

Infant Feeding Report: Centering the Parent
Fredericton Downtown Community Health Centre

by

Brook M. Ramos

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Supervisor: Petrea Taylor, PhD, Nursing and Health Science

Examining Board: Lisa Keeping-Burke, PhD, Nursing and Health Science, Chair
Catherine Hamilton, PhD, Nursing and Health Science
Maryam Kebbe, PhD, Kinesiology

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Abstract

This report, developed in collaboration with the Fredericton Downtown Community Health Centre (FDCHC), critically examines infant feeding practices and support services with a particular focus on parental satisfaction and well-being. Drawing on a review of the literature and dialogue with FDCHC staff, this report highlights how infant feeding is often narrowly conceptualized, with an emphasis on increasing breastfeeding rates by focusing on breastfeeding exclusivity and duration. Such a narrow approach does not consider the complex emotional and practical realities of infant feeding, including the challenges of meeting exclusive breastfeeding guidelines and the lack of guidance and emotional support for families using alternative methods. This report addresses this gap by first identifying the pressing need for inclusive and accessible infant feeding supports. And second, the report will provide a toolkit to guide the facilitation of an evidence-informed infant feeding support group, that prioritizes the well-being of parents and infants.

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Curriculum Vitae

Abbreviations

BFI – Baby-Friendly Initiative

DECH – Dr. Everett Chalmers Hospital

FDCHC – Fredericton Downtown Community Health Centre

HHN – Horizon Health Network

LPN – Licensed Practical Nurse

MCAF- Multicultural Association of Fredericton

mPINC – Maternity Practices in Infant Nutrition and Care survey

NICU – Neonatal Intensive Care Unit

NP – Nurse Practitioner

RNs – Registered Nurses

TVIC – Trauma- and Violence-Informed Care

WHO – World Health Organization

Infant Feeding Report Proposal: Centering the Parent

Note: Use of Inclusive Language

In this report, the term *parent* is used as an inclusive term to refer to all persons who engage in mother work. This term recognizes that not all persons who give birth, lactate, human milk feed or parent in any, or all, capacities identify as mothers or women.

Although inclusive language is used throughout, it is important to note that the report is largely grounded in data and experiences specific to cisgender women, as most existing literature and research informing this work is based on studies with cisgender women who gave birth. In the literature review section, the term *mother* is often used, reflecting the terminology most frequently found in the literature. The term *parent* will be used throughout the report with this context in mind.

Introduction

Infant feeding is more than a nutritional task, it is a deeply personal experience shaped by identity, culture, and individual circumstances. Although extensive scientific evidence supports human milk as the optimal source of nutrition for infants, offering numerous short- and long-term health benefits for both infants and the breastfeeding parents (WHO, 2021), this evidence has contributed to a narrow national focus of increasing breastfeeding initiation, exclusivity, and duration rates. This focus often occurs with little consideration of alternative feeding practices or the complex realities that shape parents' feeding decisions (Nathoo & Ostry, 2009; Smith, 2018).

In Canada, breastfeeding promotion has been strongly shaped by historical efforts to reverse declining breastfeeding rates during the twentieth century. Public health authorities framed breastfeeding as the normative and preferred standard of infant

feeding, positioning other feeding practices as inferior (Nathoo & Ostry, 2009). While these efforts successfully increased breastfeeding rates, they also entrenched a singular narrative that continues to influence policy, funding priorities, and clinical practice today.

Public Health Emphasis and Parental Well-being

The sustained emphasis on breastfeeding as a public health imperative can have unintended psychological consequences for parents. In New Brunswick, nearly half of parents are not exclusively breastfeeding by hospital discharge, with exclusivity declining further in the early postpartum period, highlighting a measurable gap between public health targets and actual feeding practices (Benoit et al., 2023; Horizon Health Network, 2022). This leaves parents navigating feeding challenges with insufficient guidance, particularly when their experiences fall outside the dominant breastfeeding framework.

Breastfeeding promotion can also intensify pressure on parents, reinforcing harmful gendered norms that frame breastfeeding as a moral duty rather than a personal choice (Smith, 2018; Nathoo & Ostry, 2009). Such pressure is rooted in long-standing systems of gender inequality and the historical medicalization of childbirth, which constrained parental autonomy throughout much of the twentieth century (Nathoo & Ostry, 2009). Contemporary “breastfeed at all costs” messaging risks reproducing these dynamics, leaving parents vulnerable to guilt, shame, isolation, and a sense of failure when breastfeeding does not unfold as expected (Benoit et al., 2023; Smith, 2018).

Infant Feeding as Choice: A Critical Perspective

This report is grounded in a critical theory perspective that resists framing breastfeeding as the singular, unquestioned “best” option for all families. It is not anti-human milk; rather, it is pro infant feeding choice. To be a true choice for parent’s, infant

feeding must be approached as a matter of what is best for each individual dyad and family, with human milk recognized as highly beneficial when it aligns with parents' goals and capacity, but never at the expense of a parent's emotional or mental well-being.

Now that breastfeeding has rebounded from the brink of extinction in Western countries, there is an opportunity to reframe infant feeding support. Rather than prioritizing breastfeeding rates as the primary indicator of success, care models should focus on supporting all parents in ways that reflect diverse needs, circumstances, and values. Parents must have access to safe, non-judgmental spaces and appropriate resources regardless of how they choose to feed their infant.

Decisions to formula feed or combine feeding methods are often complex and multifactorial, shaped by intersecting influences such as lack of support, perceived insufficient milk supply, trauma, and cultural or family norms. Supporting parents in an equitable and inclusive manner therefore requires the creation of accessible and safe spaces that honor human milk feeding, formula feeding, and mixed feeding. Evidence suggests that when parents are freed from pressure and judgment, satisfaction with feeding experiences increases, family well-being improves, and, often as an unintended outcome, rates of human milk feeding also rise (Grattan et al., 2024). However, increasing breastfeeding rates is not the motivation of this report. Instead, its purpose is to challenge the societal ideology of "breast is best" and advocate for care that centers parental dignity, autonomy, and choice. This position aligns with the Baby-Friendly Initiative, which emphasizes that parents who supplement or choose not to breastfeed must be fully supported in their decisions making and feeding plan (WHO & UNICEF, 2009).

Trauma and Violence Informed Care as a Framework for Infant Feeding Support

This report is grounded in a trauma- and violence-informed care (TVIC) framework, which recognizes that parents' health experiences and decision-making are shaped by past and ongoing trauma, structural inequities, and social contexts rather than individual choice alone (Benoit et al., 2016; Varcoe et al., 2019). TVIC emphasizes the creation of care environments that promote emotional safety, trust, collaboration, empowerment, and cultural humility, particularly in settings serving marginalized populations.

Evidence from perinatal and trauma-informed care literature demonstrates that experiences such as intimate partner violence, medical trauma, social isolation, and judgmental health messaging can negatively affect parental mental health, confidence, and infant feeding experiences (Hughes & Jones, 2014; Smith, 2018). Infant feeding is therefore not only a nutritional practice but also an embodied and relational experience shaped by power dynamics, perceived safety, and emotional well-being.

Applying a TVIC lens allows infant feeding support to move beyond outcome-focused measures, such as breastfeeding rates, and instead prioritize parental dignity, autonomy, and well-being. In this report, TVIC provides the theoretical foundation for the development of a parent-centered infant feeding toolkit designed to reduce harm, support informed choice, and create inclusive, non-judgmental spaces for all feeding practices.

Historical Context

Nathoo and Ostry (2009) describe infant feeding in Canada as a shifting landscape shaped by medicine, culture, and public policy. Between 1850 and 1920, infant feeding

underwent a profound transition as breastfeeding, long considered the natural and expected form of infant nourishment, was increasingly scrutinized through the lens of medical expertise (Nathoo & Ostry, 2009). Physicians and public health officials promoted “scientific motherhood,” encouraging mothers to adopt standardized, regulated approaches to feeding and childcare. At the same time, technological advancements, such as the production of condensed and evaporated milk, created new alternatives to breast milk, marketed as modern, safe, and hygienic (Nathoo & Ostry, 2009).

From 1920 to 1960, these developments contributed to a steady decline in breastfeeding, as commercial milk products and infant formulas became increasingly normalized and widely promoted (Nathoo & Ostry, 2009). Women’s growing participation in the paid workforce, and cultural ideals of modernity reinforced the perception of formula feeding as superior to or more practical than breastfeeding. By the 1960s, however, a resurgence of breastfeeding began to take shape, influenced by feminist critiques of medical authority, countercultural movements that valued “natural” approaches to health, and emerging research on the unique nutritional and immunological benefits of human milk (Nathoo & Ostry, 2009).

By the twenty-first century, breastfeeding rates had stabilized, yet infant feeding practices remained shaped by societal narratives that positioned breastfeeding as a marker of maternal responsibility and good parenting. These narratives continue to inform public health messaging and contribute to ongoing tensions between health promotion goals and parental autonomy.

Systemic and Structural Influences on Infant Feeding

Infant feeding practices are profoundly shaped by systemic and structural factors that extend beyond individual choice. Social determinants of health, including income, education, employment conditions, and access to healthcare, directly influence parents' ability to initiate and sustain human milk feeding (WHO, 2021). For example, limited paid parental leave, inflexible workplaces, and inadequate access to lactation support can constrain feeding options, while poverty may limit access to nutritious food, safe housing, and clean water (Smith, 2018). Studies consistently demonstrate lower rates of breastfeeding initiation and duration among parents with lower income, limited education, precarious employment, and reduced access to postpartum care, reinforcing that infant feeding practices are patterned by structural inequities rather than individual choice alone (WHO, 2021; Smith, 2018).

A growing body of literature highlights how intersecting forms of injustice, such as gender inequality, racism, poverty, and violence, shape feeding experiences and outcomes (Smith, 2018). Survivors of intimate partner violence may experience trauma, stress, and bodily disconnection that complicate breastfeeding both physically and emotionally (Benoit et al., 2016; Hughes & Jones, 2014). Gendered expectations further position infant feeding as an individual maternal responsibility, obscuring the need for shared caregiving and structural supports such as trauma-informed care and equitable parental leave (Crossley, 2009; Benoit et al., 2016).

Healthcare institutions also play a critical role. The Baby-Friendly Initiative emphasizes practices such as skin-to-skin contact, rooming-in, and access to trained lactation support as facilitators of human milk feeding (WHO & UNICEF, 2009). Evaluations of Baby-Friendly Initiative show improved initiation and continuation of

human milk feeding when institutional supports such as trained staffing and consistent protocols are adequately implemented, although these benefits are not experienced equally across populations (*WHO & UNICEF, 2009*). Conversely, fragmented care, inadequate staffing, and lack of culturally safe services can unintentionally reinforce inequities. Addressing these systemic and structural determinants is essential to ensuring that all parents, regardless of socioeconomic status or life circumstances, have *equitable* opportunities to meet their infant feeding goals.

Report Purpose

In collaboration with the Fredericton Downtown Community Health Centre (FDCHC), this report proposes a reoriented conceptualization of infant feeding, one that centers on the emotional well-being, autonomy, choice, and lived experiences of parents. Serving a diverse and often marginalized population, including newcomers, single parents, gender-diverse individuals, Indigenous families, individuals experiencing homelessness, and low-income households, the FDCHC supports individuals who face systemic social, cultural, economic, and structural barriers. In this report, marginalized refers to individuals and groups who experience reduced access to health services, resources, and decision-making power due to these systemic factors. Therefore, the FDCHC is uniquely positioned to lead a shift toward more inclusive, respectful, and compassionate care.

Through a critical review of the literature and dialogue with FDCHC staff, this report aims to reframe how infant feeding support is understood and delivered. It offers practical tools to guide the development of a parent-centered infant feeding support group. While the benefits of breastfeeding and human milk will continue to be

acknowledged, the primary indicator of success will be parental satisfaction and informed, individualized decision-making, rather than feeding method alone (Grattan et al., 2024).

Positionality Statement

I approach this work as both a mother and a healthcare professional, bringing personal and professional experiences that have shaped my perspective on infant feeding. I have personally navigated the complexities of feeding my own child, including moments where I hid formula in the fridge, aware of the judgment that can accompany infant feeding decisions. I will never forget the moment at a family dinner when someone very close to me asked, after I fed my infant, “Why is he still crying? Did you bottle-feed or breastfeed?” When I replied “breastfeed,” they said, “Oh, so that is why he is crying, he is still hungry, I’ll get him a bottle.” This moment caused me profound hurt and a deep sense of failure, highlighting the powerful impact of judgment on parents’ emotional well-being.

I have also witnessed, among peers, colleagues, and patients, the ways in which parents may feel compelled to misrepresent their feeding practices to healthcare providers, not from fear of judgment, but because of actual judgment they have received. I have seen parents who report exclusive breastfeeding often met with praise and encouragement, whereas those who disclose formula referred to lactation consultants or the breastfeeding specialist in Fredericton and pressured to “do better.” I have known parents who avoid feeding in public, or delay mixing a formula bottle until they are alone, due to fear of scrutiny. These experiences reinforce isolation, shame, and a sense of failure, and I have seen long-lasting emotional impacts, with some parents carrying feelings of inadequacy related to formula feeding decades later.

These experiences have reinforced my commitment to an approach that centers parental autonomy, emotional well-being, and lived experience. I recognize that my

perspective is informed by my own positionality, including my experiences of parenthood and professional work within healthcare systems, and I strive to maintain reflexivity in examining how societal, cultural, and systemic pressures shape infant feeding practices. This positionality informs my aim to contribute to more inclusive, supportive, and nonjudgmental infant feeding practices, particularly for those populations most affected by structural and cultural pressures.

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Literature Review

This literature review is organized into three distinct sections, each developed from separate, focused literature reviews. The first section, *A Critical Analysis of Social and Health Conceptualization of Infant Feeding*, examines the social and health frameworks that inform understandings of infant feeding, with particular attention to cultural influences, gender expectations, and the impact of violence. The second section, *Navigating Infant Feeding*, explores influencing factors that shape feeding decisions, caregivers' information-seeking behaviors, and the challenges and barriers encountered when seeking support. The final section, *Support Services for Infant Feeding*, focuses on policy and systemic supports, the availability and outcomes of services, and parents' experiences in accessing them. Together, these sections provide a comprehensive analysis of the social, experiential, and structural dimensions of infant feeding.

A Critical Analysis of Social and Health Conceptualization of Infant Feeding

To support this analysis, a structured literature search was conducted across PsycINFO and CINAHL, supplemented by relevant textbooks and cross-references. Keywords combined terms related to infant feeding, culture, gendered roles, and feminist perspectives to capture the sociocultural and healthcare dimensions of feeding practices. Inclusion criteria limited articles to those peer-reviewed, published in English between 2000–2025, and addressing the lived experiences or sociocultural influences on infant feeding. This process yielded 48 initial records, reduced to 22 after title and abstract screening, and ultimately 20 studies were included in this review. Full search details and the PRISMA flow diagram are provided in *Appendix A*.

The way infant feeding is conceptualized and understood within society and healthcare is critical for both the parents' ability to care for their infant and their own well-being. Infant feeding, as defined by the World Health Organization (WHO, 2021), refers to the process by which caregivers provide nourishment to their infants, typically through breast milk, formula, or a combination of both. The recommendation for exclusive breastfeeding for the first six months of an infant's life, alongside the well-documented nutritional, physical, and emotional benefits of breastfeeding, is widely recognized. However, despite these recommendations, many parents encounter barriers that can make it difficult to meet breastfeeding recommendations or achieve their breastfeeding goals (McCloskey & Pei, 2022). This review will examine the complex challenges embedded within societal structures and cultural ideologies that shape infant feeding practices, with particular attention to the main themes identified in the literature: cultural influences, gendered expectations, and the impacts of violence.

Cultural Influences

Breastfeeding is promoted within the literature and healthcare as the "gold standard" and is often depicted as a natural, instinctual act. Martucci and Barnhill (2018), discuss how the concept of "natural" is prevalent in public health messaging, citing the WHO's statement that 'breast milk is the natural first food for babies' and the Department of Health's breastfeeding campaign called "It's Only Natural". They argue that this framing may reinforce the notion that natural options are presumptively healthier, safer, and better (Martucci & Barnhill, 2018). Furthermore, Hemeon et al. (2023) discussed how breastfeeding is considered the "obvious" way to feed an infant, with some asserting "that it is the reason women have breast in the first place" (p. 944).

This view positions breastfeeding as the superior and right way to nourish an infant (Callaghan & Lazard, 2012). In contrast, Hemeon et al. (2023) highlight how formula is seen as “artificial, synthetic” positioning it as a failure or compromise (p. 944). This cultural framing creates pressure for parents to conform to these “ideal” and “natural” standards of infant feeding, often ignoring broader systemic and cultural factors (Callaghan & Lazard, 2012; Hemeon et al., 2023; Martucci, 2012).

Beyond the cultural framing discussed above, three main themes, individualism, choice, and medicalization, emerged in the literature as key aspects of cultural influences of infant feeding. Individualism reinforces the idea that infant feeding is a personal choice, placing the responsibility for making the “right” decision solely on the parent (Williams et al., 2013). This perspective often disregards broader factors, such as societal expectations, inadequate maternity leave, and lack of workplace support, which can influence feeding decisions (Joseph et al., 2019; Meyer & de Oliveira, 2003). As a result, the narrative of choice can be misleading, as mothers may not have the freedom to choose as they are constrained by external pressures and the idealized standards promoted by society (Callaghan & Lazard, 2012). The medicalization of infant feeding further complicates this landscape, positioning breastfeeding not only as the healthiest choice but as a duty, reinforced by public health and health care providers (Hemeon et al., 2023; Martucci & Barnhill, 2018; Williams et al., 2013). This creates an environment where parents may feel guilty or inadequate if they cannot breastfeed exclusively, even when facing significant external barriers, a dynamic shaped by cultural norms and policies promoting exclusive breastfeeding (Hemeon et al., 2023; Nathoo & Ostry, 2009; Williams et al., 2013).

Media representations and societal expectations also play a significant role in shaping infant feeding norms. Women's magazines and public health campaigns often emphasize breastfeeding as the ideal, yet frequently fail to acknowledge the challenges many mothers face (Bylaska-Davies, 2015; O'Brien et al., 2017). This reinforces societal pressure to conform to these ideals, while formula feeding is often underrepresented or negatively portrayed. These media narratives contribute to the gap between societal expectations and the lived realities of infant feeding, further complicating parents' decision-making, and emotional experiences.

Gendered Expectations

The literature on infant feeding is almost exclusively about women; part of the reason women are disproportionately highlighted in the literature is due to the exclusive and narrow focus on breastfeeding with little attention given to the role of other caregivers or alternate ways of feeding. Much of the research centers on the concept of "natural motherhood," positioning breastfeeding as the expected responsibility of mothers, with studies by Benoit et al. (2016), O'Brien et al. (2017), and Goldberg and Campbell-Yeo (2016) highlighting how media, societal pressures, promotional practices, and health guidelines disproportionately target women, reinforcing breastfeeding as a feminine duty and further entrenching gender inequities. The weight of these expectations can be disempowering for women, limiting their autonomy in making infant feeding decisions and reinforcing the idea that breastfeeding is a key marker of maternal identity (Crossley, 2009; Símonardóttir & Gíslason, 2018).

A tension within this literature arises from the sexualization of breasts, which complicates the moral discourse around breastfeeding and exacerbates gendered

expectations. Callaghan and Lazard (2012) discuss how public perceptions of breastfeeding are entangled with sexualized images of women's bodies. This creates a dilemma for mothers who are simultaneously encouraged to breastfeed as the best choice while being pressured to do so privately (Callaghan & Lazard, 2012). This tension highlights the broader cultural discomfort with the female body's being both sexual and maternal. This reinforces restrictive gender norms, forcing women to navigate conflicting expectations of motherhood that may undermine their agency in infant feeding decisions.

The gendered dimensions of infant feeding are evolving in response to changing societal and cultural paradigms, challenging the traditional heteronormative and cisnormative narrative. Angeletti and Angeletti (2024), emphasized the need for inclusive, equitable support for LGBTQI+ families, acknowledging diverse gender identities and family structures by adopting the term "human milk feeding" instead of breastfeeding. Furthermore, researchers with feminist perspectives, such as those discussed by Volk and Franklin (2020), noted that breastfeeding can be seen as both empowering and coercive. While some feminists view breastfeeding as a natural and liberating expression of femininity; others critique it as a form of social control that restricts women's choices (Volk & Franklin, 2020). Furthermore, breastfeeding alone challenges the feminist principle of gender-neutral childbearing due to being sex specific and that it may reinforce the binary expectations of motherhood (McCarter-Spaulling, 2008). It becomes increasingly important to critically examine how gender expectations shape not only individual feeding choices but also broader societal perceptions of family roles and maternal identity.

Impact of Violence

Women have long been subjected to systemic oppression which has deeply influenced their ability to make autonomous choices (Benoit et al., 2016). Historically, gender oppression has been embedded in societal structures restricting women rights personally and professionally. This inequality has not only marginalised women but also deprived them of the ability to make choices that align with their own desires and cultural values (Benoit et al., 2016). Although society is making strides towards gender equality, this ongoing oppression has had lasting impacts, particularly in motherhood, where it deeply shapes infant feeding practices.

Colonialism, forced assimilation, and racial violence have disrupted traditional caregiving practices, especially within Indigenous communities, where breastfeeding was once central to cultural identity and community health (Abbass-Dick et al., 2018). Abbass-Dick et al. (2018) discussed how the trauma of these historical injustices has created intergenerational barriers to breastfeeding, as parents and families struggle to reclaim practices that were once central to their culture identity. Their work focused on the restoration of breastfeeding within Indigenous families, emphasizing the need to honour and restore these cultural values.

Additionally, trauma such as adverse childhood events (ACEs) and intimate partner violence (IPV) can cause increased challenges to breastfeeding. For women who have survived IPV it may be difficult for them to see breastfeeding as a positive, nurturing act as their bodies may carry associations from the abuse, making it hard to connect with their bodies in a positive way (Benoit et al., 2016; Hughes & Jones, 2014). Women who have experienced ACEs also face increased challenges with breastfeeding, often exacerbated by lack of support and the stigma surrounding their experiences

(McCloskey & Pei, 2022). This intersection of trauma and oppression highlights the critical need for trauma-informed, gender-sensitive support that acknowledges the complex realities of women's lives and prioritizes their agency in infant feeding choices.

Navigating Infant Feeding

When a baby is born, parents are faced with a significant choice: how to feed their baby- breast milk, formula, or a combination of both. Each option offers distinct advantages and comes with its own set of challenges, making the decision process complex. This is further complicated by the evidence that breastfeeding is the best option for infants, which can create feelings of guilt or pressure for parents to breastfeed. Furthermore, they may feel judged or as though they are failing if they choose not to breastfeed. The decision that parents must make for themselves, and their infant can be extremely challenging and influenced by a range of factors- many of which are beyond the parents control.

To ensure a comprehensive and systematic review of the literature on navigating infant feeding, a database search was conducted in CINAHL. The search focused on key concepts such as infant feeding, parental experiences, barriers, support, and attitudes toward feeding. Inclusion criteria were peer-reviewed articles published in English that examined parental experiences, barriers, or supports related to infant feeding. Articles were excluded if they focused on acute care settings, COVID-19-specific contexts, NICU stays, or were conducted outside a Western context. After applying these criteria and screening for relevance, 21 articles were included in the final review. Across these studies, three main themes were identified: influencing factors, information seeking, and

challenges and barriers to seeking support. Full search details and the PRISMA flow diagram are provided in *Appendix B*.

Influencing Factors

A review of the literature identified several key factors that influence how parents navigate infant feeding, including psychological perceptions, economic constraints, environmental access to resources, and beliefs about the nutritional benefits of different feeding methods. Psychological factors, such as parent's perceptions of infant weight or growth, have a direct influence on infant feeding. For example, mothers who think their infant is underweight are more likely to introduce solids early and pressure their infant to eat, while restrictive feeding practices are correlated with mothers' concerns about infants being overweight (Harrison et al., 2018). Women with depressive or anxiety symptoms in the postpartum period are at increased risk for having breastfeeding and bonding difficulties (Dennis & McQueen, 2009; Olalere & Harley, 2024). Infant behaviors, such as temperament, latching ability, and feeding cues, also affect feeding decisions, as parents often adjust their feeding method in response to these behaviours (Harrison et al., 2018).

Economic factors, such as financial constraints, hinder access to essential feeding supplies such as breastfeeding pumps, bottles, and formula. These financial limitations can significantly restrict a mother's ability to provide her preferred feeding method (Harison & Lahav, 2024). It has also been found that mothers with lower education levels are more likely to rely solely on infant formula (Harison & Lahav, 2024). Environmental factors, such as access to healthcare services and community resources, also influence how parents navigate infant feeding. The availability of lactation consultants, pediatric

care, and post-discharge support can enhance feeding success, while inadequate access can hinder feeding practices (Fuhrman, 2020; Olalere & Harley, 2024).

Radzyminski (2016) found that infant feeding is largely influenced by the nutritional benefits they believed each method offered. Mixed milk feeding (MMF), or combining breastfeeding with formula feeding, is common with reasons including concerns with insufficient milk supply, the need for flexibility, and external pressures like returning to work (Monge-Montero et al., 2024). These reasons for MMF are particularly true for infants age three months and younger. Bonia et al. (2021) found that mothers chose formula feeding due to a mix of perceived necessity such as infant hunger and perceived choice such as flexibility.

Seeking Information

Parents seek infant feeding information through both formal and informal support systems. Formal support includes healthcare professionals like pediatricians, lactation consultants, and midwives who provide personalized guidance. Mobile tools, such as LactApp also assist mothers by offering evolving medical advice for feeding as the infant grows (Padró et al., 2021). Additionally, women in maternity wards have been seen using curtain positioning to signal privacy or seek formal support from health care providers (Burden, 1998).

Informal networks, such as family, friends, and online communities, also play a significant role. Internet searches and online parenting communities are vital sources of information, with infant feeding being one of the most discussed topics (Chivers et al., 2021; Dol et al., 2022; Kallem et al., 2018). Dol et al. (2022) found that mothers in Eastern Canada most frequently used internet searches to seek health information in the

postpartum period. Platforms like Facebook provide emotional support and peer connection (Kallem et al., 2018), while Rhee and Kim (2023) noted that mothers' motivation to join these online support groups was to combat feelings of isolation and to connect with others facing similar challenges. While these informal sources are accessible, their advice can vary in quality and may not align with medical guidelines (Kallem et al., 2018). Despite this, these networks provide the essential connection and emotional support that mothers are seeking, highlighting the importance of helping mothers navigate both formal and informal resources.

Social Support

Benefits. Social support plays a vital role in reducing stress and fewer difficulties in feeding, while a lack of social support has the opposite effect (Phang Koh Ni & Koh Siew Lin, 2011). Informal networks provide emotional encouragement, practical guidance, and reassurance, which can help parents feel more confident in their feeding decisions (Kallem et al., 2018; Rhee & Kim, 2023). Formal support from healthcare professionals, including pediatricians, midwives, and lactation consultants, offers personalized, evidence-based guidance that complements advice from informal networks (Chivers et al., 2021; Dol et al., 2022). Together, these sources can create a supportive environment that promotes both emotional wellbeing and practical problem-solving.

Challenges and Barriers. Many women face significant barriers to seeking help during the postpartum period, primarily due to the stigma and fear of judgment surrounding the act of asking for assistance in something society often views as a natural, instinctual process. Mothers may avoid healthcare professionals due to fear of judgment regarding how they feed their infant (Harison & Lahav, 2024). Some mothers,

particularly those experiencing perinatal anxiety, avoid seeking help due to concerns that requesting assistance may be seen as a reflection of their inability to care for their children (Negron et al., 2013; Powell et al., 2023). Even when mothers do consider seeking help, they often feel that others cannot provide the support they need or that their requests would be seen as burdensome (Negron et al., 2013). This reluctance to seek support is particularly pronounced among certain groups, such as Latina, English-speaking, and white mothers who often view asking for help as a criticism of their parenting skills (Negron et al., 2013). African American mothers may also hesitate to seek help, fearing they would appear ungrateful for the joy surrounding their baby's arrival, further perpetuating feelings of guilt and isolation (Negron et al., 2013). In countries like China, Japan, and Malaysia, traditional confinement practices offer substantial support to new mothers, allowing them to rest and recover with the help of family or professional caregivers (Corrigan et al., 2015). In contrast, American mothers often experience a lack of both professional and familial support due to the cultural emphasis on individualism and self-reliance, leaving many mothers feeling isolated (Corrigan et al., 2015).

Certain people, such as Indigenous mothers and sexual minority women, face even greater barriers to seeking support. Indigenous mothers, for example, experience additional obstacles due to historical and ongoing social inequalities, including lack of access to culturally relevant healthcare, language barriers, and mistrust of the healthcare system, which can hinder their ability to seek and receive appropriate support (Monteith et al., 2024). Similarly, sexual minority women often experience lack of inclusive

healthcare resources, social isolation, and concerns about judgment from healthcare providers or their communities (Jenkins et al., 2021).

Support Services for Infant Feeding

Infant feeding is an inherently challenging and complex process, often overwhelming for many parents and caregivers. In response, various support services have been established to help families navigate this crucial stage of infant care. However, much of the existing literature on these support services is heavily focused on improving breastfeeding rates to meet targets set by the World Health Organization (WHO), framing it as a public health issue. As a result, there is limited attention given to alternative feeding methods and the overall wellbeing of both parent and infant. This trend is not only prevalent at the national policy level but also within community and individual-level services. Although breastfeeding offers significant health benefits, this narrow focus on increasing breastfeeding rates can inadvertently marginalize parents who are unable to breastfeed or who choose alternative feeding methods. Consequently, parents may face fewer resources and support options to assist them in their feeding journey.

To better explore this gap in the literature, a systematic search was conducted in CINAHL on March 11, 2025. Keywords included terms related to support services, interventions, infant feeding, accessibility, availability, effectiveness, and parental experiences. The search was limited to peer-reviewed articles published between 2020–2025. Studies were included if they examined parental experiences with infant feeding support services or assessed the availability and effectiveness of such services in North America. Articles focused solely on COVID-19 or international contexts were excluded. The search initially retrieved 103 results, with 22 articles retained following screening

and application of the inclusion and exclusion criteria. The main themes identified across these articles were policy and systemic support, availability of services, outcomes of support interventions, and parental experiences with using these services. Full details of the search strategy and the PRISMA flow diagram are provided in *Appendix C*.

Policy and Systemic Support

The Baby-Friendly Initiative (BFI), a global program supported by the WHO, emphasizes breastfeeding as the optimal form of infant nutrition and has led to improved breastfeeding outcomes in various countries (Benoit et al., 2023). This initiative includes 10 steps aimed at optimizing breastfeeding outcomes, one of which is ensuring that all staff have the knowledge and skills to support breastfeeding (Benoit et al., 2023). Organizations can obtain “baby-friendly” designation through successful implementation of the ten steps and compliance with the International Code of Marketing of Breast Milk Substitutes, which provides guidelines and restrictions regarding the marketing of breast milk substitutes such as infant formula (Benoit et al., 2023). Additionally, studies have highlighted the success of this initiative in reducing racial disparities in breastfeeding initiation, although challenges remain in sustaining breastfeeding among racialized women, particularly Black women (Hemingway et al., 2021).

In Canada, the Prenatal Nutrition Program provides essential health and nutrition supports to mothers who are vulnerable, with a strong emphasis on breastfeeding promotion to improve birth and breastfeeding outcomes (Francis et al., 2020; Mildon et al., 2021). In the United States, the Special Supplemental Nutrition Program for Women, Infants, and Children, established in 1974, safeguards the health of low-income women, infants, and children who are at nutritional risk by providing nutritious supplemental

foods, breastfeeding support, and nutrition education (Caulfield et al., 2022). In addition to these initiatives, The Center for Disease Control and Prevention in the United States promotes breastfeeding through various campaigns and reports, such as the Breastfeeding Report Card and the Maternity Practices in Infant Nutrition and Care (mPINC) survey. The Report Card provides national and state-level breastfeeding data, and the mPINC survey evaluates hospital practices related to infant nutrition offering feedback to improve breastfeeding practices and support (Hernandez et al., 2022). These efforts aim to improve breastfeeding initiation and sustainment rates by offering evidence-based guidelines and support to healthcare providers (Hernandez et al., 2022). While these initiatives have made significant strides in improving breastfeeding outcomes, it is crucial to recognize that supports focused on initiating and sustaining breastfeeding should not be the only feeding support option for families.

Availability

Breastfeeding support services are offered through various channels, including hospitals, community clinics, in-home support, peer assistance, and digital platforms. Hospitals, especially those with neonatal intensive care units (NICUs), often provide lactation support. The majority (79%) of NICUs offer lactation assistance, although the nature and intensity of the support can differ (Lingnong Pan et al., 2024). Some hospitals provide reactive support which is support that is offered only when a request for help or issue arises, while others take a more proactive approach offering support to everyone admitted or a combination of both (Lingnong Pan et al., 2024). Just over half of hospitals offer follow-up lactation support, ensuring continued breastfeeding help for new mothers (Lingnong Pan et al., 2024). In the community, prenatal classes, local lactation support

groups, and in-home lactation programs are common. Peer support programs, such as La Leche League, provide accessible, community-based guidance and encouragement for breastfeeding parents, complementing formal healthcare services and contributing to improved feeding confidence and duration (La Leche League Canada, n.d.). However, access to these, particularly in-home support is often limited for marginalized groups, such as low-income families, new immigrants, those with lower levels of education, and young or single mothers (Mildon et al., 2021). Tele-lactation services have become increasingly popular, providing guidance on milk expression and breastfeeding support remotely (Alvarado et al., 2024; Bogulski et al., 2023; Demirci et al., 2023). These services are particularly valuable for rural or isolated families where in-person support may be less accessible.

Despite the widespread availability of breastfeeding services, significant gaps in accessibility persist. Geographic and socio-economic disparities affect access to professional lactation consultants, especially in rural or underserved urban areas. For example, metropolitan areas have a higher concentration of breastfeeding support, often favoring predominately white, affluent, and suburban communities (Grubestic & Durbin, 2021; Uscher-Pines et al., 2022). The cost of breastfeeding support remains a considerable barrier, as many families, cannot afford private lactation services (Francis et al., 2020). Although doulas are beneficial for increasing breastfeeding rates, especially for vulnerable populations, the high cost of their services, compounded by limited insurance coverage, restricts access for many families (Spatz, 2024). Peer counseling has also been proven to be an effective, low-cost solution to enhance breastfeeding outcomes, but availability is often constrained by location and funding (Chepkirui et al., 2020;

Rhodes et al., 2021). Furthermore, vulnerable populations, such as undocumented immigrants, may avoid seeking support due to fears about their legal status being exposed by healthcare providers, exacerbating access challenges (O'Neil, 2024). Although the BFI promotes global breastfeeding support, ensuring equitable access to these services, particularly for mothers in rural and underserved areas, remains a significant challenge for the initiative (Benoit et al., 2023).

Many mothers may seek breastfeeding support services not necessarily because breastfeeding is their preferred method, but because these services are often the most accessible—and sometimes the only—option when they need help during a challenging period (Dessi et al., 2024). While services that focus on improving breastfeeding rates aim to enhance health outcomes for both mother and baby, they can challenge maternal identity and emotional well-being, leading to feelings of embarrassment, guilt, and humiliation (Dessi et al., 2024).

To minimize these negative emotions, it is essential to support mothers in their chosen feeding methods, whether breastfeeding or formula feeding (Dessi et al., 2024).

Outcomes

Breastfeeding-friendly practices and lactation support services have been shown to significantly improve breastfeeding rates. For example, breastfeeding education and/or support interventions increase exclusive breastfeeding by 43% at day one, and by 90% at 1 to 5 months of age (Imboden & Lawson, 2021). Specialized lactation support services in neonatal intensive care units (NICUs) have also been linked to increased rates of exclusive breastfeeding for infants facing early challenges (Lingnong Pan et al., 2024). Additionally, including both mothers and their co-parents in breastfeeding education has

demonstrated increased breastfeeding initiation rates, duration rates, and exclusivity (Abbass-Dick et al., 2023). Access to eHealth resources on breastfeeding education has enhanced teamwork between mothers and co-parents, further elevating breastfeeding rates (Abbass-Dick et al., 2020). The involvement of doulas during birth is associated with fewer interventions, increasing early breastfeeding initiation rates, and increasing skin-to-skin contact (Spatz, 2024).

Programs such as the Breastfeeding Heritage and Pride program in the U.S. have also increased breastfeeding initiation and duration (Rhodes et al., 2021). Breastfeeding peer support in hospital settings across low- and middle-income countries has enhanced prevalence of breastfeeding, early initiation, and exclusive breastfeeding rates (Chepkirui et al., 2020). Furthermore, breastfeeding support groups led by midwives increased breastfeeding rates, reduced postpartum depression, and enhanced general self-efficacy among mothers (Rodríguez-Gallego et al. 2024). While the literature highlights the ability to increase breastfeeding rates, duration, and exclusivity through various interventions, the last study by Rodríguez-Gallego et al. (2024), provides a broader measure by considering the overall impact of infant feeding practices. This approach contrasts with the sole focus on breastfeeding rates, suggesting that a more inclusive perspective on infant feeding may yield additional benefits beyond breastfeeding alone.

Parental Experiences

Parental experiences with breastfeeding support services have highlighted the benefits of accessible and tailored guidance. Latina parents who participated in a study assessing the effect of tele lactation on breastfeeding outcomes found it to be accessible, and a practical substitute for in-person support, particularly in pediatric settings

(Alvarado et al., 2024). Tele lactation services are valued for their convenience, educational content, and the emotional support provided, which make breastfeeding guidance more accessible for many families (Bogulski et al., 2023). Similarly, mothers and co-parents found a co-parenting eHealth breastfeeding resource in Canada that allowed access to breastfeeding resources from the prenatal period to one year postpartum to be useful, informative for both parents, and easy to understand. The objective of the study was to determine maternal, and co-parents use and satisfaction with the health intervention and to help them meet their breastfeeding goals, which is taking a step forward from the narrow focus on breastfeeding rates (Abbass-Dick et al., 2023). Furthermore, mothers who had access to free in-home lactation support reported that the personalized, non-judgmental care from lactation consultants addressed their specific struggles, which they would not have been able to overcome without this support due to financial constraints (Francis et al., 2020). However, challenges remain, particularly for Black women who reported difficulties in receiving adequate postpartum support and often felt their concerns were dismissed by healthcare providers, which exacerbated their struggles with breastfeeding (Rodriguez et al., 2023).

Conclusion

A narrow focus on breastfeeding as the singular “right” way to feed an infant fails to recognize the complex, intersecting realities that shape parents’ experiences and choices. Such a perspective overlooks the cultural, gendered, and historical forces that influence feeding practices and perpetuates stigma and judgment toward those who do not exclusively breastfeed (Nathoo & Ostry, 2009; Smith, 2018). Most parents do not meet their intended feeding goals, often due to structural and emotional barriers,

including societal expectations, inconsistent messaging, and lack of accessible support (Benoit et al., 2023; Perrine et al., 2012).

Parents consistently express a desire for care that centers emotional reassurance, peer connection, and individualized, non-judgmental guidance. Yet, global and national health policies continue to prioritize breastfeeding promotion over responsive, family-centered support. This is reflected in the data, only 26.8% of infants in Nova Scotia and 34.5% across Canada are exclusively breastfed for the first six months of life (Benoit et al., 2023), revealing a significant gap between public health goals and lived realities.

To bridge this gap, infant feeding supports must move beyond a narrow focus on increasing breastfeeding rates and toward a more holistic, compassionate model of care that values parental autonomy and emotional well-being. There is a pressing need for inclusive and flexible programs that provide practical guidance, emotional support, and validation for all feeding methods. This understanding forms the foundation of this initiative: the development of an infant feeding support group that prioritizes relational care, emotional safety, and informed choice, creating a community where every parent feels seen, supported, and empowered in their feeding journey. This proposed report seeks to bridge this identified gap by developing a practical toolkit and guide to support the implementation of an inclusive infant feeding group open to all parents. By translating evidence and lived experiences into actionable resources, the report aims to foster sustainable, equity-oriented feeding supports within community care settings.

Project Design

This project was designed to support the Fredericton Downtown Community Health Centre (FDCHC) in developing an equity-oriented, Trauma and Violence-Informed (TVI) infant-feeding support group for parents in the community. Guided by TVIC literature, which emphasizes the role of safety, trust, choice, collaboration, and empowerment in reducing harm and promoting engagement in health services (Benoit et al., 2016; Varcoe et al., 2019), this toolkit was developed in response to the realities at the FDCHC and provides facilitators with practical tools and guidance to create supportive, inclusive, and non-judgmental group spaces.

The values of FDCHC closely align with the principles underpinning this toolkit. Grounded in TVIC, the toolkit recognizes that many parents accessing the clinic have experienced trauma, ongoing stress, or structural violence that can influence their health and parenting experiences. Consistent with TVIC principles, design decisions prioritized emotional safety, transparency, and flexibility, guiding facilitators to foster environments where parents feel heard, respected, and in control of their decisions. By centering flexibility, cultural safety, and responsiveness, this toolkit supports FDCHC's ongoing commitment to equity, connection, and holistic family well-being.

Guided by a critical lens, the project aimed to integrate TVI principles while working collaboratively with FDCHC to build staff capacity to offer an inclusive infant-feeding support group. This approach aligns with FDCHC's focus on equity and care for marginalized populations, while challenging dominant biomedical models of infant feeding that prioritize physiological outcomes over broader definitions of health. In

contrast, a TVI lens emphasizes parental emotional well-being and acknowledges the complex social determinants of health that shape infant-feeding experiences.

Central to this approach was the explicit acceptance of formula feeding, human milk feeding, and mixed feeding. Informed by evidence that coercive feeding messages can undermine parental well-being and autonomy (Smith, 2018; Benoit et al., 2016), the toolkit affirms feeding choices, including formula feeding and mixed feeding. This design choice reflects TVIC in practice by resisting coercive healthcare norms, avoiding individual blame for socially driven health outcomes, and rejecting paternalistic expectations of “perfect” health behaviours.

In collaboration with FDCHC, the project supported the development of a culturally safe support group grounded in harm-reduction and strength-based practices. These approaches align with TVIC literature emphasizing the importance of recognizing existing strengths and reducing the risk of re-traumatization (Varcoe et al., 2019). The group was intentionally designed to welcome all parents, build on parents’ existing strengths, and foster peer support through shared experiences. Creating an environment of belonging and mutual understanding was intended to enhance parents’ sense of confidence and self-worth, with the overarching goal of supporting emotional and relational well-being.

The concept for the support group emerged from the clinic’s historical context and identified service gaps through an iterative process of dialogue and reflection. Initial informal discussions with FDCHC staff occurred over several months within the broader context of ongoing conversations about reintroducing a community-based infant-feeding support group. Prior to the COVID-19 pandemic, the clinic offered a breastfeeding

support group that was widely regarded as a valuable resource for families who chose to human milk feed. Since its discontinuation, both staff and community members have expressed sustained interest in reviving this form of support.

Early discussions helped identify broad priorities for infant-feeding support. These discussions evolved into more focused engagement using Appendix D. Based on staff feedback highlighting the need for a community-based support group, additional, targeted data collection focused specifically on the toolkit using Appendix E. This stage generated concrete, actionable input such as: staff requested hands-on session equipment, access to bus passes and formula (leading to a funding request letter); four staff suggested discussion prompts, with one noting, “peer sharing is what always draws parents and baby groups together,” resulting in structured prompts; and one staff member recommended an anonymous exit survey, prompting the creation of a feedback form. Feedback from this toolkit-focused stage was integrated into successive revisions, ensuring that content, language, and facilitation guidance were refined in real time and directly reflected staff-identified needs and clinical realities.

At the core of this toolkit is a clearly articulated philosophy: to create a safe, equity-oriented space where parents feel respected, free from judgment, and comfortable discussing infant-feeding concerns. A key feature is the explicit affirmation that parents who formula feed or mix feed are welcome. This is particularly significant within the broader Horizon Health Network context, where breastfeeding initiatives and institutional standards can inadvertently place pressure on parents and discourage formula use. By explicitly addressing these systemic tensions, the toolkit operationalizes TVIC by prioritizing harm reduction, choice, and emotional safety over prescriptive health

outcomes. By acknowledging and addressing these systemic tensions, the support group was intentionally designed to help reduce feelings of guilt or inadequacy for some parents. Participant experiences will be explored through an anonymous exit survey, with future program evaluation recommended to examine longer-term outcomes, including parental well-being and satisfaction at three- and six-month intervals.

Methods: Engagement with FDCHC Staff

Step 1: Relationship-building and informal consultation

Between September and December, I engaged in ongoing informal dialogue with FDCHC colleagues approximately two to five times per week. These conversations focused on infant feeding practices, existing supports, and logistical considerations for developing an infant feeding support group and facilitator toolkit. Discussions addressed space, scheduling, staffing, registration processes, safety considerations, and alignment with HHN requirements. Insights from these informal exchanges informed the initial structure and content of two data collection tools: the FDCHC Staff Discussion Guide (Appendix D) and the FDCHC Staff Toolkit Feedback Form (Appendix E).

Step 2: Formal staff consultation on infant feeding needs

To systematically understand infant feeding needs within the clinic population, a structured staff consultation was conducted.

Participants

Four FDCHC staff members were invited to share their insights into the unique needs, challenges, and strengths of the parents they serve. These participants were selected because they have current or extensive experience working directly with infants and parents in the postpartum period. To protect anonymity, staff were informed that their responses would be de-identified; therefore, detailed role descriptions are intentionally limited. The participants included one nurse practitioner (NP), two registered nurses (RNs), and one licensed practical nurse (LPN), all but one who continue to work regularly with infants and caregivers. Participation in this dialogue was voluntary

and confidential, with responses de-identified in this report to protect privacy. Select quotes are included without attribution to preserve anonymity.

Data Collection

Participants were given the option to respond to Appendix D in writing, virtually, or in person. All participants chose to complete the questions in writing on their own time, as this approach offered the flexibility needed to accommodate their complex work schedules and allowed them to engage thoughtfully at their own pace. Each participant received FDCHC Discussion Guide (Appendix D) via email, which they reviewed and signed. This form includes a brief overview of the project, details on how their responses would be used, a statement on confidentiality and voluntary participation, and a set of guiding questions. These questions were developed using an exploratory framework designed to elicit both practical insights and broader reflections on infant feeding support in the community. Participants responded with their written responses via email.

Questions for participants focused on what they were seeing and hearing from parents during the postpartum period, the challenges and successes around infant feeding, how parents are managing difficulties, recurring concerns emerging in the prenatal or postpartum periods, and what an effective infant feeding support group should look like for parents in our community. Additional prompts invited participants to reflect on the emotional experiences and to share anonymized examples that illustrated barriers or facilitators to positive feeding experiences. The intent behind these questions was to center the immediate needs and lived realities of families, ensuring that the data collected would directly inform the feasibility and design of a support group tailored to the FDCHC.

Step 3: Organizational Alignment and Feasibility Discussions

Findings from the consultation were shared with FDCHC management to assess feasibility and alignment with clinic priorities. Discussions emphasized the need for an inclusive, non-judgmental infant feeding model that supports all feeding approaches rather than exclusively breastfeeding. Management and the former facilitator expressed strong support for this broader, equity-focused approach. These discussions confirmed organizational readiness to explore reintroducing a support group.

Step 4: Toolkit Needs Assessment

A second formal data collection focused specifically on identifying the needs and priorities related to the proposed toolkit.

Procedures

The Toolkit Feedback Form (Appendix E) was developed and distributed to staff. The feedback form was made available to staff on November 27, with a submission deadline of December 12. To encourage honest and voluntary participation, the forms and folder was placed in a shared common area, allowing staff to complete it at their convenience. Completion was optional, and staff were not required to include their names. Due to the anonymous nature of the responses, the full range of disciplines represented is not entirely known; however, seven completed forms were received. Respondents included representation from management, administrative staff, a nurse practitioner, a registered nurse, a nursing student, and potentially other disciplines.

Instrument

The Form consisted of four open-ended questions designed to gather comprehensive input from FDCHC staff regarding the content and structure of the

proposed toolkit. The first question asked what types of materials or resources would be most helpful for facilitators leading a support group, with the intent of identifying practical tools to support facilitation. The second question explored whether there were specific activities, exercises, or strategies that staff believed would best engage parents and foster a welcoming and supportive group environment. The third question focused on identifying ongoing supports or guidance that should be included in the toolkit to assist facilitators in maintaining group quality, inclusivity, and sustainability over time. The final question invited any additional considerations or suggestions to ensure the toolkit would be practical, usable, and responsive to the needs of parents accessing services at FDCHC.

Analysis

Responses to all four questions on the form were analyzed collectively looking for themes and patterns in the data to identify priorities for toolkit content and structure.

Step 5: Integration of Findings into Toolkit Development

Findings from both staff consultations directly informed: the design of the infant feeding support group, facilitator preparation materials, toolkit structure and content, logistical planning, and key principles of the group.

Findings from Staff Consultations

Infant Feeding Needs FDCHC

Theme 1: Emotional Aspect of Infant Feeding

A core theme highlighted throughout the staff dialogue was the emotional experience tied to infant feeding for parents in our community. Many parents express a strong desire to breastfeed and feel proud when they are successful. However, when parents experience difficulties with breastfeeding or when their baby is not gaining weight as expected, they often feel discouraged, frustrated, and worried. As one staff member noted, “Moms often blame themselves and feel like they are doing something wrong.” Another shared, “They feel defeated when they have to top up or go to formula feeding.” For some, reassurance comes from monitoring their baby’s weight. “Many moms become very focused on weighing the baby for reassurance that breastfeeding is going well.”

There is often significant emotional pressure to breastfeed, with many parents experiencing guilt and shame when they struggle or are unable to continue. One nurse observed, “Especially if others in their peer group are successful,” the feelings of failure are heightened. Another explained, “There are often concerns expressed from mom that she is not a good mom or providing the best for baby,” and “they may also feel judged for giving formula and that they are ‘less than’ for doing so.” Family expectations can add another layer of pressure: “There may also be pressure from family members to feed the way they once did.”

Beyond feeding, some parents experience social and emotional isolation. One staff member shared, “Some moms are lonely and feel isolated, adjusting to being home

all day with children, missing work, and normal daily interactions with others.” This can be especially difficult “if minimal family or friends [are] in the area—more isolated.”

Theme 2: Common Practical Feeding Concerns

Staff emphasized that one of the most common postpartum concerns among parents is infant feeding. Many parents have numerous questions and worries, particularly around breastfeeding. As one staff member noted, “The main concern is having struggles with or not being able to breastfeed.” Another added, “Most moms would rather not give formula.”

Financial stress emerged as a key concern. “Especially with our population, there are often concerns about the price of formula,” one staff member shared. Another emphasized, “Finances are a big factor in infant feeding—the cost of formula is stressful.” Staff also noted that some parents choose formula due to extreme exhaustion.

Parents often worry that their baby is not getting enough milk. Staff identified a range of common concerns, including actual or perceived such as difficulties with latching, low milk supply, nipple pain, thrush, and extreme fatigue. Many parents also express stress about not being able to track exactly how much milk the baby is consuming. Concerns about infant growth are also prevalent: “Poor weight gain” and stress related to “growth curves/percentiles” were frequently mentioned.

Theme 3: Support for New Parents in the Community

Staff emphasized the importance of accessible, consistent support for new parents navigating infant feeding. As one staff member noted, “Breastfeeding is challenging, and having access to support is very helpful.” In the early postpartum period, the Mother-Baby Clinic located at the Dr. Everett Chalmers Hospital (DECH) was highlighted as an

essential resource. This clinic provides immediate follow-up in the first days and weeks after birth and was described by several staff members as particularly helpful for addressing early breastfeeding concerns and weight checks.

Beyond the hospital setting, parents often rely on their primary care providers for ongoing infant feeding support. In New Brunswick, first-time mothers may also qualify for public health nurse home visits, offering additional guidance during the transition home. Indigenous communities in the province have dedicated nurses who provide both home-based and community-level infant care support.

A unique resource noted by several staff members is a medical doctor in New Brunswick who specializes in breastfeeding. This provider is available through a referral from a nurse practitioner or physician and is recognized for their expertise in addressing complex breastfeeding challenges. While lactation consultants are also available, their services are not publicly funded and may be inaccessible to some due to cost.

Theme 4: Vision for Infant Feeding Support at FDCHC

Staff shared what the parent in our community are looking for regarding infant feeding support at the FDCHC. They emphasized the need to center the group around connection. A strong emphasis was placed on the value of peer support, helping parents feel less alone in their experiences. As one staff member put it, *“We need a support group, so moms know they are not alone.”* Another emphasized the importance of helping parents *“get connected to supports.”*

The vision includes informal gatherings like “coffee and conversation sessions hosted in the Graham Smith Room”—an inviting space “with comfortable chairs and access to a change table”. Having a “drop-in” style group that is open to all feeding

methods was noted by multiple staff. One stated, *“A support group for moms who are either breastfeeding or formula feeding or both at the FDCHC would be so beneficial.”* Staff repeatedly highlighted how powerful it is for parents to connect in a judgment-free, supportive environment, surrounded by others who understand the emotional and physical demands of feeding.

Key elements also include access to a scale so parents can weigh their babies for reassurance, as well as support from someone with expertise to troubleshoot feeding concerns and help build confidence. One staff member also noted the importance of access to Dr. Jack Newman’s nipple cream through a provider, recognizing the practical needs that often arise in early feeding journeys. Staff shared that mothers who previously accessed feeding support at FDCHC often felt empowered and connected: *“Moms felt connection and support that empowered them to be successful—they felt connected with the nurse and other moms”*.

Personal Story: Supporting the Parent, Not Just the Feeding

One staff member shared a powerful story that highlights the emotional and physical toll of infant feeding, and the importance of meeting the needs of both parent and baby.

A new parent, visibly exhausted and in tears, expressed that her baby had been breastfeeding all night. Her partner was holding the baby as she cried, saying, “I am so tired, and I just want to have a shower, but all baby wants to do is feed.” She mentioned that she had some ready-to-serve formula at home. The staff member encouraged her to ask her partner to warm a bottle so she could take a break, shower, and rest, reminding her that she could return to breastfeeding for the next feed.

This story illustrates the importance of validating and supporting parents in whatever path their feeding journey takes. As the staff member reflected, “It is important to support people in their breastfeeding journeys if that is what they choose, but we also need to support the mothers. It is not always an easy or linear journey.” They added, “You cannot pour from an empty cup.” The best decision in that moment was to ensure the parent had time to care for herself, knowing her baby was safe and fed.

The next day, the parent returned to the clinic feeling more rested and emotionally supported. She shared her appreciation for not being judged, for having options, and for being reminded that “formula was ok.”

Toolkit Priorities

Theme 1: Accessibility and Low barrier Participation

Staff consistently emphasized the importance of minimizing barriers to participation. Drop-in group formats were identified as particularly beneficial for parents with infants, as they offer flexibility and reduce pressure to attend regularly. Considerations such as time of day, room location, and whether participants require assistance navigating to the space were noted as important logistical factors. Several responses highlighted the need for administrative coordination, including informing administrative staff of group schedules, room bookings, and the use of posters or signage to promote awareness. Transportation was also identified as a significant barrier. Suggestions included providing bus tickets or passes, as well as exploring partnerships with community organizations such as MCAF to enhance access and support. ***Theme 2:***

Facilitator Preparation and Session Structure

Staff identified a strong need for clear guidance to support facilitators in planning and delivering group sessions. Suggested resources included session outlines, discussion prompts, and examples of weekly themes or topic lists, ideally informed by participant interests. Being prepared with basic information or research was viewed as helpful, while still allowing space for open discussion.

Several respondents recommended including guidance on how to set up and facilitate a group, including strategies for encouraging participation, managing group flow, and facilitating open question periods where parents can share feeding challenges and successes. Tools such as true-or-false questions to address common myths and visual prompts to support hands-on learners were also suggested.

Theme 3: Peer Connection and Group Engagement

Peer sharing was consistently identified as a core strength of support groups and a key factor in fostering connection and trust among participants. Staff noted that parents are often drawn to these groups to feel less isolated and to learn from one another's experiences. Suggested strategies to support peer connection included icebreakers, talking in a circle, name tags to promote familiarity, and open discussion periods. Occasional interactive activities, such as parent-and-baby yoga or gentle movement, were also suggested as ways to enhance engagement and create a welcoming atmosphere.

Theme 4: Inclusive, Non- Judgmental Infant Feeding Support

A prominent theme across responses was the importance of providing balanced, non-judgmental infant feeding information. Staff emphasized that resources should be equally supportive of breastfeeding and formula feeding, with clear messaging that

reduces stigma and shame for parents who are unable to breastfeed. Suggestions included offering practical, affordable feeding options and emphasizing choice and flexibility.

Educational content on infant feeding, such as how to increase milk supply or safely prepare formula, was recommended. Easy access to credible, up-to-date online resources, such as websites accessed via QR code, was also highlighted as a practical tool for both facilitators and participants. While growth charts were noted as not needing emphasis, staff acknowledged that parents still value having access to this information.

Theme 5: Cultural Safety and Responsiveness to Diverse Needs

Staff stressed the importance of using inclusive language and ensuring that toolkit content reflects diverse family structures, cultures, and socioeconomic contexts. Suggestions included providing information that is culturally responsive and considering collaboration with public health or other community partners to support parents with postnatal benefits and services. While uncertainty was expressed around the best way to involve culturally diverse partners such as MCAF, there was clear interest in strengthening these connections.

Theme 6: Ongoing Feedback and Quality Improvement

To support sustainability and continuous improvement, staff recommended including mechanisms for ongoing feedback. Anonymous exit surveys at the end of group sessions were suggested to gather participant input and inform future sessions. Feedback was viewed as essential for adapting group content, structure, and resources to better meet participant needs over time. Additionally, the creation of an online platform of resources, accessible via QR code, was recommended to ensure participants can easily access reliable information beyond group sessions.

Toolkit Overview

This toolkit includes a collection of practical documents designed to support the implementation of a community-based infant feeding support group at the FDCHC.

Developed in collaboration with FDCHC management and staff, the toolkit reflects the unique needs of the population served and aligns with the centre's values and capacity.

These resources were created to offer concrete, user-friendly tools that can guide and sustain the delivery of infant feeding support in a group setting. The contents are intended to be adaptable and responsive, allowing for ongoing feedback and collaboration from participants to ensure the program remains dynamic, relevant, and responsive to evolving needs.

The toolkit is intended for use by FDCHC staff who support parents and infants, including nursing staff and other frontline providers. The specific staff who will implement the toolkit will depend on future funding and staffing capacity. More broadly, all FDCHC staff at the clinic work with diverse and marginalized populations and bring experience supporting families who face systemic social, cultural, economic, and structural barriers. As such, the toolkit was designed to be flexible and applicable across disciplines within the clinic.

This toolkit was intentionally designed with consideration for varying literacy levels, learning preferences, and attention spans. The drop-in format allows parents and caregivers to come and go as needed, reducing pressure to follow a set agenda or engage with lengthy written materials. There is no required PowerPoint, structured presentation, or mandatory reading; instead, information is shared through conversation, visuals, and

optional handouts so families can engage in ways that feel accessible, comfortable, and manageable for them.

The complete toolkit that will be provided to the FDCHC is in Appendix F and is broken down into three main sections: background, objectives, and deliverables. In this section I will go in more detail explaining each section of the toolkit.

Background

Support groups play an important role in helping parents feel connected, supported, and confident in their infant feeding choices. Becoming a new parent can be both joyful and challenging, and many people experience isolation, uncertainty, or pressure to make the “right” decisions about how to feed their babies. Support groups provide a safe place for sharing experiences, asking questions, and receiving encouragement from peers and professionals. Research shows that when parents feel supported and accepted, their overall well-being improves and they are better able to care for themselves and their infants (Dessi et al., 2024; Grattan et al., 2024).

Literature and staff dialogue at the Fredericton Downtown Community Health Centre (FDCHC) have emphasized the need to change how infant feeding is approached. Infant feeding conversations have been shaped by the “breast is best” message. While this message was intended to promote human milk at a time when the practice of breastfeeding was being lost to the majority of families, it can unintentionally exclude or shame parents whose experiences differ from this idealized standard. The focus on one “best” method overlooks the complex realities of parenting, such as certain health conditions, trauma, overall health, cultural traditions, work demands, and access to supports. Patient-centred care cannot end once someone becomes a parent and needs to

make a choice about how they feed their baby. Every parent deserves compassionate, respectful care and the right to make informed and supported feeding choices that work best for their family without fear of judgment or guilt.

Across Canada, infant feeding practices are diverse. National data show that while approximately 91% of parents in Canada initiate breastfeeding (Public Health Agency of Canada, 2024), a significant portion introduce formula, combination feeding, or expressed milk in the first three months. Parents in New Brunswick reflect this national trend, with nearly half of parents not exclusively breastfeeding by hospital discharge (Horizon Health Network, 2022). By six months of age only 34.5% of infants in Canada are exclusively breastfed (Benoit et al., 2023). Regardless of public health recommendations, families need inclusive, practical, and non-judgmental support that meets their real-life infant feeding practices.

Around the world, support group programs have been shown to build parents' confidence, reduce stress, and promote positive infant feeding relationships. However, many global models and interventions are based on single approaches, such as breastfeeding-only groups. While helpful for some, these models do not always meet the needs of communities, especially those with diverse family structures and experiences, or for most parents in our community who are not exclusively breastfeeding. This model aims to remove pressure and guilt, avoid language that promotes one feeding method over another, and create an inclusive environment where all caregivers feel valued and empowered.

Toolkit Objectives

This toolkit was developed to support facilitators and staff at the Fredericton Downtown Community Health Centre (FDCHC) in providing inclusive, compassionate, and evidence-based infant feeding support. It is designed to guide the reintroduction of an infant feeding support group that reflects the diverse experiences and needs of families within our community.

This group is built on a TVIC approach to ensure parents feel safe, respected, and in control of their own infant feeding choices. In this model, staff do not act as teachers or leaders; instead, parents lead the conversation, and health care professionals simply facilitate and provide evidence-based information when it is asked for. The goal is not to push any specific feeding method but to support emotional well-being and reduce the risk of trauma or pressure. While adhering to the evidence-based practice that human milk is the biologically optimal food for most infants, we recognize that “breastfeed at all costs” messaging can be harmful to parents. Using a TVIC lens helps us avoid these harms and ensure that every parent’s experience, informed choice, and comfort level is honored while supporting families to meet their individual infant feeding goals and chosen infant feeding practices.

The main objectives of this toolkit are to:

- Enhance staff capacity to provide inclusive, evidence-based, and non-judgmental infant feeding support across diverse infant feeding practices, choices, and family experiences, including newcomers, single parents, gender-diverse individuals, and low-income families.

- Foster reflective practice by encouraging staff to examine how language, assumptions, and systemic norms influence care and how these factors can unintentionally create pressure or exclusion for parents.
- Rebuild confidence and trust among parents by ensuring that all feeding methods and family structures are supported with empathy, cultural sensitivity, and accurate, evidence-based information.
- Guide group facilitation for an infant feeding support group that is welcoming to all parents and caregivers, regardless of gender, family structure, or feeding approach, and that promotes peer connection and community.
- Embed trauma and violence informed principles in all aspects of group facilitation, ensuring safety, choice, collaboration, and empowerment for participants.
- Support continuous learning and improvement by offering facilitators tools and resources to adapt group content, reflect on feedback, and respond to evolving community needs.

Through these objectives, the toolkit aims to strengthen FDCHC’s commitment to equity, inclusion, and holistic family well-being. It provides practical guidance, discussion tools, and reflection prompts to help facilitators create supportive spaces where every parent feels seen, respected, and confident in their feeding journey.

Deliverables

This toolkit provides a collection of resources, templates, and activities to guide facilitators in planning, delivering, and evaluating inclusive infant feeding support groups at the FDCHC. The deliverables are organized into three stages: Pre-Group Preparation,

During Group Sessions, and Post-Group Follow-Up, each supporting facilitators in creating a welcoming, reflective, and trauma and violence informed experience for parents and caregivers.

The Facilitator Ready Toolkit, located in Appendix F, contains all the practical materials needed to run the support group, including forms, activity instructions, timing guides, and materials lists. To prevent information overload and ensure the toolkit is easy to use, the details and background for each exercise and resource are provided here, rather than in the appendix that will be provided to staff at FDCHC. This section explains the deliverables in more detail than what will be found in Appendix F.

Pre-Group Preparation

These tools and templates support planning, promotion, and participant engagement before the group begins.

- Request for Funding Letter: This letter was drafted to secure resources for essential elements of the group, such as staffing, snacks, formula, transportation vouchers, and culturally relevant supplies. This letter helps ensure the group is financially sustainable and removes cost barriers that can prevent parents from participating (Francis et al., 2020; Spatz, 2024),
- Advertising Poster: This poster was designed to invite parents in a welcoming and inclusive way. The language emphasizes that all feeding journeys are supported and that there are no expectations for how participants feed their babies (Angeletti & Angeletti 2024). The handout can be posted in the clinic, online platforms, shared by staff during visits, shared in the prenatal group, or distributed through

community partners to reach a broad range of families, explicitly signaling that parents will be met with respect and acceptance.

- **Pre- Programming Planning Form:** This form was designed to gather parent's preferences and priorities before the group begins. This form asks about ideal group format (in-person, virtual, or other), preferred topics (e.g., breastfeeding, formula feeding, emotional support), preferred style of information sharing (formal presentations vs. informal conversations), ideal timing of sessions, and recommendations for group logistics such as room setup or privacy needs. It also invites participants to name the most important things the group should or should not include, ensuring that the group's structure, environment, and content align with what families themselves identify as supportive. This detailed feedback allows facilitators to design a group experience that is accessible, comfortable, and responsive to diverse needs, central principles of trauma and violence informed care, while proactively removing barriers and empowering parents to shape the group according to their lived realities (Varcoe et al., 2019).
- **Facilitator Preparation Checklist:** This Facilitator Preparation Checklist is designed to support staff in thoughtfully and confidently preparing for an infant feeding support group by ensuring both practical readiness and trauma and violence informed care. The form guides facilitators through essential steps, such as booking space, gathering resources, and reviewing session content, while emphasizing inclusive, non-judgmental language and culturally responsive practices that help create emotional safety for all parents and caregivers. By prompting attention to the physical environment, accessibility, privacy, and

sensory needs, the checklist supports a space where participants can feel comfortable and respected. It also highlights safety planning, boundaries, and confidentiality, reinforcing a predictable and trustworthy group atmosphere.

- **Facilitator Reflection Prompts:** This reflection tool was created to help facilitators approach the Infant Feeding Support Group through the lens of trauma and violence informed care, particularly for families from diverse backgrounds. By encouraging staff to examine their assumptions, language, and emotional state before the group begins, the prompts help reduce the risk of unintentionally reinforcing stigma, power imbalances, or cultural biases. The questions are intentionally open-ended and self-directed, promoting curiosity, humility, and respect for participants as experts in their own experiences.

During Group Sessions

Resources and activities to help facilitators create a supportive, interactive, and inclusive environment during the sessions.

- **Guiding Principles Poster:** It outlines five core values of the infant feeding support group that is grounded in principles of TVIC, intended for display during drop-in sessions to help foster a welcoming and respectful environment and to directly shape group practices.
 - *Come As You Are:* Each session will begin by welcoming every participant without assumptions about their feeding choices, family situation, or background. This principle reflects TVIC's emphasis on creating a safe, inclusive, and welcoming environment, helping participants feel that they

belong and are respected regardless of their circumstances (Varcoe et al., 2019).

- *Nonjudgmental Support*: Facilitators will model respectful listening, redirect unhelpful comments, and remind participants of the shared agreement to honor every feeding journey. This approach reflects TVIC’s principle of building trust, as it reduces the risk of shaming or re-traumatizing participants and fosters an atmosphere where people feel safe to share openly (Varcoe et al., 2019).
- *Shared Knowledge and Experiences*: A portion of each session will invite parents to share stories, tips, or questions, with facilitators providing evidence-based information when needed. By recognizing participants as experts in their own lives, this principle aligns with TVIC’s commitment to building on people’s strengths and valuing lived experience alongside professional knowledge (Varcoe et al., 2019).
- *Practical, Real-World Support*: Each group will include time for discussing day-to-day challenges like latching, bottle-feeding techniques, pumping logistics, or formula preparation. This reflects TVIC’s principle of acknowledging the barriers people face by meeting participants where they are and ensuring that support is relevant, actionable, and accessible (Varcoe et al., 2019).
- *Empowerment and Choice*: Facilitators will prioritize giving parents control over their experience in the group. Activities such as a “check-in circle” allow participants to decide what and how much they wish to

share, highlighting their agency in contributing to discussions. The preprogramming form gives parents the opportunity to shape the group's focus based on their current needs and priorities, ensuring their voices directly influence the content and structure of sessions. To further support empowerment, sessions may end with optional relaxation or grounding exercises, providing practical tools that parents can choose to use at home in ways that fit their individual preferences and circumstances. These strategies reflect TVIC principles by actively promoting autonomy, validating participants' decision-making, and supporting their resilience in the face of challenges (Varcoe et al., 2019).

- **What an Average Drop-In Day May Look Like:** This guide is intended to give facilitators a clearer sense of how time in the drop-in group can naturally unfold. It offers a flexible framework to support consistency, confidence, and intentional engagement, while still honoring the responsive, drop-in nature of the space.
- **Ice-breaker Activities:** This baby-centered icebreaker is intentionally designed using trauma- and violence-informed principles, prioritizing choice, emotional safety, predictability, and inclusiveness for caregivers and their infants. By inviting participants to share only a single word and an optional baby moment, the activity avoids any pressure to tell personal stories or disclose information that may feel vulnerable. It supports caregivers' autonomy by offering multiple ways to participate, speaking, gesturing, smiling, or passing entirely, so no one feels put on the spot. The warm, predictable structure helps create a sense of grounding for participants who may be navigating stress, trauma, or ongoing life challenges.

Additionally, the activity includes multiple variations so facilitators can adapt it week to week, keeping the group experience fresh while still maintaining a familiar, safe rhythm. These options also allow facilitators to respond to the group's energy, cultural differences, feeding realities, and infant needs, ensuring the activity remains accessible and welcoming to all families. An icebreaker activity was recommended multiple times in the toolkit feedback form distributed to staff at FDCHC. As with all resources in this toolkit, it will be adjusted based on parents' and caregivers' feedback.

- **Relaxation Exercise Guide:** Trauma-informed and relaxation practices, such as gentle guided breathing, sensory awareness, and accessible relaxation options, are recognized as helpful components in group support settings because they promote emotional regulation and safety without requiring disclosure of personal experiences (Odyssey Domestic Violence Network, 2020). This relaxation guide is shaped to reflect a trauma and violence informed approach by creating an environment that feels predictable, respectful, and welcoming for caregivers and their babies. It avoids silence, stillness, or closed-eye expectations, which can be uncomfortable or triggering for some participants, and instead invites people to participate in whatever way feels comfortable. Baby sounds, movements, and needs are woven into the exercise, so caregivers never feel pressure to control their surroundings. Each step offers gentle options rather than instructions, allowing participants to decide what feels right for them. The guide also includes multiple variations that facilitators can use from week to week, helping maintain familiarity while offering different ways to settle into the group. Overall, this

approach supports a space where caregivers can arrive as they are, feel respected in their experiences, and engage at a pace that feels safe and manageable.

- **Discussion Themes & Gentle Conversation Prompts:** These discussion themes were created to support facilitators in guiding gentle, open conversations rather than leading a lecture-style session. The prompts are intentionally simple, flexible, and parent-led, encouraging caregivers to share only what feels comfortable and to recognize themselves as the experts in their own journeys. By centering lived experience, choice, and the message that there is no single “right way” to feed or care for a baby, the approach helps parents feel empowered, respected, and validated. This design also reflects trauma and violence informed principles by avoiding pressure, judgment, or assumptions, and instead fostering a space where people can participate at their own pace, learn from one another, and feel supported in a calm, predictable environment. Having discussion prompts was noted as something staff at FDCHC identified as helpful in the toolkit feedback form. The goal is to create a discussion that feels welcoming, collaborative, and grounded in mutual learning.
- **Infant Weight Slip:** This take-home weight slip was created to give parents a private, optional way to record their baby’s weight without pressure, oversight, or expectations. By placing the slips beside the scale and not collecting them, facilitators reinforce that weight is not the focus of the group, nor is it a judgment of feeding success. Parents can choose whether to weigh their baby, whether to record it, and whether to talk about it, supporting autonomy and reducing stress. This approach aligns with trauma- and violence-informed care by respecting

privacy, avoiding power dynamics around health information, and offering tools that caregivers can use only if they find them reassuring or helpful.

Post-Group Follow-Up

Tools to support reflection, evaluation, and continued connection after the sessions.

- **Participant Feedback form:** This form is intended to be completed during or at the end of group sessions. For parents that attend multiple sessions they will not be expected to fill out a form each visit to prevent participant burden but will recommend/offer every third visit. This form invites parents to share what aspects of the group are working well and what could be improved. Collecting this feedback regularly will allow facilitators to adapt the content, approach, and environment to better meet participants' evolving needs, ensuring the group remains responsive and participant centered (Butler et al., 2020).
- **Resource Handouts:** This handout was created to provide parents with easily accessible information about free baby play groups, community programs, and professional support services in Fredericton. It lists fun and engaging activities, such as library story times and family resource center programs, that promote social connection and reduce feelings of isolation — factors shown in the literature to positively impact postpartum mental health (Corrigan et al. 2015; Phang & Koh, 2011). The handout also includes contact details for essential supports including social work, dietitian services, breastfeeding specialists, and nursing phone line, ensuring parents know how to reach trusted professionals when they need extra help. Distributing this resource during group sessions helps

parents build community connections. A QR code in the bottom right corner links families to online resources for continued support after the group.

- **Facilitator Reflection Log:** This facilitator reflection log was created to support thoughtful, responsive facilitation rather than evaluation or critique. It encourages facilitators to pause after each session, notice what went well, and identify gentle adjustments that can strengthen future groups. The questions focus on group comfort, engagement, safety, and emotional tone—key elements of trauma- and violence-informed care—while also offering space for facilitators to reflect on their own well-being and needs. By looking at group dynamics, participant responses, and emerging themes, facilitators can continue shaping sessions that honour caregiver experiences, celebrate strengths, and remain flexible to the changing needs of families. Ultimately, this log helps maintain a supportive, grounded environment where both facilitators and parents feel valued and empowered.
- **Data & Next Steps Form:** This form serves two purposes: it allows facilitators to collect useful session data to guide potential future research while simultaneously guiding content updates and planning for future groups. It keeps participant autonomy, privacy, and choice at the forefront, data is optional and never tied to personal identifiers unless a parent chooses to share. The structure supports trauma and violence informed care by focusing on participant needs, engagement, and well-being rather than evaluation or judgment. By capturing emerging topics, responses, and caregiver priorities, facilitators can adapt content week to week to reflect what caregivers want and need. Additionally, the aggregated insights from

these forms can inform future research and program development in community infant feeding support, helping identify common challenges, resource gaps, and best practices that strengthen local support networks and guide evidence informed improvements.

Conclusion

This tool kit operationalizes trauma and violence informed care by creating a space where parents' experiences are validated and external factors such as racism, poverty, or harmful gender norms are recognized as contributors to feeding challenges, rather than placing blame on individual parents. For instance, discussions can highlight how lack of workplace accommodation or unsupportive partners can influence feeding plans, helping parents understand these pressures as systemic failures rather than personal, which is a core component of TVIC (Varcoe et al., 2019). Together, these materials and strategies form a practical framework for launching a support group rooted in best practices. This framework ensures that the group environment upholds the four key values of TVIC safety, trust, strength, and empowerment, for the families served by the FDCHC.

This structured approach ensures that the toolkit is grounded in evidence, responsive to community needs, and provides concrete resources to support high quality, inclusive infant feeding support groups at FDCHC. This initiative is designed as a pilot project, with the potential for subsequent research focusing on systematic analysis of parent feedback forms as well as longitudinal engagement with parents at three- and six-month intervals. These follow-up points of contact will provide critical data to assess the ongoing safety, inclusiveness, relevance, acceptability, and impact of the support groups,

while also informing ongoing enhancements and contributing to the broader evidence base on community-based infant feeding interventions.

Program Evaluation

To evaluate the success of this initiative, two distinct areas will be measured: Toolkit Effectiveness and Group Satisfaction and Impact. These must be evaluated separately to determine whether the program is functioning as intended before entering the research phase.

1. Toolkit Measurement

The toolkit itself will be evaluated based on clarity, usability, and facilitator confidence.

Measurable outcomes may include:

- At least 80% of facilitators report that the toolkit increased their confidence in leading a drop-in session.
- At least 80% of facilitators report the toolkit is easy to navigate and implement without additional training.
- Facilitators demonstrate consistent use of core components.

Data collection methods may include facilitator surveys, structured feedback forms, and brief debrief interviews after implementation.

2. Group Satisfaction and Program Impact

The second area of evaluation focuses on parent and caregiver experience. Measurable outcomes may include:

- At least 90% of participants report feeling welcomed and respected.
- At least 90% of participants report feeling supported in their feeding choices.
- Increased self-reported confidence in parenting or feeding decisions after attending.

- Repeat attendance rates (an indicator of perceived value and safety).
- Anonymous feedback indicating that the space feels non-judgmental and inclusive.

Data collection methods may include anonymous post-visit surveys, attendance tracking, and informal qualitative feedback.

By clearly separating toolkit evaluation from group satisfaction outcomes, the program can be assessed for both structural integrity and participant impact. This ensures the toolkit is not only well-designed in theory, but effective in practice.

Discussion

The work presented in this report offers a novel approach to supporting parents seeking assistance with infant feeding. The proposed support group differs from usual care within the Horizon Health Network and from approaches guided by the Baby-Friendly Initiative (BFI), as it is intentionally designed to offer parents a broader and more holistic range of supports. Rather than promoting a singular or prescriptive approach to infant feeding, the group actively works to reduce feelings of guilt, pressure, and inadequacy that can arise from breastfeeding-only messaging.

While the group includes the provision of evidence-informed education about infant feeding, its goals extend beyond nutrition alone to encompass emotional support and responsiveness to parents' self-identified priorities. By centering parents' needs for confidence, validation, and emotional well-being, the group supports families in nurturing their infants in holistic ways that recognize relational, social, and contextual factors alongside feeding practices.

This approach challenges dominant models of healthcare delivery by explicitly acknowledging the potential for unintentional harms associated with breastfeeding-exclusive initiatives and the paternalistic, prescriptive tendencies of the biomedical model that position healthcare providers as the sole experts. In contrast, this project adopts a strength-based framework that recognizes parents as experts in their own families' well-being. By shifting power and authority toward parents, the support group creates opportunities for increased confidence and self-efficacy.

Overall, this work reflects a TVI approach in which the potential harms of healthcare interactions are intentionally addressed and dismantled. Through collaborative

relationships with trusted FDCHC staff, parents are supported to draw on their own strengths, knowledge, and values to make decisions that are best for their families.

Comparing Literature and Staff Insights

The comparison between the literature on infant feeding and the responses from staff at the FDCHC reveals both meaningful similarities and important differences. Overall, both sources highlight that most existing support services are tailored primarily toward breastfeeding. For example, resources that the staff mentioned, such as the Mother Baby Clinic, lactation consultants, the medical doctor in Fredericton, and Public Health nurses, largely focus on supporting breastfeeding initiation and continuation. This aligns with research showing that most national and community-level supports, such as the Baby-Friendly Initiative and the Canada Prenatal Nutrition Program, emphasize breastfeeding as the primary goal (Benoit et al., 2023; Francis et al., 2020; Mildon et al., 2021). Some staff noted that certain providers and services discuss alternative feeding options, and they expressed a desire to see support become more inclusive of all feeding choices. This emphasis on inclusivity reflects findings that parents often lack support for formula feeding and that over-prioritizing breastfeeding can marginalize families using other methods (Dessi et al., 2024; Martucci & Barnhill, 2018).

A significant shared theme across both the literature and staff responses was the recognition of pressure to breastfeed and the emotional impact this can have when feeding does not go as planned. Both highlighted that this can lead parents to experience guilt, shame, and feelings of failure, echoing findings that parents internalize societal expectations and often feel judged when they cannot breastfeed (Callaghan & Lazard, 2012; Hemeon et al., 2023). These emotional responses underscore the need for sensitive,

nonjudgmental, and person-centered care, as emphasized in research advocating for trauma and violence informed infant feeding supports (Benoit et al., 2016; Hughes & Jones, 2014; Varcoe et al., 2019).

Despite these strong overlaps, there were notable differences in emphasis. The literature review focused more on understanding the *why* behind infant feeding decisions and the emotional experiences, exploring historical, cultural, and gendered norms that shape societal expectations around breastfeeding (Martucci & Barnhill, 2018; Símonardóttir & Gíslason, 2018). These broader systemic influences were less prominent in staff discussions, likely reflecting the nature of the discussion prompts, which emphasized more practical concerns rather than structural critiques.

Conversely, staff responses brought to light highly practical and immediate concerns that were less emphasized in the literature reviewed. Staff repeatedly noted parents' worries about insufficient milk supply, infant weight gain, growth curves, latching, nipple pain, and finances. While the literature does acknowledge some of these challenges, such as maternal concerns about growth and the cost of feeding supplies (Harrison et al., 2018; Harison & Lahav, 2024), staff accounts foregrounded them as central daily realities influencing feeding choices. These concerns are critical to address, as they represent concrete anxieties that can compound the emotional pressures already associated with infant feeding (Dennis & McQueen, 2009).

Taken together, the comparison suggests that while both the literature and staff recognize the emotional complexity of infant feeding and the need for supportive, inclusive care, staff also see a need to address highly practical feeding concerns that may be overlooked in more theoretical analyses. This underscores the value of combining both

perspectives when designing and delivering infant feeding support services at the FDCHC, ensuring they are both emotionally attuned and practically responsive to parents' needs (Dessi et al., 2024; Francis et al., 2020; Hemeon et al., 2023).

Intervention Considerations

The design and implementation of this support group align closely with existing literature on effective, equity-oriented infant feeding interventions. First, the structure of the group is consistent with TVIC principles, which emphasize emotional safety, choice, collaboration, and the reduction of power imbalances. By positioning parents as leaders and health care professionals as facilitators rather than educators, this model reflects TVIC best practices and responds directly to concerns raised in research about the harm caused by pressured based infant-feeding messaging.

The availability of a baby cupboard during the support group, stocked with formula, diapers, breast pumps, and other essential supplies, further aligns this work with global standards such as the Baby-Friendly Initiative (BFI). Although BFI is often interpreted narrowly as breastfeeding focused, more recent interpretations emphasize that all parents should be supported in their chosen feeding method. BFI guidance still recommends that formula be stored in a designated cupboard, and this respects that requirement while ensuring that formula and other essential supplies remain freely accessible to families. In doing so, the baby cupboard reflects both the principles of BFI and the expectations of the HHN Network, which continues to strive toward BFI designation, while also addressing equity and the practical needs of families at FDCHC.

This toolkit parallels previous infant feeding interventions that emphasized support groups and peer support such as La Leche League Canada, Breastfeeding

Buddies program, and Canada Prenatal Nutrition Program community groups. Many existing models, both past and present, focus on peer connection, emotional support, and skill-building; however, they often also aim to increase breastfeeding duration and exclusivity, rely on directive teaching, or provide prescriptive feeding guidance. These programs are sometimes advertised specifically as “breastfeeding groups,” and they frequently use language such as “mom,” which does not reflect the diversity of parents and caregivers.

The FDCHC model aligns with these earlier interventions in its supportive intentions, particularly the emphasis on peer connection and access to evidence-informed resources, while intentionally diverging in ways that center inclusivity, autonomy, and emotional well-being. It seeks to reduce guilt and avoid language that could be experienced as blaming or coercive. This toolkit is explicit about reducing trauma and violence that can be unintentionally enacted on clients within the health care system, empowering parents, and creating a space where all feeding choices are supported without judgment. Together, these elements represent a meaningful adaptation within the Canadian community health context, placing emotional safety for all parents and caregivers at the forefront.

The of this pilot project highlight the importance of designing infant-feeding support programs that prioritize emotional safety, inclusivity, and parental autonomy. Traditional models often emphasize a single “best” way to feed an infant, exclusive breastfeeding, which can unintentionally create pressure, guilt, or feelings of inadequacy for parents who are unable or choose not to follow this approach. By centering a trauma and violence informed approach, non-judgmental support, and respect for diverse feeding

choices, this toolkit offers a model that is more responsive to the needs of families in the community.

Additionally, the emphasis on peer connection and access to evidence-informed resources highlights the importance of relationship focused, community-centered approaches in supporting families. This model demonstrates that supporting parents goes beyond promoting one “best” feeding method, it involves creating safe, empowering spaces where all caregivers can access guidance, connection, and validation in their feeding decisions. These insights may guide other community health centers seeking to implement inclusive and parent centered infant-feeding support programs.

Limitations

A key limitation of this report is the absence of direct input from parents and caregivers in the Fredericton community during the data collection process. While the toolkit was informed by existing literature, best practices, and staff at the FDCHC, the perspectives of local parents were not formally integrated at this stage. Additionally, data from staff were collected primarily via written responses, supplemented by informal discussions. While this approach was flexible and accommodated staff schedules, it may have limited the depth of insight compared with more interactive methods, such as structured interviews or focus groups, where real-time probing could have uncovered more nuanced perspectives. As a result, the recommendations may not fully reflect the lived experiences, cultural contexts, or specific needs of families who will ultimately use this resource.

This report should therefore be viewed as an initial step, a pilot version of the toolkit designed to establish a foundation for future development. The accompanying

feedback form provides an important opportunity to gather insights directly from parents and caregivers as the toolkit is implemented. Their reflections, suggestions, and critiques will be essential for refining the model, strengthening its relevance, and ensuring it remains responsive to the diverse feeding experiences within the Fredericton community.

Ongoing engagement with families will be crucial for validating the toolkit's approach and informing future refinements.

Directions for Future Research

Future research should prioritize direct engagement with parents and caregivers in the Fredericton community to ensure that the toolkit accurately reflects their lived experiences, cultural contexts, and feeding needs. The feedback form accompanying this pilot version provides a starting point for collecting community perspectives; however, more robust qualitative methods, such as focus groups or interviews, could deepen understanding of infant feeding supports at the FDCHC and where improvements are needed.

Further study is also warranted to assess the toolkit's impact on parental confidence, emotional safety, feeding satisfaction, and overall program accessibility. Evaluating outcomes across diverse populations, including those who have historically faced barriers to infant feeding support, will be essential for determining its applicability and potential for broader implementation in other community health settings.

Closing Statement

This pilot project represents an important first step in developing a more inclusive and emotionally safe approach to infant feeding support within the FDCHC. While further refinement will depend on feedback from parents and caregivers, the foundations

established through this work offer a promising direction for strengthening family centered care. Continued collaboration with the community will ensure that the toolkit evolves into a resource that truly reflects and supports the diverse feeding journeys of all families.

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Appendix A

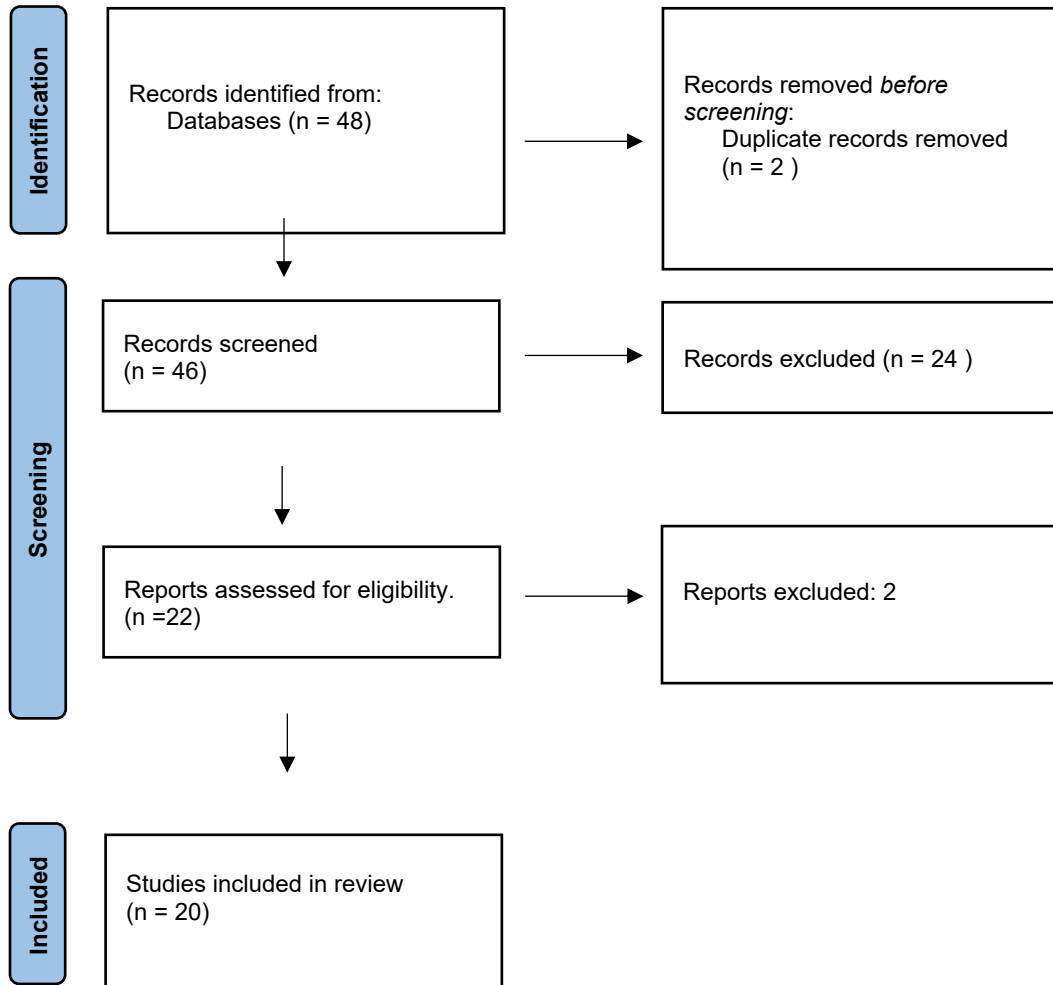
Search Details and Prisma Diagram: A Critical Analysis of Social and Health

Conceptualization of Infant Feeding

Search String:

infant feeding AND (culture or cultural or ethnicity or identity or values or cultural influences or social norms or cultural practices or western culture or cultural attitudes or sociocultural factors or social determinants) AND (gendered roles or motherhood or gender or fathers or gendered expectations or gender division or gendered practices) AND (feminist theory or feminist or trauma or oppression or violence or "the one best way") AND (breastfeeding or complementary feeding or formula feeding or responsive feeding or mixed feeding or infant nutrition or feeding practices or infant feeding choices or infant feeding methods or nourishment in infancy)

PRISMA Flow:



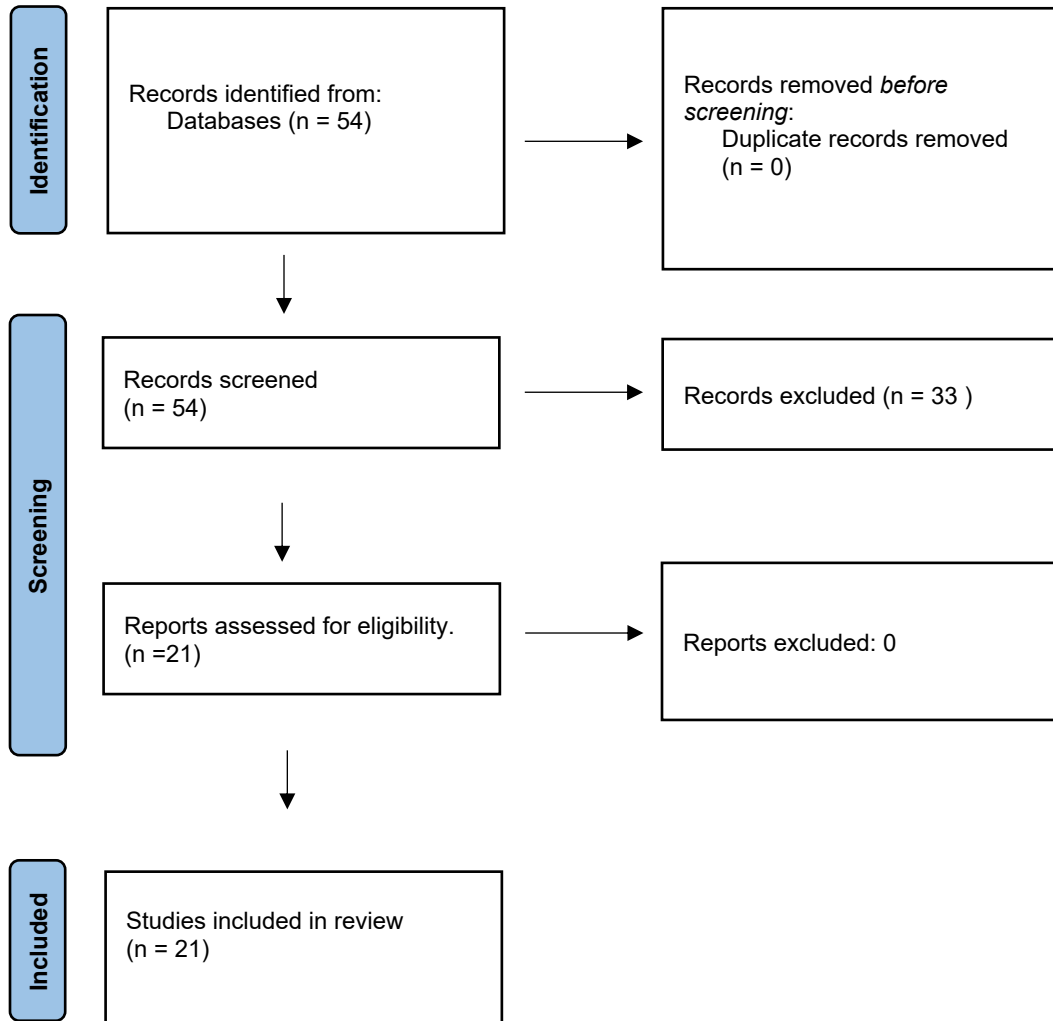
Appendix B

Search Details and Prisma Diagram: Navigating Infant Feeding

Search String:

"infant feeding" OR breastfeeding OR "complementary feeding" OR "formula feeding"
OR "responsive feeding" OR feeding OR bottle OR nutrition AND "help seeking" OR
"support seeking" OR support OR help AND mother* OR parent* OR maternal OR
parental
AND barrier* OR experience* OR access* OR challenge* OR "information seeking" OR
"parental attitudes" OR "maternal attitudes" OR "support group*" AND infant* OR
newborn*

PRISMA Flow:



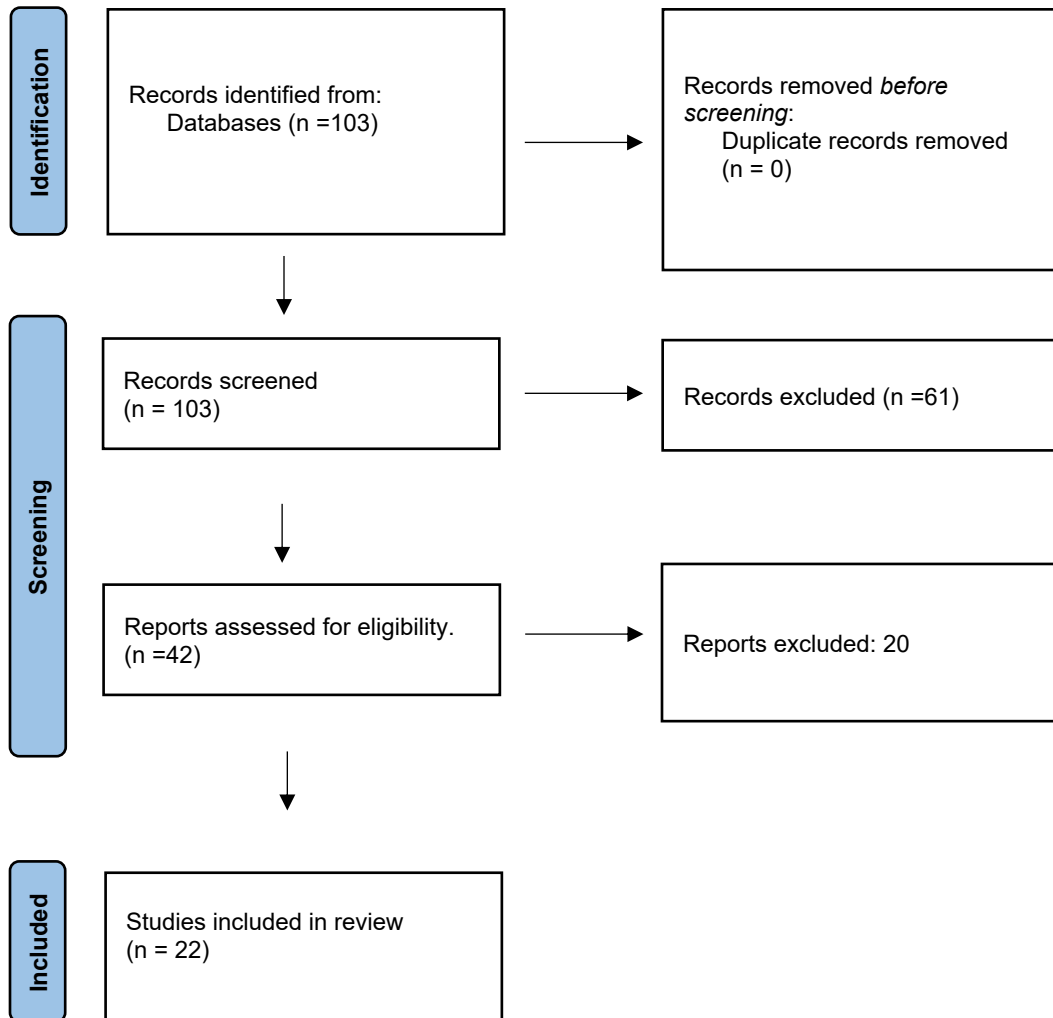
Appendix C

Search Details and Prisma Diagram: Support Services for Infant Feeding

Search Sting:

("support services" OR "available support" OR interventions) AND ("infant feeding" OR breastfeeding OR "complementary feeding" OR "formula feeding" OR "responsive feeding" OR "combo feeding" OR "mixed feeding") AND (availability OR accessibility OR access OR effectiveness OR "parental experiences") AND (Canada OR "United States" OR "North America" OR "Indigenous")

PRISMA Flow:



Appendix D

FDCHC Staff Discussion Guide

FDCHC Staff Interview Guide – Infant Feeding Report

Master of Nursing Report – Brook Ramos, RN, MN Student

Purpose of This Report

This interview guide is part of a Master of Nursing final report for the University of New Brunswick. The purpose of this report is to explore infant feeding experiences at the Fredericton Downtown Community Health Centre (FDCHC), with the aim of informing the potential reintegration of a community-based infant feeding support group at the FDCHC. The goal of interviewing staff is to better understand the unique needs, challenges, and strengths of the parents served at the FDCHC.

The final report will be submitted to the University of New Brunswick as a requirement for the Master of Nursing program. It may also be shared with FDCHC leadership and staff to inform care practices and programming. It is not intended for publication or broader academic dissemination at this time.

How Your Responses Will Be Used

Your insights will help identify themes and patterns that reflect the real-life experiences of parents at the FDCHC. These themes will be presented in the report in a general, de-identified way. Some quotes may be used but will not be assigned to a specific staff member.

Confidentiality and Voluntary Participation

- Participation is completely voluntary.
- There is no obligation to complete the questions.
- Whether or not you participate will not be known to your employer and will have no impact on your role at the FDCHC.
- All responses will be kept anonymous and will not be linked to your name or position.

If you choose to participate, you are welcome to respond in writing (using this form) or verbally (in person, virtually, or by phone).

Your Name: _____

Date: _____

By checking this box, you consent to allowing me to use the information you share below in my report that will be submitted to the University of New Brunswick as part of the graduation requirements for my Master of Nursing program.

Interview Questions

1. What are you seeing and hearing from parents in the postpartum period?

Prompt: What are you observing and hearing from them? Tell me about their challenges...

2. What are parents telling you about their infant feeding experiences—either challenges or what is working well?

Prompt: What would you say about their level of support? Tell me about what they are saying about access to help...

3. How are parents managing the challenges of infant feeding?

Prompt: What can you tell me about their satisfaction? Tell me about the difficult times, such as difficult emotions they may be having (guilt, shame, frustration) ...

4. What specific concerns come up regularly during the prenatal or postpartum period related to infant feeding?

5. From your perspective, what would an effective and supportive infant feeding group at the FDCHC look like, and why?

Prompt: What topics should be covered? What kind of approach would make parents feel safe and supported?

6. Please share an example—without identifying details—of a parent who struggled or felt good about their infant feeding journey.

Prompt: What seemed to support or hinder their experience?

7. Is there anything else you would like to share regarding parents and infant feeding at the FDCHC?

Thank you for taking the time to share your experience and insights.

If you have any questions about the project, please do not hesitate to contact me or my supervisor:

Brook Ramos, RN

Master of Nursing Student

bbilling@unb.ca

Dr. Petrea Taylor

Faculty of Nursing, University of New Brunswick

petrea.taylor@unb.ca

Appendix E

FDCHC Staff Toolkit Feedback

FDCHC Staff Toolkit Feedback – Infant Feeding Report

Master of Nursing Report – Brook Ramos, RN, MN Student

Purpose of This Report

This guide is part of a Master of Nursing final report at the University of New Brunswick. Its purpose is to gather input from staff at the Fredericton Downtown Community Health Centre (FDCHC) to inform the development of a community-based infant feeding support group and a corresponding facilitation toolkit. Staff feedback will help ensure that the toolkit reflects the needs, challenges, and strengths of the parents served at the FDCHC.

The final report will be submitted to the University of New Brunswick as a requirement for the Master of Nursing program. It may also be shared with FDCHC leadership and staff to inform care practices and programming. It is not intended for publication or broader academic dissemination at this time.

How Your Responses Will Be Used

Your responses will help identify priorities, strategies, and practical tools for the support group toolkit. All feedback will be presented in a general, de-identified manner. Some illustrative quotes may be used, but no responses will be attributed to specific staff members.

Confidentiality and Voluntary Participation

- Participation is completely voluntary.
- There is no obligation to complete the questions.
- Whether or not you participate will not be known to your employer and will have no impact on your role at the FDCHC.
- All responses will be kept anonymous and will not be linked to your name or position.

If you choose to participate, you are welcome to respond in writing (using this form) or verbally (in person, virtually, or by phone).

Your Name: _____

Date: _____

By checking this box, you consent to allowing me to use the information you share below in my report that will be submitted to the University of New Brunswick as part of the graduation requirements for my Master of Nursing program.

Toolkit Feedback Questions

1. What types of materials or resources would be most helpful for facilitators in a support group toolkit (e.g., session outlines, icebreaker activities, discussion prompts, evaluation tools)?

Dr. Petrea Taylor

Faculty of Nursing, University of New Brunswick

petrea.taylor@unb.ca

Appendix F

Facilitator Toolkit

See next page.

**Facilitator Toolkit for
Infant Feeding Support Group at
Fredericton Downtown Community Health Centre (FDCHC)**

Prepared for:

Facilitators and Staff of FDCHC

Prepared by:

Brook Ramos RN MN(c) in collaboration with FDCHC Staff

Supervised by:

Dr. Petrea Taylor, PhD, MN, RN, PMHN(c) – University of New Brunswick

Committee Members:

Dr. Rosann Edwards, PhD, MScN, RN, IBCLC – University of New Brunswick

Tricia Van Roeden, RN, Nurse Manager – FDCHC

Amy Hughes, BA, RN, CAPP – FDCHC

Date:

February 2026

Purpose:

This guide provides practical resources, templates, and activities to support the planning, delivery, and evaluation of inclusive, trauma- and violence-informed infant feeding support groups. It is designed to be user-friendly and adaptable to meet the diverse needs of parents and caregivers in the FDCHC community.

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Background

Support groups play an important role in helping parents feel connected, supported, and confident in their infant feeding choices. Becoming a new parent can be both joyful and challenging, and many people experience isolation, uncertainty, or pressure to make the “right” decisions about how to feed their babies. Support groups provide a safe place for sharing experiences, asking questions, and receiving encouragement from peers and professionals. Research shows that when parents feel supported and accepted, their overall well-being improves and they are better able to care for themselves and their infants (Dessi et al., 2024; Grattan et al., 2024).

Literature and staff dialogue at the Fredericton Downtown Community Health Centre (FDCHC) have emphasized the need to change how infant feeding is approached. Infant feeding conversations have been shaped by the “breast is best” message. While this message was intended to promote human milk at a time when the practice of breastfeeding was being lost to the majority of families, it can unintentionally exclude or shame parents whose experiences differ from this idealized standard. The focus on one “best” method overlooks the complex realities of parenting, such as certain health conditions, trauma, overall health, cultural traditions, work demands, and access to supports. Patient-centred care cannot end once someone becomes a parent and needs to make a choice about how they feed their baby. Every parent deserves compassionate, respectful care and the right to make informed and supported feeding choices that work best for their family without fear of judgment or guilt.

Across Canada, infant feeding practices are diverse. National data show that while approximately 91% of parents in Canada initiate breastfeeding (Public Health Agency of

Canada, 2024), a significant portion introduce formula, combination feeding, or expressed milk in the first three months. Parents in New Brunswick reflect this national trend, with nearly half of parents not exclusively breastfeeding by hospital discharge (Horizon Health Network, 2022). By six months of age only 34.5% of infants in Canada are exclusively breastfed (Benoit et al., 2023). Regardless of public health recommendations, families need inclusive, practical, and non-judgmental support that meets their real-life infant feeding practices.

Around the world, support group programs have been shown to build parents' confidence, reduce stress, and promote positive feeding relationships. However, many global models and interventions are based on single approaches, such as breastfeeding-only groups. While helpful for some, these models do not always meet the needs of communities, especially those with diverse family structures and experiences, or for most parents in our community who are not exclusively breastfeeding. This model aims to remove pressure and guilt, avoid language that promotes one feeding method over another, and create an inclusive environment where all caregivers feel valued and empowered.

Objectives

This toolkit was developed to support facilitators and staff at the Fredericton Downtown Community Health Centre (FDCHC) in providing inclusive, compassionate, and evidence-based infant feeding support. It is designed to guide the reintroduction of an infant feeding support group that reflects the diverse experiences and needs of families within our community.

This group is built on a TVIC approach to ensure parents feel safe, respected, and in control of their own infant feeding choices. In this model, staff do not act as teachers or leaders; instead, parents lead the conversation, and health care professionals simply facilitate and provide evidence-based information when it is asked for. The goal is not to push any specific feeding method but to support emotional well-being and reduce the risk of trauma or pressure. While adhering to the evidence-based practice that human milk is the biologically optimal food for most infants, we recognize that “breastfeed at all costs” messaging can be harmful to parents. Using a TVIC lens helps us avoid these harms and ensure that every parent’s experience, informed choice, and comfort level is honored while supporting families to meet their individual infant feeding goals and chosen infant feeding practices.

The main objectives of this toolkit are to:

- Enhance staff capacity to provide inclusive, evidence-based, and non-judgmental infant feeding support across diverse infant feeding practices, choices, and family experiences, including newcomers, single parents, gender-diverse individuals, and low-income families.

- Foster reflective practice by encouraging staff to examine how language, assumptions, and systemic norms influence care and how these factors can unintentionally create pressure or exclusion for parents.
- Rebuild confidence and trust among parents by ensuring that all feeding methods and family structures are supported with empathy, cultural sensitivity, and accurate, evidence-based information.
- Guide group facilitation for an infant feeding support group that is welcoming to all parents and caregivers, regardless of gender, family structure, or feeding approach, and that promotes peer connection and community.
- Embed trauma and violence informed principles in all aspects of group facilitation, ensuring safety, choice, collaboration, and empowerment for participants.
- Support continuous learning and improvement by offering facilitators tools and resources to adapt group content, reflect on feedback, and respond to evolving community needs.

Through these objectives, the toolkit aims to strengthen FDCHC's commitment to equity, inclusion, and holistic family well-being. It provides practical guidance, discussion tools, and reflection prompts to help facilitators create supportive spaces where every parent feels seen, respected, and confident in their feeding journey.

Deliverables

Pre-Group Preparation:

Request for Funding Letter

Fredericton Downtown Community Health Centre

339 King Street

Fredericton, NB E3B 1E4

[Date]

[Recipient Name]

[Title]

[Organization Name]

[Address]

Dear [Recipient Name],

Re: Funding Request to Support Infant Feeding Support Group at FDCHC

On behalf of the Fredericton Downtown Community Health Centre (FDCHC), I am writing to request funding to support the reintegration of an infant feeding support group for parents and babies in our community.

FDCHC is in the ideal location in the downtown core and serves a diverse and often underserved population, including low-income families, newcomers, refugees, and individuals who experience systemic barriers to healthcare. There is a need for a safe and supportive space where parents can receive guidance, build confidence, and share their infant feeding experiences among fellow parents. This group would address gaps in care by offering a consistent, safe space for all parents in the community regardless of the way they feed their baby.

To ensure the group is welcoming, accessible, and sustainable, we are seeking funding for:

- Staffing: A trained facilitator with expertise in infant feeding and culturally responsive care
- Nutritious snacks for participating parents and their children
- Essential supplies, such as feeding pillows, printed resources, formula, and materials to support education and engagement.

Evidence from the literature and staff at FDCHC highlights the importance of emotional and peer support as well as support that addresses practical concerns of infant feeding.

With your support, this group has the potential to provide both emotional and practical support, improving parental and baby health.

We would be happy to provide a detailed budget or meet to discuss how your support could make this project possible. Thank you for considering our request and for your ongoing commitment to supporting the health and well-being of families in our community.

Sincerely,

[Your Name]

On behalf of the Fredericton Downtown Community Health Centre

University of New Brunswick

339 King Street, Fredericton, NB E3B 1E4

[Your Email Address]

[Your Phone Number]

YOU ARE NOT ALONE

Infant Feeding Support Group

Drop-In Style — Open to Anyone with a Baby

Come As You Are. Feed As You Are.

Whether you're breastfeeding, formula-feeding, pumping, combo-feeding, or figuring it all out — you are welcome here.

Join us for a casual, supportive space to connect with other parents and babies & get evidence-based infant feeding info and support.

 Peer Support  Real Conversations  No Judgment

Where?

Fredericton Downtown Community Health Centre
339 King Street, Fredericton, NB
Graham Smith Room — Cozy seating, change table, scale, and feeding pillows available.

What to Expect:

- Coffee, tea, and light snacks
- A welcoming circle of parents
- Trained supportive staff
- Infant feeding resources to take home
- Relax, ask questions, and share stories




When?

[Insert Day] at [Insert Time]
(Drop-in — no registration needed!)

Why Join?

Parenting is hard, feeding can be complicated, and you deserve support — no matter how you feed your baby.

Questions?

 506-452-5683  bbilling@unb.ca  Or just drop in!

Supported by the Fredericton Downtown Community Health Centre
Serving families with compassion, respect, and care.



Pre-programming Planning Form

FDCHC Infant Feeding Support Group: We Want to Hear from You

We're planning an infant feeding support group at the Fredericton Downtown Community Health Centre (FDCHC) and would love to hear from you! Your input will ensure the support group is tailored around the current needs of families in our community.

Consent

By completing this form, you are agreeing to allow FDCHC staff to use your responses to help guide the planning and development of the infant feeding support group. Your responses are voluntary and confidential.

I consent to the use of my responses for program planning by FDCHC staff.

I am expecting a baby or have a baby (under 1 year of age).

Signature: _____ Date: _____

1. What format would you prefer for the support group?

In-person group drop-in style at FDCHC

Virtual/online group sessions

Other (please specify): _____

2. What topics or types of support would be most helpful to you?

Prompt: What is or was your main concern regarding infant feeding

Check all that apply or write your own:

Breastfeeding support

Formula feeding support

- Pumping and storing milk
- Combo feeding (breastmilk and formula)
- Nutrition for parents & babies
- Emotional support
- Connecting with other parents
- Other: _____

3. How would you like information shared? (Circle one)

- | | | |
|----------------------|----|---|
| Formal | | Informal |
| (presentation style) | OR | (e.g., conversation, posters, handouts) |

4. What time of day works best for you and baby to attend a group?

- Morning
- Midday
- Afternoon
- Evening
- Other: _____

5. Do you have any ideas or recommendations on what this group should look like?

(Prompt: What equipment would you like to be available, what should the room look like, should there be a private area for parent and baby?)

6. What is the most important thing for this group to have/include?

(Could be an object, a value, something to do with the structure of the group- no wrong answer)

7. What is the most important thing for this support group NOT to do?

Optional: Would you like to be contacted when the group starts?

Name: _____ Phone or Email: _____

Infant Feeding Support Group: Facilitator Preparation Checklist

1. Administrative & Logistics

- **Confirm and book the education room** (date, time)
- **Verify funding/resources** (snacks, printed materials, taxi vouchers, supplies, etc.).
- **Confirm advertising/promotion** has been completed and is accurate (flyers, social media, clinic posting, community partners).
- **Prepare and print any forms** (feedback form, community resources, activities)

2. Content & Facilitation Readiness

- **Review group goals and session plan** (topics, flow, timing).
- **Ensure inclusive language** is used throughout materials and facilitation:
 - *Say parents, caregivers, families* instead of assumptions (e.g., “moms”).
 - Avoid judging feeding choices; affirm all safe feeding methods.
 - Consider cultural and linguistic diversity—have translated line available).
- **Review key support information** (common feeding challenges, local lactation resources, formula-feeding supports, referral pathways).
- **Prepare supplies** (dolls, pumps, bottles, nursing pillows, formula, etc.).

3. Room & Environment Setup

- **Arrange seating** to be comfortable, accessible, and non-hierarchical (circle, soft seating if available).

- **Set up a private or low-stim space** for participants who need quiet or extra privacy.
- **Ensure the room is physically accessible** (stroller access, wide pathways, waiting room chairs not in way).
- **Temperature, lighting, and noise levels** checked and adjusted.
- **Refreshments and hydration** available.
- **Hand hygiene supplies** stocked and visible.
- **Posters** put on wall (guiding principles poster)

4. Safety & Well-Being

- **Review safety considerations:**
 - Emergency exits, evacuation plan, and who to contact for emergencies.
 - Allergens in the room (clean surfaces; avoid strong scents).
- **Check infant-safe environment** (no choking hazards, clean floor space for tummy time).
- **Ensure facilitators are aware of boundaries** (supportive listening, empower, respect)
- **Plan for confidentiality reminders** at session start.

5. Final Pre-Group Check

- **Technology tested** (videos, slides, Wi-Fi, if used).
- **Facilitators check in** with one another about roles and flow.
- **Take a moment to center:** calm, warm, non-judgmental presence.

Facilitator Reflection Prompts: Preparing for an Infant Feeding Support Group

Before the session begins, take 5–10 minutes to reflect on the questions below. These prompts are meant to support grounding, self-awareness, and a compassionate, inclusive approach for all participants.

1. Examining Assumptions & Biases

- What assumptions am I bringing today about infant feeding, parenting roles, or family structure?
- Am I holding any “default images” of who I expect to attend (e.g., gender, culture, age, feeding method)?
- How might my personal feeding experiences—positive or challenging—shape the way I support others?
- Are there any opinions I hold that might unintentionally show up in my tone, body language, or responses?

2. Language & Communication

- Am I prepared to use inclusive, person-centered language (e.g., “parents/caregivers,” “chest/human milk feeding,” “feeding journey”)?
- How will I avoid language that suggests judgment, hierarchy, or assumptions about what is “best”?
- What phrases can I practice ahead of time to ensure I respond with empathy, neutrality, and respect?

3. Cultural Humility & Diversity

- How am I preparing to welcome families with diverse cultural practices or feeding traditions?
- Am I open to learning from participants rather than assuming expertise?
- How will I ensure accessibility for participants who speak different languages, have different literacy levels, or communicate in different ways?

4. Power Dynamics & Safety

- How might my role as facilitator influence how participants speak or share?
- What can I do to reduce power imbalances and support participant choice and voice?
- How can I maintain trauma- and violence-informed boundaries—listening supportively without overstepping?

5. Emotional Readiness


- What do I need in this moment to show up calm, grounded, and present?
- If a participant becomes distressed, how will I respond in a way that centers safety, dignity, and empowerment?
- Which self-regulation strategies can I use before and during the group (breathing, grounding, brief pause, co-facilitator check-in)?

During Group Session:

Guiding Principles Poster

 Our Guiding Principles 

Infant Feeding Support Group

 1. Come As You Are

This is a welcoming space for all parents, babies, and feeding journeys.

 2. Nonjudgmental Support


We listen with respect and understanding, honoring every feeding choice.

 3. Shared Knowledge and Experiences


We learn together, sharing real stories, practical tips, and reliable information.

 4. Practical, Real-World Support

We talk openly about everyday concerns like weight, growth, and feeding challenges.

 5. Empowerment and Choice

We help you feel confident and supported in making the feeding decisions that work best for you.

 *You Are Not Alone. You Are Welcome, Here.* 

What an Average Drop-In Day May Look like

For Infant Feeding Support Group

Because this is a drop-in Parent Centre, no two days will look the same. Families will arrive and leave at different times, and the flow of the space will naturally shift based on who is present and what parents and caregivers need that day. Rather than following a rigid group schedule, the facilitator's role is to create a welcoming, responsive environment with gentle structure woven throughout.

Arrival & Welcome

Each parent and baby should be warmly greeted at the door whenever possible. This first interaction sets the tone. During this time, you may:

Introduce yourself and thank them for coming.

- Ask their name and their baby's name (and use them).
- Briefly explain how the drop-in works (stay as little or as long as you'd like).
- Show them where the bathroom and diapering area are.
- Invite them to help themselves to snacks or refreshments.
- Point out key areas in the room (handouts, infant scale, free supplies, seating areas).
- Ask if they have any immediate questions or needs.

The goal is to ensure each family feels seen, oriented, and comfortable right from the start.

Settling In & Informal Connection

As families settle into the space, conversation will often happen organically. Some days may feel lively and social; others may be quieter and more reflective. During this period, you may:

- Move gently between families to check in.
- Offer support around feeding, soothing, sleep, or other parenting questions.
- Highlight relevant handouts or resources based on conversations.
- Facilitate light introductions if it feels natural (“It sounds like you both have babies around the same age.”).

Because arrivals are staggered, large group discussions may not always be appropriate. Instead, think of your role as weaving together small moments of connection.

Optional Guided Moments

If a few parents appear settled and open to engagement — especially if peer interaction is minimal — this can be an opportunity to gently offer something optional. For example:

- “Would anyone be interested in a short relaxation exercise?”
- “I have a few discussion prompts about sleep/transitions/self-care if that would be helpful.”
- “We could do a brief check-in about how everyone’s week has been.”-

These offerings should always be invitational, not mandatory. The drop-in nature means flexibility is key.

Ongoing Support

Throughout the session, remain attentive to:

- New arrivals who may need orientation.

- Parents who seem withdrawn or overwhelmed and may benefit from a quiet check-in.
- Opportunities to normalize common parenting experiences.
- Providing information about community resources when appropriate

The rhythm of the space may ebb and flow — this is expected.

Departure & Closing Moments

As families begin packing up, this is an important time for connection and continuity.

During this period, you may:

- Ask if they have any final questions or concerns.
- Invite them to complete an anonymous feedback survey.
- Offer encouragement or affirm something you noticed (“You responded so calmly when your baby was upset — that was lovely to see.”).
- Thank them genuinely for coming.
- Invite them to return next week.

Even brief closing interactions help families feel valued and more likely to return.

Icebreaker Activity: “One Word and a Baby Moment”

For Infant Feeding Support Group

1. Purpose

“One Word and a Baby Moment” is a warm, low-pressure icebreaker that helps caregivers settle into the group, acknowledge how they are doing, and connect around shared infant experiences. By inviting participants to share **one word** and an optional **tiny baby moment from the day**—a smile, a stretch, a squeak, a snuggle—it gently highlights the realities of life with a baby without requiring personal storytelling. This activity supports comfort, belonging, and normalization of the ups and downs of caring for an infant.

2. Duration

5–10 minutes, flexible based on group size and infant needs.

3. Materials Needed

- None required
- Optional: a small, soft baby toy for turn-taking
- Seating arranged in a loose circle that accommodates strollers, carriers, and floor space
- A warm, slow-paced tone from the facilitator

4. Facilitator Introduction (Script)

“Before we begin today’s session, we’re going to take a gentle moment to check in. This activity is called *‘One Word and a Baby Moment.’*”

You’re invited to share **one word** that describes how you're feeling right now, and if you’d like, a tiny moment from your baby today—maybe a funny face they made, a good burp, a long nap... or no nap at all.

There’s absolutely no pressure to explain anything in detail. You can share a word, a gesture, or simply smile. And please take care of your baby however you need—feeding, rocking, soothing, changing—this is all part of the group.”

5. Instructions

Step 1: Invite Participation

“When it’s your turn, share one word that fits your day so far—like ‘sleepy,’ ‘hungry,’ ‘hopeful,’ ‘learning,’ or anything that feels real for you.

If you’d like, you can add a baby moment, but you don’t have to.

And if sharing doesn’t feel right today, a nod or smile is more than enough.”

Step 2: Optional Soft Toy Pass

If using a plush toy:

“We’ll pass this little toy around to help us take turns. If your hands are full—or your baby has claimed the toy—just point to the next person.”

Step 3: Model It First

Begin with your own:

“I’ll start. My word today is... *gentle*. And my baby moment was seeing a big baby stretch this morning.”

Step 4: Keep It Baby-Friendly

Normalize the flow:

- “Baby noises are welcome.”
- “Take your time—there’s no rush.”
- “If your baby joins in, even better.”

6. Variations

• Baby Sound Check-In

Invite caregivers to make a baby sound that fits their day—a *coo*, *sigh*, *giggle*, *yawn*, or soft “babble.”

• Baby Gratitude Twist

Each caregiver names one small thing their baby did today that brought them a moment of relief or joy:

“A long nap,” “a big stretch,” “a quiet feed,” “a new sound.”

• Baby Pose Version

Parents gently hold up a hand to show a “baby pose” that sums up their morning—
e.g., a starfish stretch, a curl-up, hands-in-the-air, sleepy-head.

- **Hands-Free / Feeding-Friendly Version**

Parents can simply look toward the next person or give a thumbs-up if they are feeding and cannot speak.

7. Facilitator Debrief

After everyone has shared:

“Thank you all for sharing—no matter how you chose to participate. Hearing these tiny words and baby moments reminds us that every caregiver is arriving from a different place, and that all experiences are welcome here. Some of us had calm mornings, some chaotic ones, and some a mix of both. What we share is that we’re here together, doing the best we can.”

Optional gentle reflection:

“Did it feel grounding to share a small moment from today?”

Or simply:

“Anything comforting about hearing others’ words?”

Relaxation Exercise Guide for Facilitators

Infant Feeding Support Group

Purpose of This Guide: This relaxation exercise helps caregivers gently settle into the group in a way that is calming and grounding, without expecting silence or stillness. Baby sounds, wiggles, and needs are all welcomed. The goal is to create a moment of ease and connection that fits the real rhythm of a baby-friendly environment.

Duration: 3–6 minutes

Materials: Comfortable seating or floor space; no quiet environment required

Tone: Warm, slow, and non-judgmental

1. Setting the Tone

“Before we begin our group today, we’ll take a short moment to arrive. This isn’t a quiet-time activity—babies will make sounds, move, and have their own things to say, and that’s completely welcome. You don’t need to quiet your baby or your body. This grounding moment works with whatever is happening right now.”

Pause briefly.

2. Comfortable Positioning

“Find a position that feels good for your body—seated, leaning back, rocking, holding your baby, or sitting on the floor together. Choose what feels safest and most comfortable for you.”

Invite gentle movement:

“If you need to adjust or shift at any point, please do. Let your baby and your body guide you.”

3. Grounding in the Present

“Notice where your body is supported—your seat, your back, your feet on the ground, or the warmth of your baby near you. Let your attention rest there for a moment.”

Pause. “If your mind drifts, gently return to that sense of support beneath you.”

4. Breath Without Pressure

“We’re not aiming for deep breaths or perfect breathing. Just notice your natural breath—however it is.”

Optional invitation:

“If it feels good, release a soft exhale—like a gentle ‘ahhh.’ No expectations, no pressure.”

5. Baby-Inspired Awareness

“Now let your awareness include your baby. Notice their warmth, their weight, their wiggles, their noises. Their movements can be part of your grounding, not something to work against.”

Normalize the environment:

“If your baby makes noise or moves, that’s not an interruption—it’s part of the moment.”

6. Noticing the Environment

“Take in the room: the soft chatter, baby sounds, hum of movement, or light in the space. Instead of tuning it out, imagine all these sounds blending together into the background, like a busy but comforting morning at home.”

Pause. “Notice anything around you that feels supportive, your chair, a warm drink, a friendly face, or your baby’s presence.”

7. Gentle Release

“Let your shoulders soften. Unclench your jaw. Soften your hands.”

Offer small movements:

“You can slowly roll your shoulders or stretch your neck from one side then to the other if that feels good.”

8. Closing the Pause

“We’ll slowly come back into the space. Maybe wiggle your fingers or toes... stretch... or look around the circle.

When you’re ready, return your attention to the group, carrying whatever steadiness you found, even if it’s just a small shift.”

9. Alternative Variations

“Three Soft Things”: Notice three soft things in the room—baby blankets, tiny socks, soft breaths, gentle sounds.

“Hand-to-Heart or Hand-to-Baby”: Caregivers place a hand on their own chest or gently on baby’s back and notice warmth and connection.

“Rocking Together”: Invite a gentle rocking motion—seated, standing, or while holding baby.

“Look Around & Land”: Guide caregivers to look around the room and rest their eyes on something calming.

“Baby Breath Sync”: Notice how the caregiver’s breath and the baby’s rhythms naturally influence one another.

Discussion Themes & Gentle Conversation Prompts

Infant Feeding Support Group

These themes can be used weekly or rotated throughout the program. Each one offers a few simple questions to help facilitators start a conversation in a supportive, low-pressure way. Facilitators do not need to use these prompts if natural conversation is already flowing or parents seem comfortable in the environment. These questions are optional and are meant to be used only when helpful, to gently support discussion, not direct it. Please use the pre-programming form to adjust or adapt these discussion themes so they reflect the current needs, concerns, and experiences of the parents and caregivers attending the group.

1. Feeding Experiences (Breastfeeding, Chest feeding, Formula, Combo Feeding)

Purpose: Normalize different journeys and support sharing without judgment.

Prompts:

- “What’s one thing that has surprised you about feeding your baby?”
- “What has been going well with feeding lately?”
- “Is there anything that has made feeding easier for you this week?”
- “What’s one tip you wish someone had told you earlier?”

2. Storing & Preparing Formula

Purpose: Share practical tips and reduce stress around safe preparation.

Prompts:

- “What routines have you found helpful when preparing bottles?”
- “How do you usually handle feeding when you’re out of the house?”
- “What questions do you have about storing or mixing formula?”
- “Has anything helped make nighttime formula feeds a little easier?”

3. Breastfeeding / Chest feeding

Purpose: Offer space for wins, questions, and shared learning.

Prompts:

- “How has breastfeeding/chest feeding felt for you lately, emotionally or physically?”
- “Is there a position or technique that’s been working better recently?”
- “What supports (people, tools, info) have helped you the most?”
- “Is there anything about breastfeeding you’re curious about today?”

4. Returning to Work or School

Purpose: Explore transitions in a supportive way.

Prompts:

- “What feelings come up for you when you think about going back to work or school?”
- “Is there anything you’re planning or preparing ahead of time?”
- “What support would be helpful during this transition?”
- “What’s one thing that feels manageable right now for your family’s routine?”

5. Self-Care (Realistic, Gentle, Attainable)

Purpose: Help caregivers reconnect with small, doable moments of care.

Prompts:

- “What is one small thing you’ve done for yourself recently—even if it was just a minute?”
- “What helps you feel a tiny bit more grounded during busy days?”
- “Is there anything you’ve found that gives you a brief moment of calm?”
- “Who or what has helped lighten your load lately?”

6. Mental Health, Mood, and Adjustment

Purpose: Acknowledge emotional experiences without inviting heavy disclosures.

Prompts:

- “How would you describe the overall tone of your week in one word?”
- “What has helped you get through challenging moments lately?”
- “Is there anything that has lifted your mood recently, even a little?”
- “What support feels helpful right now—practical or emotional?”

7. Postpartum Depression/Anxiety (PPD/PPA) Awareness

Purpose: Reduce stigma and support gentle conversation, not diagnosis or disclosure.

Prompts:

- “What signs or feelings do you think more parents should know are *normal* to experience?”
- “What helps you feel connected or supported on harder days?”
- “Are there resources or tools that others have found helpful?”
- “What would you tell a parent who feels overwhelmed right now?”

8. Partner and Family Support

Purpose: Explore support systems in ways that feel safe for diverse family situations.

Prompts:

- “What’s something that has felt supportive to you lately big or small?”
- “Are there ways you and family have found to share the load?”

- “What would support look like for you this week?”

9. Sleep, Routines & Baby Cues

Purpose: Validate the ups and downs of infant rhythms.

Prompts:

- “What’s one thing you’ve learned about your baby’s cues or patterns?”
- “What has helped make nighttime or naps a little easier?”
- “How do you rest or recharge when you can?”
- “What’s one nighttime win—big or small—from this week?”

10. Celebrating Small Wins

Purpose: Build confidence and highlight everyday successes.

Prompts:

- “What’s one small win you had this week with your baby?”
- “What moment made you smile recently?”
- “Is there something you feel proud of today?”
- “What new thing did your baby do that you enjoyed noticing?”

Infant Weight Slip (Optional Take-Home Tool)

This slip is for you to take with you. You may write as much or as little as you like. You do not need to share this information with anyone unless you choose to. Weight is only one piece of your baby's story; there is no expectation to weigh your baby during group.

Your Baby's Weight (Optional)

Date: _____ **Baby's Weight:** _____ (kg / lb)

Your Own Notes (Optional)

You can leave this blank, jot down a thought, or use them however you like.

- **How feeding has felt this week:**
- **Anything new or different with baby:**
- **Something I want to remember from today:**
- **Questions for myself or my care team (only if I want to follow up):**

Reminder for Parents & Caregivers

- This slip is yours.
- Your baby's weight is not a measure of your success or your worth as a parent.
- You can choose to:
 - keep it
 - throw it away
 - bring it next week

- or not weigh your baby at all
- If you ever want to talk about feeding, growth, or concerns, facilitators are here to support you—only if and when you want.

Post Group:

Feedback Form

FDCHC Infant Feeding Support Group Feedback Form

Thank you for joining us today!

Your feedback helps us improve and make this group a safe, supportive, and helpful space for everyone.

Date of Session: _____

1. How did you feel about today's group?

= Yes = No

Statement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
I felt welcomed and comfortable	<input type="checkbox"/>	<input type="checkbox"/>
The space felt safe and inclusive	<input type="checkbox"/>	<input type="checkbox"/>
I received helpful support or information	<input type="checkbox"/>	<input type="checkbox"/>
I connected with others / felt less alone	<input type="checkbox"/>	<input type="checkbox"/>
The group met my needs today	<input type="checkbox"/>	<input type="checkbox"/>

2. What did you enjoy most about today's group?

Check all that apply:

Talking with other parents

- Support from staff or facilitators
- Having a safe space to feed my baby
- Access to feeding pillows / scale
- Hot drinks / snacks
- Something else: _____

3. Is there anything you didn't like, or wish was different?

- Yes – please tell us below
- No

Comments:

4. Would you attend again or recommend this group to others?

- Yes
- No- why?
- Maybe

5. Any other thoughts, feedback, or ideas?

Resources in Our Community

Fun, connection, and support for you and your baby!

Free Baby Play Groups

Fredericton Regional Family Resource Centre

- Life with Baby (Mondays 2:00–3:30 PM)
- See Facebook page for more programs and weekly updates

Fredericton Public Library

- Storytime & Craft (Tuesdays & Fridays at 10:30 AM)
- See Facebook page for more programs and weekly updates

Nashwaaksis Public Library

- Storytime (Wednesdays & Fridays at 10:30 AM)
- See Facebook page for more programs and weekly updates

Talk With Me – Fredericton/Oromocto

- Mother Goose, Infant Massage, Baby Communicates, Baby Time at Nashwaaksis Library
- Visit the Facebook page or email talkwithmefredericton@nbed.nb.ca for more information

Extra Support

- Social Work (FDCHC): 506-452-5900 (Call to make appointment)
- Dietitian (FDCHC): 506-452-5900 (Call to make appointment)
- Mom & Baby Clinic: 506-452-5878 (Call to make appointment)
- Dr. Boone (Breastfeeding Specialist): Request referral from your NP/MD
- Nursing line (FDCHC): 506-452-5683
- 811: Speak with a healthcare professional 24/7



Facilitator Reflection Log

(To be completed after each Infant Feeding Support Group session)

Session Information

- Date: _____
- Facilitator(s): _____
- Approx. number of caregivers: _____
- Approx. number of babies: _____

1. What Went Well Today? *(What moments felt supportive, connecting, or smooth? What worked well for parents and babies?)*

2. What Could Be Improved? *(Environment, flow, timing, transitions, materials, facilitation style, etc.)*

3. Participant Response & Engagement *(How did caregivers seem to respond to the environment, the pace, the themes, and each other? Any signs of comfort or discomfort?)*

4. Themes or Concerns That Emerged (*Use to help shape future sessions and adjust the pre-programming form.*)

5. Group Dynamics & Safety (*Did the group feel welcoming, calm, inclusive? Anything to celebrate or be mindful of next time?*)

6. Facilitator Self-Reflection (*How are you feeling after this session? Any needs, supports, or adjustments for yourself?*)

7. Follow-Up Actions (*Referrals, resources to bring next week, materials to print, environmental changes, etc.*)

Note for Facilitators: *This reflection is meant to support learning and growth—not evaluation. Use it to celebrate strengths, identify gentle improvements, and help keep the group aligned with trauma- and violence-informed principles.*

Data & Next Steps Form

Infant Feeding Support Group

Session Information

- Date: _____
- Facilitator(s): _____
- Number of caregivers present: _____
- Number of babies present: _____

1. Session Topics & Content Covered *(Check all that apply; add notes for specifics)*

- Breastfeeding support
- Formula feeding / storage / preparation
- Infant cues & behavior
- Returning to work
- Mental health / PPD / self-care
- Partner or family support
- Other (please specify): _____

Notes / Highlights:

2. Participant Engagement & Response (*Optional: observations about comfort, participation, interest in topics, or group interaction*)

3. Emerging Needs / Requests (*New themes, questions, or resources participants expressed interest in*)

4. Optional Data / Metrics

- Number of caregivers requesting follow-up resources: _____
- Number of caregivers interested in next week's topic: _____
- Optional infant weight checks (if parent shares): _____

5. Next Steps / Content Updates for Future Sessions

(Use this section to plan adjustments based on session feedback, observations, or emerging needs)

- Topics to expand or revisit:

- Resources / handouts to provide:

- Icebreakers or activities to try: _____

- Room / environmental changes:

- Facilitator notes / reminders:

Curriculum Vitae

Candidate's full name: Brook Morgan Ramos

Universities attended: University of New Brunswick 2017-2021, Bachelor of Nursing

Publications: N/A

Conference Presentations: N/A