than having to formally make an appointment or formally refer themselves somewhere, or even wait for the availability of an appointment. I find we're very flexible here to our client's needs." (Participant 12)

"Everyone who's coming in for a well baby appointment—feeding comes up." (Participant 13)

"They're coming for their prenatal appointments so we're catching them while they're here and offering that [lactation education]." (Participant 19)

Theme 4: Social Media (Rural)

Although social media was mentioned, it was not a dominant strategy in Thunder Bay often due to staffing or organizational capacity and the use of other successful strategies.

"Honestly, [the organization] has no communications lead. We have barely a social media presence because of lack of staffing." (Participant 8)

In contrast, the District participants and the Thunder Bay and District serving participants described social media as an outreach tool. Providers used platforms like Facebook to share updates, promote services and partner with organizations that could help amplify their messaging.

"I mean, we use a lot of social media." (Participant 11)

"We have our Facebook page and stuff like that. We have a communications officer who is able to post on our clinic website to try and reach people that way because a lof of people who are within childbearing age do have access to technology and a lot of them are more tech savvy than say the older generation and the elders." (Participant 15)

"We reached out to an organization to help us build our pre/postnatal program because they have easier access to posting to social media… and they were able to make a poster and post it to Facebook and we actually had quite a bit of people turn out so it was nice." (Participant 14)

Summary of Effective Strategies for Reaching the Intended Audience

Participants highlighted a range of strategies used to

promote lactation services and enhance visibility, with varying degrees of effectiveness across regions. Urban programs benefited from strong inter-organizational networks and formal referral systems, while word of mouth emerged as a powerful and consistent tool for outreach across all settings. Although social media was less commonly used in Thunder Bay, it played a more prominent role in outreach for rural and combined-region programs. These findings underscore the importance of leveraging both formal and informal channels to strengthen service reach and integration, while also recognizing the need to address gaps in referral systems and promotional capacity in certain regions.

Barriers to Access

While participants across the scan were committed to providing accessible lactation support, they also shared a range of barriers that prevent individuals from engaging with services. Five major themes emerged across both urban and rural settings, highlighting similar challenges in both Thunder Bay and the District.

Theme 1: Transportation and Travel (Combined)

Transportation and travel emerged as a consistent barrier to accessing lactation services across all regions. In Thunder Bay, despite the presence of public transit, service providers noted that many clients faced transportation challenges such as unreliable transit schedules or limited parking. The District specific participants and agencies serving Thunder Bay and District also reported limited or unreliable access to medical transportation, such as community vans, which further restricted families' ability to attend appointments. In interviews with participants who service Thunder Bay and District, the problem identified was a lack of rural services, requiring families to travel considerable distances for lactation services. Even in Thunder Bay, if specialized services are not available locally, families may need to travel to larger urban centres such as Toronto to access the care they need. These findings underscore the critical role that transportation and travel play in determining whether families can access timely and consistent lactation support.

"Lactation support has grown incredibly within our city [Thunder Bay] but outside the city, it's very limited for families and they have to travel great distances to get any in-person services." (Participant 5)

"There are people who … had to travel to Toronto to see Dr. Newman at the Toronto IBC clinic. If there's not me doing this right now, there's no one else." (Participant 7)

"Travel is a barrier because sometimes people aren't able to make their appointments or aren't able to make their appointments on time, bus schedules, just for different reasons…" (Participant 12)

"People are nervous to take the medical van in, because if the provider happens to be running a bit behind, the medical van will leave without them." (Participant 13)

"I would say transportation [is a barrier]. Such a big catchment area… 45 minutes…three different bus routes." (Participant 14)

Theme 2: Financial Barriers (Combined)

Participants in Thunder Bay and District described a range of financial challenges that hinder families' ability to access lactation services. These included both direct costs, such as service fees and indirect costs, such as transportation, parking, childcare and accommodations. Service providers offering fee-based services reported that clients typically accessed them after using publicly funded services. For lower-income families, even free services could become inaccessible due to the high costs associated with attending appointments. Some programs attempted to reduce these barriers by offering support such as bus passes, taxi vouchers or including childcare with their services; however, this type of assistance was not universally available. These financial barriers often heightened existing inequities, making access to care especially difficult during the postpartum period.

"Cost is certainly a barrier… I'm not typically most families first stop… If they need more support than they have been able to receive through public services then they'll come to me next." (Participant 5)

"The cost for parking… the cost associated with attending appointments… we can offer patients a taxi voucher or bus ticket to make it to their appointments. We have funding for that which has been super helpful." (Participant 12)

"We have a high number of families that we work with that are financially vulnerable… they don't have their own means of transportation so it can be harder to get them out to our programs…communication barriers because not all our families have access to a device… so it can be hard for us to get in touch with them." (Participant 14)

"Financial barriers… the amount it costs us to travel into communities, to really spend more time on the ground, hearing about the needs and the gaps and ways to address them… it's very expensive." (Participant 20)

Theme 3: Service Availability and System Capacity (Combined)

While participants expressed a strong commitment to providing accessible lactation support, many identified organizational and structural barriers that limited service capacity. Common challenges included staff shortages and high caseloads. Differences between Thunder Bay, the District and outside regions were notable. Urban providers often worked within larger systems where multiple staff members shared responsibilities, but still faced high demand and caseloads. Thunder Bay generally had more service options, which allowed families some flexibility in accessing care. In contrast, the District and outside region participants described limited resources and one person tasked with multiple portfolios. All regions reported a lack of formally trained personnel. These conditions made consistent service delivery difficult and reduced the availability of continuous follow-up care.

"Capacity maybe on my end, is one of them [a barrier], and just kind of meeting all of the needs that might come up for that audience, I would say maybe that's the biggest one [barrier]... the extra stuff that we were able to do was more feasible when we had two positions." (Participant 2)

"People living in the District are probably pretty under-serviced and there's sometimes not even a public health nurse in that community where there should be to even do some of that breastfeeding support." (Participant 3)

"[we need] time and resources, as well as good education… I'm part of a whole bunch of perinatal committees and stuff but rarely do I get a chance to really engage with them because it's a small program and I've got other priorities that take my attention." (Participant 9)

"I do prenatal and well-baby visits, and we do breastfeeding discussions in that. We don't have a specific lactation consultant or anything here, so we just do prenatal visits, myself and the dietician…We don't have specific training to do breastfeeding and lactation consulting, it's just what I've learned through my training. But I'm not a lactation consultant, so obviously I don't know everything." (Participant 10)

"More staff would probably be helpful, because then they could increase the number of appointments. More staff could be able to do more home visiting". (Participant 12)

"I have one nurse to serve a region that is so vast geographically, so expensive to travel to and you know maybe less densely populated than some areas but the... *lack of health equity means the need is so much greater. We don't have sufficient resources to do this work." (Participant 20)*

Theme 4: Awareness and Information (Urban)

Participants serving Thunder Bay shared that many families face barriers to accessing lactation support due to limited awareness of available services and unclear or inconsistent information during pivotal teaching moments. This issue was particularly evident in the early postpartum period, where missed referrals and confusion among clients reported to be common. Participants reported a disconnect between existing services and public awareness. Some participants attributed this gap to weak communication between organizations. Other participants reported inconsistent and contradictory breastfeeding guidance from different healthcare professionals further undermining trust in the system. Without standardized training and coordinated messaging, families were not accessing the services available and were at risk of receiving outdated or inaccurate advice, sometimes resulting in the premature cessation of breastfeeding. These findings highlight the need for clearer communication and better coordination to improve awareness and understanding of available lactation services.

"I think some of the barriers are that a lot of these programs, you have to seek out and then get yourself there to attend. So, families that maybe aren't as connected on social media, aren't as connected with community, are not getting connected to these programs and services, and they're probably the ones that would benefit the most." (Participant 1)

"Sometimes they're [the staff] not giving all the information or maybe not the most up to date information about managing breastfeeding and infant feeding." (Participant 3)

"There's a lot of old advice that's out of date … and there's a lot of people who feel like, Oh, you just can't make milk… or you just aren't trying hard enough … Neither of those are the case. If patients are well educated and if their providers are really supportive of breastfeeding, they tend to really encourage them and get them the right help." (Participant 7)

"Half the time they [clients] don't even know that [Organization 1] will call them, [Organization 1] can come see them. They're like, 'Oh, [Organization 2] does home visits? They can see me within a day?' … We're seeing postpartum parents like three weeks later, and they're like, 'Oh, we didn't know.'" (Participant 8)

"I mean, this program specifically is quite new, so people don't even necessarily know about us". (Participant 11)

Theme 5: Patient Accountability and Comfort Level (Rural)

District and outside region participants reflected on the uncertainty surrounding why some families do not access available lactation services, despite considerable outreach efforts. Providers described feeling as though they were constantly trying to connect with clients who did not respond or engage, raising questions about comfort, trust and perceived need. While some participants speculated that a lack of awareness or logistical barriers might play a role, others acknowledged that deeper issues may be at play such as hesitation to seek help, prior negative experiences with healthcare or discomfort discussing feeding challenges. In some cases, families appeared disengaged from prenatal or postpartum services altogether, making it difficult to initiate support early. Rural participants emphasized that without a clear understanding of these client-level dynamics, it remains challenging to assess demand or adapt services effectively. The low volume of clients in certain areas may not reflect a lack of need, but rather a lack of trust or readiness to engage. These insights point to the importance of relationship-building and culturally sensitive care to foster trust and encourage earlier, more consistent service use.

"There are some days where we do have lots of gaps [in our bookings], but I know that there's people out there who need help because… somebody mentioned,'We're seeing moms down the line, and they've given up on breastfeeding.' It's like—well, why? Like, what? Where are these people? We're here. We're available to support. We can come and see you." (Participant 3)

"Accountability. I feel like I'm seeing that not everyone is accountable. We feel like we're chasing people down but we're not really sure. Do they need support? Do they not need support? … is personal interest there?" (Participant 6)

"I think it's just more of a comfort level…some of these moms are very seasoned breastfeeders and they don't really require my help." (Participant 15)

"A lot of it is relationship building, building trust and when working with First Nations families with a history of trauma related to accessing health services, patience is required." (Participant 20)

Summary of Barriers to Access

Together, these themes illustrate the complex, overlapping barriers that limit equitable access to lactation services across Thunder Bay and District. While service providers are deeply committed to supporting families, persistent challenges related to transportation, cost, staffing, information access and client engagement continue to restrict service use. These barriers are often interconnected and disproportionately impact those in rural or lower-income communities. Addressing these gaps will require system-level changes alongside community-based strategies that build trust, improve coordination and ensure services are both accessible and responsive to the diverse needs of families in the North.

Gaps and Opportunities Identified

This section outlines the primary gaps and opportunities in current lactation services as identified by participants across Thunder Bay and District. While some participants acknowledged improvements in recent years, many still described challenges that limit the effectiveness and accessibility of lactation care. These gaps include limitations in timely follow-up, fragmented awareness of services, inequitable rural resources, inconsistent training standards and insufficient peer or outreach rural programming. The themes presented below reflect participants' experiences and highlight key areas where they believe services are falling short.

Theme 1: Immediate Support and Timely Follow-Up (Combined)

Providers in Thunder Bay and District described significant challenges in offering timely support to new parents, particularly in the critical first 48–72 hours postpartum. While some hospital-based services exist, follow-up after discharge was often delayed due to high caseloads, staffing shortages and unclear referral pathways. Participants across regions also noted that when parents encounter a breastfeeding challenge, they often feel they need help immediately, not in several days, but there are currently no reported 24/7 services available to meet that urgent need. There is an opportunity to implement structured, automatic follow-up systems and expand capacity for home visits, virtual consults or early outpatient contact to better align with the urgency families experience.

"From a personal perspective, I recall feeling like I needed support right now, in this moment or I don't know if I can breastfeed another hour longer. A drop in kind of support like that isn't really an option…I know personally, if I knew I could go and see somebody right now and try to figure this out, or at least just get somebody to listen to how hard this is, that would have been huge." (Participant 1)

"Early follow-up, when we see them in the first couple of days after they leave the hospital, that would be ideal. But that doesn't always happen. Ideal would be three days after discharge or they've gone into too many problems. [When asked what gets in the way of those early follow-ups, the participant answered:] Sometimes it's coverage and sometimes it's that we don't know about them yet — our five-day work week, sometimes staff neglecting to send the referral early enough." (Participant 4)

"There's gaps sometimes in timely follow up, that families go home from the hospital and they might get an appointment with a lactation consultant in like, two weeks from discharge. But a lot happens in those two weeks." (Participant 5)

"Moms going back home [after delivery in Thunder Bay]… they fall through the cracks when they get back home to their northern communities. I also find that it's the same even when they're here [in their community]... that's why I really want to be able to see these moms before they get discharged, to make that connection before. We find trying to reach out like a week later doesn't have the same outcome." (Participant 11)

Theme 2: Awareness of Services (Urban)

Providers in Thunder Bay noted that despite a wide range of services, both healthcare providers and families remain unsure of what is available. Fragmentation between hospital and community services and a lack of centralized information were seen as key contributors to this gap. Providers felt that improving internal communication between organizations and enhancing public-facing materials could help families access care earlier and more effectively.

"The awareness of the different programs that are available. I know that I'm mostly familiar with the ones internally, and I know of a few others, but I feel like being aware of all of the other services that are happening would help meet the needs that are currently going on." (Participant 2)

"I think the biggest gaps are… people being aware of these kinds of services. They do exist and that they can get timely help and they don't have to suffer or wait for it." (Participant 7)

"Having a more comprehensive overview of what services are in the community because from my perspective… I don't really know anymore." (Participant 9)

Theme 3: District Supports and Resources (Rural)

Service providers working in the District and outside regions described a significant lack of trained lactation support available rurally. Unlike urban areas, where families are more likely to access specialized services, the District providers reported that clients often have to travel to Thunder Bay to receive hands-on lactation care. This reliance on city-based services contributes to inequities in access and outcomes, particularly for those without reliable transportation or facing financial barriers. Providers wondered why the responsibility continues to fall on families to seek out care elsewhere, rather than having services brought to their communities. Although some virtual care options are in place, providers noted that these are often not sufficient particularly when parents need help with latch, positioning or other hands-on breastfeeding support. Another gap identified was the limited availability of culturally appropriate care for Indigenous families in the District. Providers expressed concerns that mainstream services do not always reflect or respect cultural values and that more community-based, culturally safe care is needed. Overall, the absence of locally available, in-person lactation support in rural communities was seen as a major barrier to equitable service access.

"Yes, we can offer them a virtual appointment, but it's really not the same as seeing someone in person … a lot of people living in the District are probably pretty under-served." (Participant 3)

"There's a lot of Indigenous traditional breastfeeding teachings that I don't really see anywhere." (Participant 11)

"People love in person appointments, and it's so important because the practitioner is able to see you in your own environment, see what you have to work with." (Participant 12)

"We are referring to [an organization in Thunder Bay] and I'm finding that they [clients] either have to travel there or it's virtual. So then a lot of people aren't willing to do that. I would say more in-person lactation services here would be good." (Participant 19)

"You know, the culturally appropriate supports that are available to families…we need to really take a deeper look into why and how to make them more appropriate for First Nations families, because they have the lowest breastfeeding rate, essentially in the entire country." (Participant 20)

Theme 4: Evidence-Based Education and Standardized Training (Combined)

Providers from Thunder Bay and District highlighted inconsistencies in breastfeeding education and training across disciplines. Differing approaches and advice among

nurses, physicians and allied health professionals were frequently noted, which could confuse families and undermine trust. There is a clear opportunity to implement standardized, evidence-based training and develop shared protocols across care teams to ensure consistent messaging.

"Sometimes they're maybe not giving all the most up to date information…It's not mandatory that they have the 20-hour BFI course… having that information could be helpful." (Participant 3)

"I would certainly be interested in getting some training around lactation and breastfeeding support… professional training, so I could help patients." (Participant 6)

"We're not Baby Friendly there. We're nowhere near certified for that. There's lots of policies and protocols that do not favor breastfeeding and that's very blatant from the evidence that they're not doing things that would be favorable for breastfeeding outcomes. Our breastfeeding initiation is very high and then it drops in places particularly if they're not starting off in a baby friendly institution... It's really disheartening … in our training; nursing, medicine, we get little to no education on breastfeeding and those who do, it's usually just kind of piecemeal, because they had an experience of their own child being breastfed, but it's subpar." (Participant 7)

"More education for me so I can help my clients better and provide them with accurate education and resources." (Participant 10)

"We'll offer basic breastfeeding education… because I don't have my 20 hour BFI course yet… just basic breastfeeding teaching, answering any questions that they have and directing them in the right direction to get the resources that they need." (Participant 19)

Theme 5: Peer Support and Outreach Programming – Pre and Postnatal (Combined)

Providers across all regions voiced concerns about the lack of ongoing, community-based breastfeeding programs. Many pointed to limited prenatal education and a lack of postnatal peer support as key barriers to continued breastfeeding, highlighting the District as an area of particular concern. Although quantitative data suggests that prenatal breastfeeding education is being provided especially in Thunder Bay, qualitative interviews revealed that some participants still view these efforts as inadequate. Opportunities such as home visits, prenatal and postnatal groups and peer mentorship models were identified as areas with potential for further development.

"More public education so that when they come to us, they understand a little bit more…reaching moms prenatally." (Participant 4)

"Moms when they're going back home to their northern communities… it's finding someone that they're comfortable reaching out to." (Participant 11)

"I think that prenatal education around breast and chestfeeding, I often see people who are surprised that they're struggling with it and feel pretty lost. They didn't anticipate that it … could be difficult." (Participant 16)

"The in-person stuff, I know a lot of people just want that outing, that connection. Like I said, I offer the one on one, but group supports and things like that would be good. (Participant 19)

Summary of Gaps and Opportunities Identified

Service providers across Thunder Bay and District describe a range of challenges that limit families' ability to access timely, consistent and culturally appropriate lactation support. While some resources exist, providers identified key gaps in local availability particularly in rural and district areas where trained staff are scarce and care is often centralized in urban centres. Follow-up after birth is sometimes delayed, support is not always coordinated and families may be unaware of the services that are available to them. The findings in this section highlight the need for more accessible, consistent and community-based models of care.

Top Priorities and Solutions Suggested by Participants

When asked to identify key priorities and propose solutions, service providers offered a variety of visions for improving lactation services. Their recommendations reflect both clinical and community-level considerations, with a strong emphasis on integrated care, training, outreach and equity. While many of the same thematic areas emerged as in the previous section, the focus here shifts to what providers believe should be prioritized to enhance outcomes and sustainability. Their input highlights actionable strategies grounded in professional experience and service delivery realities.

Theme 1: Immediate Support and Timely Follow-Up (Combined)

Providers from Thunder Bay and District and outside the region identified timely follow-up as a top priority. They advocated for structured discharge protocols that ensure

early postnatal contact, ideally within 24 to 48 hours of discharge. Suggestions included expanding clinic hours, 24/7 crisis support and increasing hospital-community coordination. Providers stressed that immediate access can prevent feeding complications and reduce longer-term demand on acute services.

"I think continuing to grow our coordination and communication between the different agencies, so that we're not necessarily doubling up on services, but finding ways to create that timely access for families. Finding the key agencies and stakeholders, developing those relationships. Really investing in the right people to bring that mentorship program." (Participant 5)

"Is there a way to have a coordinated system between all these services? Which one can get somebody in the fastest? Families aren't going to call all of them…I wonder if there is an opportunity to coordinate availability, somehow triage what families need and that most urgent follow up." (Participant 6)

"Services overlap and everybody [healthcare professionals] gets all upset… if we could all come together and understand we're really just here to support families and give them as many resources, free resources…[by referring clients to each other's services]... try to share the care…more accessible and faster." (Participant 8)

"Monday to Friday, 830 to 430 for breastfeeding doesn't always work. We need something after hours for sure. Having a baby in general is not just Monday to Friday, lots of struggles come at night. Earlier intervention for babies and moms because the earlier we see them, and can intervene in those problems, the better the outcomes will be." (Participant 11)

"Making sure that there is that support available to families when they need it, which is not always at 2pm on a Wednesday afternoon, it is 2am on a Saturday morning." (Participant 20)

Theme 2: Awareness of Services (Urban)

To improve awareness, providers from Thunder Bay recommended the development of a centralized directory or referral hub for lactation services. They also suggested that prenatal care providers and hospital staff take a more active role in educating families about available resources before issues arise. Public awareness campaigns, consistent messaging and digital tools (e.g., service maps or appointment platforms) were also proposed to support more proactive service use.

"Having a better, more consolidated kind of place to go to find all of the services that are available to better direct people, but also for people to have more awareness of what's out there." (Participant 2)

"Instead of them [clients] muddling through it [blanket list of resources] when they get home [from hospital] when they're tired…having someone sit down with them and literally book a follow up [lactation appointment] with them before they leave the hospital. Don't just let them leave without anything booked, which we see often…lots of families do not have care and we cannot send them out with nothing and let them try to figure it out, especially newcomers to Canada to navigate our healthcare system. That alone is a huge challenge." (Participant 8)

"Better communication with our partners. Perhaps a [combined] online referral service… so we know what services are available in the community." (Participant 9)

Theme 3: District Supports and Resources (Rural)

Service providers in the District and outside the region emphasized the need to strengthen lactation services directly within rural communities, so families can access care without needing to travel to urban centres like Thunder Bay. A top priority was increasing the availability of trained lactation professionals who can offer in-person, hands-on support in rural areas. Providers suggested rotating outreach models or mobile teams that travel regularly to the District communities as one way to reduce the burden on families. While virtual care is seen as a helpful tool, providers agreed it should be supported by more in-person options. They also recommended creating more opportunities for rural health providers to receive lactation-specific training, so that even when specialists are not available, families can still receive high-quality support. Culturally safe care for Indigenous clients was also identified as a priority. Providers called for more training in cultural safety and traditional practices, better collaboration with Indigenous communities and the hiring of Indigenous staff wherever possible. These strategies were viewed as essential to building trust and providing care that reflects the values, traditions and needs of the District families.

"I would love to see more Indigenous IBCLCs… I think there would be a great benefit of having more Indigenous IBCLCs and that serves their own communities." (Participant 5)

"For example, we have speech therapy services in town, and someone from Thunder Bay travels to the District. I think if there was a comparable of that for lactation support, that would be amazing." (Participant 11)

"There's lactation consultants in Thunder Bay. It's the District communities where there's lack of access to lactation consultants. I know there's the 1-800 virtual option. I just think when people are really struggling to feed, it's that hands-on support that they need. So I would love to see lactation consultants in the District, or traveling lactation consultants." (Participant 13)

"Travel funding for these lactation consultants to travel to the remote reserves that can only fly in. That would be something to help the communities." (Participant 14)

Theme 4: Evidence-Based Education and Standardized Training (Combined)

Providers in Thunder Bay and District prioritized training across disciplines grounded in evidence-based lactation care. They recommended mandatory breastfeeding education, use of standardized tools and resources and interprofessional training models that foster consistency across care teams. Providers felt that consistency across organizations and between providers would reduce conflicting advice and improve parental confidence.

"Advocating for the 20 hour BFI course to be mandatory." (Participant 3)

"Consistency across the current providers…There still is lots of information that's completely wrong. I have patients and families feeling so frustrated when they were told the exact opposite…We need to be improving our education through prenatal groups, other social media campaigns." (Participant 7)

"I'd like to see more evidence-based education…more unity in maybe paediatricians, obstetricians [and other aligned health providers]...so much different advice that is given that is contradictory." (Participant 16)

"More people being trained at every site because there's so many [sites] so it would be nice to have one [someone trained] at each site so moms can go in." (Participant 17)

"They canceled it [the 20 hour BFI course] because there was low enrollment." (Participant 19)

Theme 5: Peer Support and Outreach Programming – Pre and Postnatal (Combined)

Expanding peer-led and outreach-based programming was a strong recommendation from providers in Thunder Bay and District with a focus on implementing these programs in rural settings. They proposed creating structured peer support programs, integrating lactation content into prenatal education continuing that education into the postnatal periods and offering culturally relevant outreach to underserved populations. Several providers also emphasized the value of community health mentors such as doulas, elders or other experienced breastfeeders with lactation training to serve as trusted, accessible supports across the perinatal period.

"I'm thinking if there are services tailored toward Indigenous culture, specific programs available or different culturally appropriate services." (Participant 2)

"Especially in those early, vulnerable days, finding ways to foster development through a peer mentorship program, more lactation support outside of the city central. So, like a doula program, kind of developing that mentorship, to expand access." (Participant 5)

"I think it would definitely be very beneficial to offer breastfeeding education from the prenatal stage because it's not really talked about a lot, it's something awkward especially for first time parents to talk about… and then also something postpartum if they're having a hard time with breastfeeding…you see a lactation consultant, they watch you feed the baby and correct the way to feed the baby. We don't have that." (Participant 6)

"I think there are some informal supports there around feeding but maybe something more formalized in terms of feeding support groups in town so people don't feel like they're doing it alone [and are receiving accurate information]." (Participant 13)

"I just don't think there are enough breastfeeding services in the region. Increasing the amount of support and awareness of breastfeeding, the amount of education around breastfeeding and what is available. Really looking at how we can better support populations, young parents, First Nations parents… We need to develop resources about how partners can support their breastfeeding partner, how communities can support new families."(Participant 20)

Summary of Top Priorities and Solutions Suggested by Participants

Providers articulated clear priorities for strengthening lactation services, emphasizing continuity of care, equitable access and system-wide coordination. Their solutions reflect a deep understanding of local needs, resource limitations and the value of early, consistent and culturally responsive support. By addressing these provider-identified priorities through policy changes, workforce development and community partnerships, there is a meaningful opportunity to improve breastfeeding outcomes and support families across the care continuum.

Discussion

While participants offered valuable insights into service challenges and areas for improvement, the following sections outline region-specific recommendations developed by the author. These proposals build on the findings and address areas that were underrepresented in participant interviews, including the critical role of public health in health promotion, service integration and equity. By considering the unique strengths and gaps within Thunder Bay and District, these recommendations aim to guide more coordinated, culturally responsive and accessible lactation care across the region.

Recommendations for Thunder Bay (Urban)

Urban areas such as Thunder Bay tend to have a well-developed network of lactation services, yet there are important opportunities to improve how these services are promoted, coordinated and accessed. One key observation is the limited reference to health promotion strategies through participant interviews. This finding did not emerge as a consistent theme, however thinking upstream and from a health promotion lens, this may be an area worth further attention. Public health and community partners can play a stronger role in promoting breastfeeding by leading inclusive campaigns that focus on education, normalization and early engagement (Beggs, Koshy & Neiterman, 2021; Francis et al., 2021; Public Health Agency of Canada, 2025). Education should start early, ideally during pregnancy or preconception, by integrating breastfeeding information into prenatal classes, school health programs and community initiatives (Haroon et al., 2013; Kehinde, O'Donnell & Grealish, 2023). Messaging in these sessions must be consistent, evidence-based, culturally relevant and accessible in multiple languages and formats (Monteith et al., 2024; Romano, Cooke & Wilk, 2019). Collaboration between physicians, lactation consultants, midwives, nurses and allied health providers ensures families receive accurate support throughout their care (Dennis & McQueen, 2009). Public campaigns should feature diverse, authentic family stories to normalize breastfeeding and reduce stigma (Russell & Ali, 2017). Early engagement can be fostered through drop-in sessions, peer groups and community events in familiar spaces, complemented by outreach tools like home visits, breastfeeding kits and coordinated messaging across social media and public facing platforms (Francis et al., 2021; Haroon et al., 2013; Kehinde, O'Donnell & Grealish, 2023). By embedding support into families' daily environments, Thunder Bay can shift from a reactive to a preventative, community driven approach that promotes breastfeeding as a natural part of early parenting.

There is also a need for stronger inter-organizational coordination. Many families still experience fragmented care or confusion about how to access support. Public health and community partners are well-positioned to take a leadership role by facilitating more integrated and collaborative service models such as service maps and centralized referral systems, helping families navigate resources more efficiently while reducing duplication. Public health and community partners can improve breastfeeding support by collaborating to create a clear, user-friendly service map that outlines available resources across hospitals, clinics and community programs. This map should be accessible both online and in print through healthcare providers and community centers. Public health and community partners can also work together to establish a centralized referral system, allowing families to access services through a single entry point for smoother, faster care. By coordinating efforts and streamlining processes, community partners can build a more accessible, integrated and equitable breastfeeding support network (Rosin & Zakarija-Grković, 2016).

Importantly, Thunder Bay lactation services should prioritize culturally safe and inclusive care for Indigenous families living in the city. Many Indigenous clients are served by mainstream programs that may not reflect their values, traditions or cultural needs. Public health and community partners can partner with Indigenous-led organizations to co-design services that honour Indigenous knowledge and practices. This collaboration might include holding regular consultation sessions with Indigenous elders and community members to guide program development. Improving cultural safety training for all staff is essential and should be developed and delivered by Indigenous educators to ensure it is authentic and impactful (Monteith et al., 2024; Romano, Cooke and Wilk, 2019). These steps help ensure that Indigenous families in Thunder Bay receive care that is respectful, relevant and culturally appropriate, ultimately strengthening trust and health outcomes within the community.

Public health and community partners can play a key role in breaking the stigma around breastfeeding and making it a normal, accepted part of everyday life. By promoting breastfeeding-friendly environments across workplaces, public spaces and community settings, parents receive visible support that encourages them to continue breastfeeding confidently (Al-Imari et al., 2019; Beggs, Koshy & Neiterman, 2021). Leveraging digital tools in

addition to in-person services like mobile apps, online classes and virtual consultations can also expand access to flexible, convenient support that meets families where they are. Together, these efforts help embed breastfeeding into Thunder Bay's culture, making it a supported and celebrated part of parenting for all families (Russell & Ali, 2017).

Recommendations for the District (Rural)

In rural and District areas, enhancing lactation services requires strategies tailored to the realities of geographic isolation, limited staffing and fewer service locations. Public health and regional partners can play a key role in building the District's capacity through community outreach and peer-based mentorship models, providing culturally safe guidance and further education and training for District healthcare providers. These approaches strengthen trust and foster local expertise, reducing reliance on urban centers such as Thunder Bay and promoting greater community independence in breastfeeding support in the District communities.

Beyond direct service delivery, public health and regional partners have an opportunity to nurture a stronger breastfeeding culture within the District communities. Health promotion and outreach efforts led by public health and regional partners at local gatherings, schools, recreational centres and community hubs can help normalize breastfeeding, address misinformation and foster positive social attitudes towards breastfeeding. These campaigns must be inclusive, equity-focused, culturally inclusive and respond to the unique challenges faced by families living in rural and District areas (Francis et al., 2021; Public Health Agency of Canada, 2025). In many of these communities, community support is highly valued so finding ways to incorporate a sense of community is crucial.

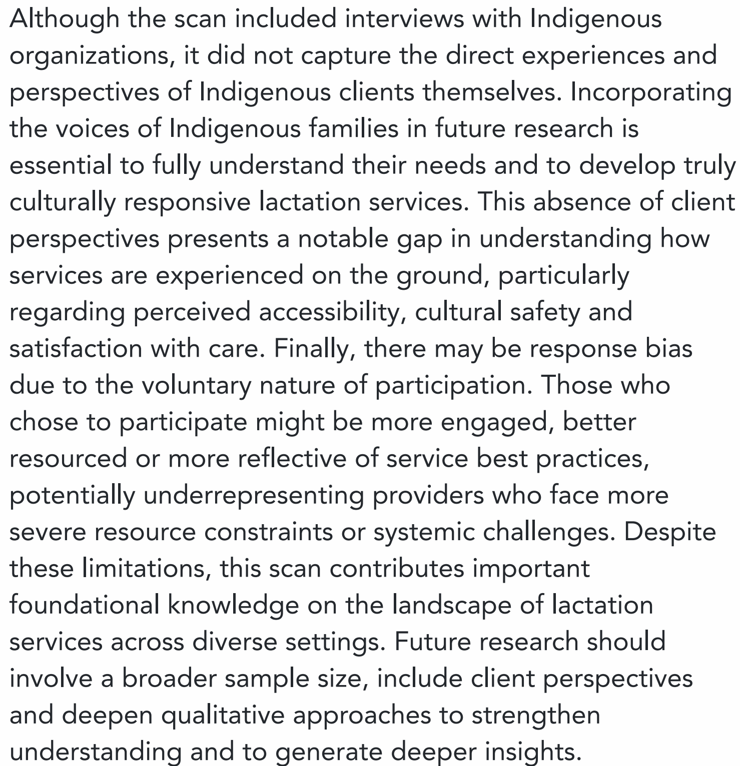
Public health and regional partners can play a pivotal role in establishing and sustaining mentorship programs and peer support networks within rural and District communities. By partnering with local organizations and Indigenous groups, public health and regional partners can facilitate the recruitment, training and ongoing support of community members and elders as breastfeeding champions. These peer-led models not only build local expertise in District communities but also foster culturally safe environments where families feel understood and respected. Importantly, support from trusted community members is often better received and more impactful than services delivered solely by external healthcare providers, helping to overcome barriers related to mistrust or cultural disconnect (Martens, 2002).

Another critical priority in the District is ensuring that lactation support is culturally appropriate and accessible to Indigenous families in rural areas. This requires more than translation or occasional training. It calls for long-term partnerships with Indigenous organizations to support culturally grounded programming. Public health and regional partners can advocate for Indigenous-led lactation initiatives, expand cultural safety training for all District providers and ensure that Indigenous perspectives are incorporated from prenatal education to postpartum follow-up (Monteith et al., 2024; Romano, Cooke & Wilk, 2019).

To improve breastfeeding support in District areas, it is important to provide ongoing training for local health care staff, including nurses, public health workers and primary care providers. This training should cover not only basic lactation support but also cultural safety, trauma-informed care and the broader factors that influence breastfeeding, such as income, housing and access to care. Using real-life examples and involving local organizations can help make the training more relevant and engaging. Public health and regional partners should also ensure that staff have enough time and resources to participate in these learning opportunities, especially since rural teams often have limited capacity (Nickel & LeDrew, 2023; LeDrew et al., 2024). By giving District staff the tools and confidence they need, we can build stronger, more culturally safe breastfeeding support that is rooted in the community and less dependent on urban services.

Gaps and Limitations

The Lactation Scan offers valuable insights into the regional variability of lactation services; however, several limitations should be acknowledged. First, the scan was based on a single round of interviews, which limited opportunities for follow-up or clarification. In several cases, participants provided brief or general responses and the absence of a second phase meant the research team was unable to probe deeper into emerging themes or resolve uncertainties in the data. Second, while the sample size (n=20) falls within acceptable ranges for qualitative inquiry, it becomes somewhat restrictive when the data is further broken down by urban (Thunder Bay) and rural (the District) contexts. The smaller sub-sample sizes may limit the generalizability of findings and reduce the ability to draw strong conclusions about regional diversity, especially within the District and combined regions having less participants. Third, the scan exclusively captured service provider perspectives, without including the voices of clients or community members who use these lactation services.



Although the scan included interviews with Indigenous organizations, it did not capture the direct experiences and perspectives of Indigenous clients themselves. Incorporating the voices of Indigenous families in future research is essential to fully understand their needs and to develop truly culturally responsive lactation services. This absence of client perspectives presents a notable gap in understanding how services are experienced on the ground, particularly regarding perceived accessibility, cultural safety and satisfaction with care. Finally, there may be response bias due to the voluntary nature of participation. Those who chose to participate might be more engaged, better resourced or more reflective of service best practices, potentially underrepresenting providers who face more severe resource constraints or systemic challenges. Despite these limitations, this scan contributes important foundational knowledge on the landscape of lactation services across diverse settings. Future research should involve a broader sample size, include client perspectives and deepen qualitative approaches to strengthen understanding and to generate deeper insights.

Conclusion

The Lactation Scan provides a thoughtful examination of the availability, accessibility, strengths and barriers of lactation services across the City of Thunder Bay and surrounding District. The scan reveals significant disparities, particularly within rural and underserved communities, that limit equitable access to essential lactation support. By identifying these gaps, the scan offers targeted, actionable recommendations from participants and the author to guide improvements in service delivery. Ultimately, the findings highlight the crucial role of public health in fostering an inclusive, culturally sensitive framework that leverages community partnerships to strengthen lactation support and promote healthier outcomes for families across Thunder Bay and District.

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Lactation Scan Literature Review

Breastfeeding/chestfeeding is widely recognized as an essential part of infant and maternal health. It offers numerous improved health outcomes, including enhanced immunity and cognitive development for infants, as well as reduced risks of postpartum complications, certain cancers and chronic health conditions for the mother (World Health Organization [WHO], n.d.). Despite these clear advantages, global breastfeeding rates often fall short of the WHO's recommendation to exclusively breastfeed for the first six months of life. In Canada, a variety of factors influence breastfeeding rates, making it important to understand the barriers that lactating individuals face when starting and continuing breastfeeding as a key step towards improving these outcomes.

Public health services have a critical role in health promotion, addressing these barriers and encouraging breastfeeding (Public Health Agency of Canada, 2014). Public health services provide a wide range of support, from prenatal education and baby-friendly initiatives to feeding assessments, postnatal support and peer counseling programs. By offering consistent, evidence-based guidance, public awareness of positive health outcomes and hands-on assistance, public health agencies help ensure lactating individuals feel supported throughout their breastfeeding/chestfeeding journey (Public Health Agency of Canada, 2019). This support is especially vital in underserved communities, where specific interventions can help close gaps in breastfeeding and chestfeeding access and equity (Vilar-Compte, Pérez-Escamilla, & Ruano, 2022).

This literature review explores the influence of public health services on breastfeeding/chestfeeding promotion and support. It examines the improved health outcomes of breastfeeding, common challenges faced by lactating individuals and the range of public health strategies used to support breastfeeding/chestfeeding practices both in Canada and globally. By summarizing recent research including studies and systematic reviews, this literature review highlights effective interventions and points to areas needing further attention and research.

To gather relevant literature for this review, multiple databases were searched, including CINAHL, Health Evidence, Medline, PubMed, and Web of Science. Priority was given to peer-reviewed articles from 2015 onwards, though some earlier influential studies were also considered. Keywords such as "breastfeeding," "breastfed," "chestfeeding," "chestfed," "lactation," "lactation supports," "infant," "maternal," "Canada," "Canadian," "public health," "health unit," "health agency," and others guided the search. From this, thirty four peer-reviewed articles were chosen for thematic analysis based on their relevance and quality.

The Improved Health Outcomes of Breastfeeding

Improved Health Outcomes for the Infant

Breastfeeding provides a wide range of improved health outcomes that promote optimal growth and development for infants. Health Canada explains that breast milk offers a perfectly balanced mix of proteins, fats, carbohydrates, vitamins and minerals tailored to a baby's needs. Breast milk is easy to digest and packed with antibodies and other immune factors that help protect against infections and diseases. This protection can extend across a lifetime (Health Canada, n.d.). Studies by Azad et al. (2013) and Ho et al. (2018) highlight how breastfeeding promotes the development of a healthy gut microbiome in infants which plays a crucial role in immune system development and long-term health. Moreover, breastfeeding reduces risks of sudden infant death syndrome (SIDS), respiratory infections, gastrointestinal problems and chronic conditions such as obesity and type 2 diabetes later in one's life (Azad et al., 2013; Dieterich et al., 2013; Ho et al., 2018). The cognitive benefits are equally important; Kramer et al. (2008) found that children breastfed in infancy tend to score higher on IQ tests and perform better academically during adolescence. These findings highlight the importance of breastfeeding in the early stages of life for promoting both physical health and cognitive development across one's lifespan.

Improved Health Outcomes for the Mother

In addition to supporting infant health, breastfeeding provides significant Improved Health Outcomes for the mother's physical and mental well-being. Del Ciampo and Del Ciampo (2018) noted that breastfeeding aids in postpartum recovery by stimulating uterine contractions, reducing postpartum bleeding and is associated with a reduced risk of postpartum hemorrhage and promoting faster uterine involution. Beyond immediate recovery, breastfeeding is linked to lower mortality rates from cancers such as breast and ovarian cancers (Walters, Phan, & Mathisen, 2019; Luan et al., 2013). Long-term maternal improved health outcomes include reduced risks of chronic illnesses such as endometriosis, cardiovascular disease, rheumatoid arthritis, Alzheimer's disease and type 2 diabetes (Del Ciampo & Del Ciampo, 2018). In addition, breastfeeding has positive effects on maternal mental health. A study by Dennis and McQueen (2009) found that breastfeeding is associated with a lower risk of postpartum

depression. Similarly, an article by Modak, Ronghe, and Gomase (2023) discusses the hormonal responses associated with breastfeeding that support maternal mental health and strengthen the emotional bond between a mother and child, reducing postpartum depression and anxiety.

Economic and Societal Improved Outcomes

Beyond individual improved health outcomes, breastfeeding also offers considerable economic and societal advantages for families, healthcare systems and the broader society. For families, breastfeeding is more affordable than formula feeding. Frank et al. (2020) estimated that infant formula costs in Nova Scotia ranged from $1,200 to $2,000 annually, whereas breastfeeding primarily involves minimal expenses like maternal nutrition and occasional lactation support. From a public health perspective Onah, Hoy, and Slofstra (2025) projected that better breastfeeding rates could save health systems millions of dollars by preventing common childhood illnesses and chronic diseases, which in turn will reduce doctor visits, hospital stays and medication needs. In Canada, less than ideal breastfeeding practices have been shown to drive up public health spending, reinforcing the importance of supporting breastfeeding, particularly for families with limited financial resources (Onah, Hoy, & Slofstra, 2025). At the societal level, breastfeeding also supports environmental sustainability by cutting down on formula production, packaging waste and carbon emissions linked to large-scale farming and manufacturing (Mohapatra & Samantaray, 2023). Tools like the "Cost of Not Breastfeeding" help policymakers understand the human and economic costs associated with non-breastfeeding feeding methods across national, regional and global levels (Walters, Phan, & Mathisen, 2019).

Barriers to Breastfeeding

Despite the many improved health outcomes discussed, breastfeeding rates in Canada remain lower than ideal due to several overlapping challenges.

Lack of Support and Misinformation

Studies have shown that many mothers in Canada report receiving inconsistent or inadequate guidance from healthcare professionals regarding breastfeeding education. Dennis and McQueen (2009) found that conflicting advice both prenatally and postpartum undermines maternal confidence and can lead to early breastfeeding cessation. Additionally, Pound et al., (2014) identified gaps in Canadian residency training, noting that key breastfeeding skills and the management of common breastfeeding challenges are often missing from formal learning objectives in medical schools. As a result, medical residents may not receive structured education specific to breastfeeding support. The study also highlighted limitations in physicians' knowledge, confidence and attitudes related to breastfeeding care. Similarly, a qualitative study by Islam et al. (2024) involving interviews with nurses, lactation consultants, midwives and physicians found that most healthcare providers felt adequately prepared to answer breastfeeding related questions from patients. However, some noted that conflicting information given by different healthcare providers occasionally contradicted their own training, which affected their confidence in offering consistent breastfeeding support. Patients themselves also frequently noticed these inconsistencies, which can increase anxiety, cause confusion and reduce breastfeeding duration (Dennis & McQueen, 2009).

Workplace Challenges

Literature indicates that returning to work presents major obstacles for many breastfeeding mothers. Bigalky et al. (2018) found that inadequate workplace accommodations such as lack of dedicated lactation spaces, time constraints and limited employer support, pose significant challenges to expressing and storing breast milk after returning to work. Al-Imari et al. (2019) reported similar findings among Canadian medical residents, who struggled with inflexible schedules, no private spaces, inadequate refrigeration for milk storage and limited workplace breastfeeding policies. While many felt generally supported, these conditions still made continued breastfeeding difficult (Al-Imari et al., 2019).

Stigma

Evidence shows that social stigma related to breastfeeding in public remains a significant barrier for many Canadian mothers. Despite legal protections, such as those in the Canadian Charter of Rights and Freedoms, many women encounter negative attitudes and discomfort from others, discouraging them from breastfeeding outside the home (Russell & Ali, 2017). A study in Ottawa found that such stigma reduces both breastfeeding initiation and duration (Russell & Ali, 2017). Beggs, Koshy, and Neiterman (2021) reviewed global research showing that fear of judgment, lack of safe public spaces and a culture associated with sexualization of women's bodies contributed to mothers avoiding public breastfeeding. The lack of accessible and designated public spaces for breastfeeding lead some mothers to adjust their feeding practices or seek privacy in less ideal locations, such as breastfeeding in bathrooms or personal vehicles. Similarly, this societal stigma of embarrassment and sexualization associated with breastfeeding has contributed to Newfoundlands low breastfeeding rates (St Croix, 2021). Over time, these social

pressures can destroy maternal confidence and willingness to breastfeed publicly, impacting overall breastfeeding practices (Beggs, Koshy, & Neiterman, 2021).

Socioeconomic Inequities

Socioeconomic factors heavily influence breastfeeding practices across Canada. Families with lower incomes often face overlapping challenges such as food insecurity, limited healthcare access and fewer educational opportunities, all of which can act as a barrier to breastfeeding initiation and continuation. For example, van den Heuvel and Birken (2018) and Francis et al. (2021) found that food insecure mothers tend to stop exclusive breastfeeding earlier than those in food secure environments. Education is another important factor. Mothers with less formal education are generally less likely to breastfeed exclusively for the recommended six months, while those who have completed high school or pursue post-secondary education are more likely to breastfeed for longer durations (Francis et al., 2020; Romano, Cooke, & Wilk, 2019). In Newfoundland and Labrador, Temple Newhook et al. (2017) observed that marginalized mothers often stop breastfeeding early due to negative initial experiences and lack of ongoing support. These issues are especially prevalent in Indigenous communities, where poverty, food insecurity and education intersect with colonialism. Romano, Cooke, and Wilk (2019) highlighted that off reserve Indigenous families face lower breastfeeding rates commonly linked to younger maternal age, low income and limited education.

Ethnic Disparities

Ethnic and cultural influences shape breastfeeding experiences, especially for Indigenous, immigrant and racialized mothers. While some groups, such as East and Southeast Asian women, have high initiation rates, maintaining breastfeeding can be difficult without culturally relevant support. Zhu (2015) described how Chinese immigrant mothers often feel isolated due to lack of culturally appropriate education and services. Additionally, the lasting effects of colonialism have disrupted Indigenous breastfeeding traditions by affecting community-based practices, altering cultural protocols and interrupting the passing down of traditional knowledge essential to maternal and infant health (Monteith et al., 2024). Romano, Cooke, and Wilk (2019) also identified cultural disconnection as a key factor contributing to lower breastfeeding rates among off reserve Indigenous mothers. These findings suggest that when healthcare systems fail to acknowledge or incorporate cultural knowledge and community voices, they risk creating significant barriers to breastfeeding support and continuation, especially for populations who have experienced historical marginalization. Overall, these studies emphasize the urgent need for culturally competent and community-informed breastfeeding care tailored to diverse populations across Canada.

Accessibility

Accessibility to breastfeeding support plays a crucial role in shaping breastfeeding outcomes, especially for mothers living in rural and remote areas of Canada. In regions such as rural Newfoundland and Labrador, specialized services like lactation consultants are typically concentrated in regional hospitals, creating significant barriers for mothers who must travel long distances with their infants to access this support (St Croix, 2021). Many rural communities lack local peer support programs, leading to increased dependence on public health nurses and community organizations to fill these gaps. Moreover, mothers often encounter challenges related to service availability, including limited appointment options, restricted hours of operation, family caregiving responsibilities and inadequate transportation. These factors collectively reduce the accessibility of breastfeeding support and contribute to disparities in breastfeeding initiation and duration (St Croix, 2021). Research shows breastfeeding support works best when delivered in person, proactively and with empathy and trust (Francis, 2020). Flexible, in-home lactation consultations that accommodate postpartum needs are highly valued, particularly where family help is limited. Addressing the geographic and logistical barriers to accessing skilled lactation support in rural communities is essential to promoting equitable breastfeeding outcomes across Canada.

Role of Public Health Services in Breastfeeding Promotion

In response to the wide range of barriers that affect breastfeeding initiation and continuation, public health services are uniquely positioned to bridge gaps, helping mothers and infants access and sustain the many improved health outcomes of breastfeeding.

Education and Awareness

Public health programs in Canada, such as the Canada Prenatal Nutrition Program (CPNP), promote breastfeeding through prenatal education, community outreach programs and postnatal support (Francis et al., 2021; Public Health Agency of Canada, 2025). Evidence from Haroon et al. (2013) and Kehinde, O'Donnell, and Grealish (2023) shows that prenatal education significantly improves breastfeeding initiation, duration and maternal confidence. Effective support also depends on how it is delivered. Chaput et al. (2019) emphasize that knowledgeable guidance, emotional

sensitivity, timely access and practical problem-solving are key components of successful breastfeeding support. Despite this, gaps remain. Some Canadian physicians report limited training in breastfeeding support and infrequently assess breastfeeding during clinical visits, while other healthcare providers report conflicting information given to patients by different healthcare providers (Dennis & McQueen, 2009; Pound et al., 2014). To address these issues, public health agencies have created tools like the *Protecting, Promoting and Supporting Breastfeeding* workbook to enhance provider education and standardize care (Public Health Agency of Canada, 2014). Public health initiatives also tailor breastfeeding support to address broader social and environmental influences. For example, community-based programs often use culturally sensitive approaches to serve vulnerable populations and reduce disparities (Francis et al., 2020; Romano et al., 2019). These programs can also promote maternal mental health and longer breastfeeding duration (Modak et al., 2023; Francis et al., 2021). Finally, by advocating for breastfeeding as an environmentally sustainable practice, public health programs support both health equity and ecological goals (Mohapatra & Samantaray, 2023). Overall, education and awareness initiatives delivered through public health services are crucial to building supportive environments where breastfeeding can thrive.

Baby-Friendly Initiative (BFI)

The Baby-Friendly Initiative (BFI), created by the World Health Organization (WHO) and UNICEF, is a global effort to support breastfeeding by encouraging maternity care practices that put families at the centre of care. In Canada, BFI has been adapted by public health agencies to promote breastfeeding-friendly environments across both hospital and community health settings (Breastfeeding Committee for Canada [BCC], 2021). The foundation of BFI is the "Ten Steps to Successful Breastfeeding," which include practical actions like encouraging skin-to-skin contact right after birth, keeping mothers and babies together (rooming-in) and avoiding unnecessary formula supplementation (WHO & UNICEF, 2018). These steps are designed to help make breastfeeding the norm and ensure families feel supported and informed every step of the way. Research has shown that these practices make a real difference. A recent review by Fan et al. (2025) found that hospitals implementing BFI, fully or even partially had better breastfeeding outcomes than those that did not. Mothers who gave birth in Baby-Friendly hospitals were more likely to start breastfeeding and continue for longer periods, highlighting how even small changes in care can have a lasting impact. In Canada, there has been a growing recognition that BFI needs to go beyond hospitals to fully support families. As Nickel and LeDrew (2023) point out, adding BFI practices into community health services helps create a smoother and more supportive experience for families across the entire perinatal journey. When hospitals and public health units work together, mothers are more likely to receive consistent care before, during and after birth. This kind of partnership makes it easier for families to access support when they need it most (Nickel & LeDrew, 2023; LeDrew et al., 2024). Public health units are playing a vital role in this expansion by training staff, shaping supportive policies and building strong links between care providers. To keep this momentum going, Canada has introduced a national BFI Coach Mentor Program that helps healthcare teams share knowledge and strengthen practices across different care settings (LeDrew et al., 2024). These efforts are especially important for reducing gaps in breastfeeding support across regions and ensuring equitable care for all families. Still, rolling out BFI across the country has not been without its challenges. Some healthcare settings, especially in rural or underfunded areas, face resource constraints, staff shortages and resistance to changing established routines (Nickel & LeDrew, 2023). Overcoming these barriers requires strong leadership, long-term investment and collaboration between health sectors. Despite these hurdles, BFI remains a powerful tool in Canada's public health toolbox, one that helps ensure breastfeeding support is not only available but embedded in the everyday care families receive.

Lactation Consultants

International Board Certified Lactation Consultants (IBCLCs) offer invaluable, hands-on support for moms who face breastfeeding challenges, especially those who might need extra help. These trained professionals work in hospitals, community clinics and public health settings, providing personalized care that makes a real difference. Research shows that when lactation consultants get involved, moms are less likely to stop breastfeeding early and tend to breastfeed for longer overall (Francis et al., 2021). Many mothers say that the kind, understanding and practical support they receive from IBCLCs helps boost their confidence and tackle the physical and emotional hurdles that come with breastfeeding (Francis et al., 2020).

Public health services play a crucial role in making this support accessible. By embedding lactation consultants within community programs and prenatal outreach, public health ensures that help is available not just in hospitals but also at home and in everyday environments where families live (Francis et al., 2021). Early connection to lactation

support, often coordinated through public health networks like the Canada Prenatal Nutrition Program (CPNP), means mothers receive timely guidance during the critical first weeks postpartum when breastfeeding challenges are most common and support can have the greatest impact (Francis et al., 2021; Public Health Agency of Canada, 2025). Furthermore, public health initiatives help coordinate care, train providers and develop culturally sensitive programs that reach vulnerable populations, reducing disparities and promoting equitable breastfeeding outcomes (Francis et al., 2020; Romano et al., 2019). In this way, lactation consultants and public health services work together to create a seamless, supportive system that empowers families and helps normalize breastfeeding as a shared community priority.

Accessibility to Services

Even with lactation consultants in public health settings, access to breastfeeding support remains a significant challenge for many mothers across Canada, particularly those living in rural, remote and northern communities where services may be scarce or difficult to reach (St Croix, 2021). Public health services are uniquely positioned to address these challenges by offering flexible, culturally sensitive programs tailored to meet families where they are. In Indigenous communities, for example, public health initiatives increasingly utilize remote prenatal education and virtual support to overcome geographic and transportation barriers. Hui, McDonald, and McNaughton (2021) found that telehealth prenatal education combined with local postpartum support teams significantly improved breastfeeding initiation rates and prenatal care participation among Indigenous women in Northern Manitoba. These remote options also reduce financial burdens by cutting travel costs and minimizing time away from work or family duties. Likewise, Beggs, Koshy, and Neiterman (2021) emphasize the value of accessible community-based supports such as peer groups, helplines and in-home breastfeeding visits that allow mothers to seek help on their own schedules. Their findings emphasize the importance of public health services investing in flexible, outreach support systems that accommodate diverse needs and help remove barriers to breastfeeding, especially in underserved areas. Furthermore, public health agencies play a vital role in coordinating care pathways between hospitals and community services, ensuring continuity and consistent breastfeeding support across vast and varied populations (Nickel & LeDrew, 2023; LeDrew et al., 2024).

Policy and Environmental Supports

Creating breastfeeding-friendly environments requires more than clinical or educational interventions. It also depends on supportive policies and infrastructure that reduce structural barriers and promote equity. Public health policies such as paid parental leave, breastfeeding-friendly public spaces and income supports play a foundational role in making breastfeeding a viable and valued option for all families. For example, provinces like Quebec, which offer more generous parental leaves and benefits, tend to have higher breastfeeding rates for longer durations compared to other provinces, highlighting how policy can shape health behaviours and outcomes (Lebihan & Mao Takongmo, 2023). Municipal initiatives in cities like Toronto and Ottawa have also contributed by establishing breastfeeding-friendly public spaces, attempting to reduce stigma and normalize breastfeeding in everyday life (Russell & Ali, 2017). These environmental changes attempt to foster social acceptance and increase opportunities for mothers to breastfeed comfortably in public settings. However, gaps remain, particularly for families experiencing food insecurity where access to appropriate infant nutrition including breastfeeding, formula or donor milk can be inconsistent and dependent on local policies and resources (van den Heuvel & Birken, 2018). Alongside structural support, it is also important to modify public health messaging to reflect the realities many mothers face. An review by Beggs, Koshy, and Neiterman (2021) suggested that since many Canadian women expect breastfeeding to happen “naturally” and challenges can discourage initiation or continuation, the common “breast is best” message, while well-intentioned, may unintentionally create pressure or guilt for mothers who struggle. By adopting more realistic and supportive communication, public health initiatives can better bolster maternal confidence and emotional well-being.

Learning from Global Approaches

While Canada has made significant strides in breastfeeding promotion, other countries offer innovative public health approaches that can serve as valuable models. In nations like Sweden and Norway, high breastfeeding rates are supported by generous parental leave policies, universal access to midwifery and lactation care and strong public messaging that normalizes breastfeeding as a cultural norm (Victora et al., 2016). These countries emphasize continuity of care from hospital to home through well integrated public health systems, something Canada is still working to achieve, particularly in rural and underserved areas. In the United Kingdom, the Baby Friendly Initiative extends across community health settings like general physician clinics and public health nursing services (UNICEF UK, 2025). Similarly, Brazil’s national breastfeeding strategy, which includes

media campaigns, hospital accreditation systems and legal protections for breastfeeding in public spaces and workplaces, has been internationally recognized for its impact on breastfeeding initiation and duration (Pérez-Escamilla et al., 2012). In New Zealand, culturally tailored breastfeeding programs, co-developed with Indigenous leaders have improved engagement, trust and breastfeeding rates by grounding support in cultural values and practices (Glover et al., 2020). These examples underscore the importance of structural supports, culturally relevant care and entire health care system coordination.

Canada can learn from these approaches by further integrating breastfeeding support into broader maternal-child health systems, ensuring equitable access to services regardless of geography and expanding culturally safe programming for Indigenous and newcomer populations. National investment in paid parental leave, regulation of formula marketing and expanded public education campaigns could also enhance public health efforts. By adapting and adopting proven strategies from around the world, Canada's public health system can take meaningful steps toward a more inclusive, accessible and sustainable breastfeeding culture.

Gaps and Limitations in the Literature

While there is a growing body of research exploring the improved health outcomes of breastfeeding and the challenges many families face, several key gaps remain especially when looking at service delivery in rural and remote parts of Canada, like Northwestern Ontario. Most studies tend to focus either on the experiences of mothers or on healthcare providers in clinical, often hospital-based settings. What is lacking in research is the perspective of community-based health services such as publicly funded prenatal programs, breastfeeding clinics and Indigenous-led health organizations that work directly with families in our communities. Yet their insights into what is working, what is not and where families are finding barriers are rarely centered in the literature.

Another limitation is that while many national and provincial programs like the Baby-Friendly Initiative or the Canada Prenatal Nutrition Program are well described in terms of policy, there is far less research on how these programs are actually delivered at the local level. Things like staff shortages, inconsistent funding and lack of culturally specific care can make it difficult for even well-intentioned programs to meet the needs of rural or underserved populations. There is very little region-specific research focused on Northern or Northwestern Ontario. Much of what is available comes from urban settings or large-scale provincial data, which does not always reflect the realities of smaller or more remote communities where access to care may be limited.

Finally, we do not know enough about how public health units and community-based health organizations are working together or in some cases, not working together, to support breastfeeding practices. These relationships are key to delivering consistent, equitable care, yet they are rarely the focus of current research. Altogether, these gaps point to the need for a qualitative scan that amplifies the experiences of the publicly funded, community-based health services providing breastfeeding support across Northwestern Ontario. Their perspectives are essential to understanding where public health can better support or collaborate to close service gaps.

Conclusion

Breastfeeding plays a critical role in infant and maternal health, and strong public health systems are essential to making sure families have the support they need. Programs that provide education, hands-on lactation support and culturally safe care can make a real difference in helping parents start and sustain breastfeeding. Still, there are challenges. Families in rural and remote areas, including parts of Northwestern Ontario, often face barriers such as limited access to care, inconsistent services or support that is not culturally considerate. Publicly funded, community-based health services like prenatal programs, lactation clinics and Indigenous health organizations work hard to fill those gaps but their voices and experiences are often missing from research and policy discussions.

The Lactation Scan project aims to change that. By listening directly to these community-based health providers, the research will explore what barriers exist, what supports are lacking and how the Thunder Bay District Health Unit can bridge these gaps in the region. These insights can help shape more responsive, inclusive and effective breastfeeding support systems so that every family, no matter where they live, has the opportunity to thrive.

Table 3. Overview of Lactation Support Services by Region - Expanded

Organization Region	Delivery Format	Mode of Service	Location of Services	Cost of Service
Thunder Bay	Group	In-Person	Ontario Early On; Hospital; Community Facility; Health Unit; Indigenous Organization	None
Thunder Bay	One-One; Group	In-Person; Virtual; Phone	Ontario Early On; Community Facility; Health Unit; Schools	None
Thunder Bay	One-One; Group	In-Person; Virtual	Ontario Early On; Hospital; Health Unit; Home	None
Thunder Bay	One-One	In-Person; Virtual; Phone; Email	Hospital	None
Thunder Bay	One-One; Group	In-Person; Virtual; Phone	Home	$20-$30 for groups; $75-$400 private packages
Thunder Bay	One-One; Group	In-Person; Virtual; Phone	Hospital; Clinic/Family Health	None
Thunder Bay	One-One; Group	In-Person; Virtual; Phone	Ontario Early ON; Clinic/Family; Health; Home	None
Thunder Bay	One-One; Group	In-Person	Ontario Early On; Hospital; Community Facility; Health Unit; Clinic/Family Health; Indigenous Organization	None
Thunder Bay	One-One	In-Person; Virtual; Email	Clinic/Family Health; Home	$125 per hour
Thunder Bay	One-One	In-Person	Community Facility	None
The District	One-One	In-Person	Ontario Early On; Hospital; Community Facility; Health Unit; Indigenous Organization; Home	None
The District	One-One	In-Person	Hospital	None
The District	One-One	In-Person	Clinic/Family Health; Home	None
The District	One-One	In-Person; Phone	Clinic/Family Health	None
The District	One-One; Group	In-Person; Virtual; Phone	Community Facility; Clinic/Family Health; Indigenous Organization; Home; Day Care	None
The District	One-One	In-Person; Virtual	Clinic/Family Health	None
Thunder Bay District	One-One; Group	In-Person; Virtual	Clinic/Family Health; Home	None
Thunder Bay District	One-One; Group	In-Person; Virtual; Phone	Community Facility; Indigenous Organization; Home	None
Thunder Bay District	One-One; Group	In-Person; Virtual; Phone; Email	Clinic/Family Health; Indigenous Organization; Home	None
Outside Region	Group	In-Person; Virtual; Phone; Email	Community Facility; Clinic/Family Health; Indigenous Organization; Home; Hostile	None

Table 3. summarizes the characteristics of lactation support programs across Thunder Bay, the District, the Thunder Bay District and outside region.