

Breastfeeding in the Community: Sharing Stories on Implementations That Work

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Keywords

breastfeeding, breastfeeding barriers, breastfeeding practices, breastfeeding support, lactation education, social support

To improve equity in breastfeeding rates and eliminate breastfeeding disparities, the Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity in 2014 funded the National Association of County and City Health Officials (NACCHO) through a cooperative agreement to implement the Reducing Disparities in Breastfeeding through Peer and Professional (Lactation) Support project (Breastfeeding Project). The purpose was to increase the implementation of evidence-based and innovative breastfeeding programs, practices, and services, specifically focusing on peer and professional lactation support for pregnant and postpartum women in predominantly African American and underserved communities with low breastfeeding rates. Between January 2015 and June 2016, NACCHO provided \$2.9 million in funding through reimbursement grants and more than 1,500 hours of training and technical assistance to 69 organizations to implement 72 breastfeeding demonstration projects in 32 states and U.S. territories. This Breastfeeding Project represents the most extensive U.S.-based implementation of coordinated community-level breastfeeding support projects.

This overview of the Breastfeeding Project highlights the work of 19 Breastfeeding Project grantees. The goal of sharing these stories is to increase awareness of the processes, successes, and challenges of implementing and expanding access to lactation support services for families and communities that have been historically marginalized and underserved. These examples can assist other communities to design sustainable breastfeeding support programs that increase availability and accessibility to skilled lactation care to improve equity in breastfeeding care.

Project Grantees

NACCHO released two requests for application to identify grantees. In October 2014, during the first competitive request for application, 63 community organizations were selected. The average grantee award among this core group was \$40,320 for the 17-month project period. The second

request for application was an invitation-only application to 27 local health departments (LHDs) in communities that included local hospitals enrolled in the Centers for Disease Control and Prevention's Enhancing Maternity Practices (EMPower) project, a quality improvement initiative designed to support hospitals in achieving Baby-Friendly USA[®] designation. A total of nine agencies—seven LHDs and two community-based organizations—were awarded an average of \$43,888 for the 5-month period of January 2016 through June 2016 to engage in creating intensive partnerships with the local EMPOWER hospitals to support them in achieving community-driven aspects of the designation. Awarded organizations (grantees) were primarily LHDs (35%) and community-based organizations (32%), followed by local hospitals (14%), community health centers and Federally Qualified Health Centers (4%), and other (14%). The grantees had varying levels of experience in providing breastfeeding support services: Whereas more than two-thirds (71%) of grantees had 5 or more years of experience, 11% of grantees had never provided breastfeeding services. Additionally, grantees provided services in different community settings: The majority of grantees (64%) provided services in urban communities, whereas 13% provided services in rural communities, 5% in suburban, 2% in tribal, and 18% of grantees served multiple populations.

Project Goals and Grantee Outcomes

The main goal of the Breastfeeding Project was to increase access and availability of breastfeeding support programs to

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African American and low-income women by providing direct services. Collectively, grantees reported 92,832 one-on-one support encounters with pregnant and breastfeeding women, and a nondistinct count of 72,380 women were served. Grantees hosted 3,332 breastfeeding support groups for a nondistinct count of 15,027 participants. More than 43% of group participants and 37% of one-on-one clients were African American. Approximately 22% of the one-on-one support encounters were with women of Asian/Pacific Islander descent, which was largely driven by services to low-income women in Palau and Hawaii. Although no client income data were collected, grantees embedded their lactation services within communities with a high volume of low-income residents or within programs including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Early Head Start, which serve families living below 200% of the federal poverty level. Lactation support was provided by peer counselors, International Board Certified Lactation Consultants® (IBCLCs), and Certified Lactation Counselors® (CLCs), or staff with equivalent training. Grantees provided support across the continuum of care, ensuring that mothers and families could access the level of support they needed.

The timing, format, and location of service provision varied. All grantees provided postpartum lactation support services and 69% offered prenatal breastfeeding education. Grantees reported offering lactation support via multiple formats including telephone (69%), home visits (45%), text (36%), hospital visits (30%), breastfeeding clinics/groups (30%), online (16%), and other (8%). Service locations included WIC program sites, private physicians' offices, public health clinics, community centers, high schools, public libraries, hospitals, public housing meeting spaces, a day spa, and client homes.

A secondary goal was for all grantees to establish collaborative partnerships with other local agencies serving women and families within their community. Collectively, grantees reported establishing or enhancing 830 community partnerships during the project period. Partners included community health centers, LHDs, private medical offices, hospitals, and community health coalitions. Nontraditional partners included faith-based organizations, food security organizations, local employers, public high schools, libraries, transportation authorities, and public housing agencies.

In addition to direct service delivery, grantees instituted or advanced innovative practices to address structural barriers to breastfeeding by building organizational capacity to meet the specific lactation support needs of women and families. Specifically, 27 grantees reported the implementation of policy, system, and environmental (PSE) change strategies. These strategies included improving organizational capacity to provide breastfeeding support or addressing community structural barriers limiting women's ability to breastfeed at levels recommended by leading health agencies. Organizations instituting PSE changes and those with advanced partnerships were the most successful at implementing sustainable

community interventions lasting beyond NACCHO funding. (See Reis-Reilly, Fuller-Sankofa, & Tibbs, 2018 [this issue], for more information and examples of grantees using the PSE change approach.)

Challenges and Successes

Approximately 60% of the grantees reported that the most common barrier was the recruitment and retention of women to their specific program. Program participant recruitment in the early start-up months was time consuming and difficult. Many grantees learned quickly that home visits and support groups needed to work around the schedule and location of the mother in order for women to access services.

Another frequently reported challenge was fulfilling the administration grant requirements. Spend downs, invoicing the funder (NACCHO), and data collection were activities that many small community-based organizations had not previously encountered, and setting up the appropriate infrastructure to do so required more time than expected.

Despite the challenges with participant recruitment, grantees successfully engaged their communities by the end of the grant period. Grantees were able to increase organizational capacity by collectively training more than 150 staff members to provide much-needed breastfeeding support services to a broad range of mothers and other family members in communities where few or no services were previously available.

An additional success was the number and types of partnerships established or strengthened among the grantees and other community organizations, especially those with other healthcare service providers, including hospitals, private care doctors, and nurses. Many grantees stated that these partnerships were sustained and have been active since the project funding ended. Much of the success for many of the programs can be attributed to the marketing campaigns promoting services in the community. Social media and text messaging played a significant role in many of the projects' marketing efforts.

Lessons Learned

Challenges as well as successes provided many opportunities for both large and small organizations to identify areas for continuous improvement in their programs. They learned that implementing a program of this size and scope, within a relatively small timeline and limited funding, can be challenging. For small organizations with limited staff and infrastructure, such as a breastfeeding coalition, a barrier to implementing planned activities within the set timeline was the lack of fiscal capacity to work with reimbursement grants. On the other hand, larger organizations, such as hospital systems and LHDs, also experienced implementation challenges due to bureaucratic processes causing delays to planned project activities. For instance, project managers were often not properly kept abreast of internal policies and

procurement procedures to order program supplies months ahead of time and did not plan accordingly.

Regarding provision of services, NACCHO identified three key lessons:

1. Providers must understand community challenges to accessing services and be flexible to modify program activities to meet families' needs.
2. Continuous outreach to mothers through multiple channels, such as reminder phone calls, emails, and text messages, is necessary to keep families engaged in the program.
3. Grantees learned the importance of including family members, partners, and siblings in breastfeeding support services, especially in African American and Hispanic communities.

Conclusion

Throughout the project, grantees provided tailored breastfeeding services to families that met their unique needs. Grantees increased organizational capacity, strengthened partnerships, and developed systems that were sustained beyond funding to improve the breastfeeding support landscape in their communities.

With gratitude, NACCHO would like to thank all 69 grantees for engaging in the project and increasing availability and accessibility to lactation support programs in African American and underserved communities in the United States.

Grantee Abstracts

Breastfeeding in Baltimore County: There's More To Do

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Motivation/problem statement: At the time the National Association of County and City Health Officials grant was announced, the Healthy Babies Collaborative was a newly formed initiative focused on improving birth outcomes in a targeted community on the east side of Baltimore County. The emphasis of the initiative is to reduce low-birth-weight births; however, a community needs assessment revealed a lack of resources for women and families from pre-conception through early childhood.

Target population or participants/setting: A subgroup of the Healthy Babies Collaborative harnessed personal passion for breastfeeding to develop a proposal to institute a community continuum of breastfeeding education and support through home visiting programs, the local hospital, and the county Special Supplemental Nutrition Program for Women,

Infants, and Children. All strategies ultimately focused on minority and underserved populations to promote breastfeeding initiation and duration.

Methods/approach: A countywide breastfeeding service assessment was conducted to determine if minority women in East Baltimore County were disproportionately lacking in services and support in comparison to the remainder of the county. This information was used to inform further initiatives and the strategy. Building the continuum of breastfeeding education and support focused on three approaches: (a) further assessment of all breastfeeding resources across the county, (b) training home visiting program staff, and (c) providing a professionally led, community-based support group. Moreover, the home visitor training engaged direct service staff from the county's two evidence-based home visiting programs—Healthy Families Baltimore County and Baltimore County Early Head Start. In addition, a modified version of the U.S. Department of Agriculture Grow and Glow curriculum was used to increase staff knowledge and capacity to promote breastfeeding initiation and duration among home visit clients. Last, the community-based breastfeeding support group was facilitated by an International Board Certified Lactation Consultant®, hosted in the public library, and provided programming responsive to participant needs.

Results/project outcomes: One home visiting public health nurse completed training to become a Certified Lactation Counselor®; 28 home visiting staff were trained to promote breastfeeding initiation and duration with their clients and the support group. Initially, there were 3 attendees in April 2015, growing to 28 attendees in May 2016. These initiatives have sustained post funding. An additional 30 home visitors were trained and their 54 (unduplicated) breastfeeding mothers participated in the support group, including a core of mothers who attended nine or more groups per quarter. This core group organized events outside of the group meeting time to engage in mother-child activities and share resources and tips. Two mothers attended the group after the birth of their second children. The strategies initially developed were refined to better meet needs, while providing the parallel benefit of strengthening the partnership's resolve to work together to promote breastfeeding. The support group was not originally designed to accommodate siblings; however, a change in location allowed for siblings and ultimately increased group attendance. The completion of the community scan of breastfeeding resources presented the partnership group with continued challenges regarding linking resources within communities and across agencies.

Conclusion/implications: Ultimately, the small grant funding spurred action that put breastfeeding on the agenda of many more organizations serving prenatal and breastfeeding mothers, which is resulting in continued efforts to promote

breastfeeding. The work of implementation ultimately enhanced partnerships and built a knowledge base for replication in other communities.

Increasing Peer and Professional Support for Breastfeeding Mothers in the Finger Lakes Region

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Motivation/problem statement: From results of a community health assessment process, Mobilizing for Action through Planning and Partnership, we identified obesity prevention as a public health priority. The community health assessment was facilitated by the S2AY Rural Health Network, a partnership of eight county public health departments in rural upstate New York. Driven by the known correlation between breastfeeding and reduced obesity rates later in life (Gillman et al., 2001), the Network applied for Reducing Disparities in Breastfeeding through Peer and Professional (Lactation) Support project funds on behalf of the Finger Lakes Breastfeeding Partnership (FLBP), a regional committee of the eight S2AY counties led by Ontario County Public Health, to increase lactation support for mothers throughout the region. Low-income mothers in the Finger Lakes region struggle to access breastfeeding support due to lengthy distances to obtain service, limited access to public transportation, and lack of trained lactation service providers. In fact, access to healthcare services is such an issue that seven of the eight counties are designated Healthcare Professional Shortage Areas (U.S. Department of Health & Human Services, 2014).

Methods/approach: To increase access to peer and professional breastfeeding support services, the FLBP and S2AY established a network of Baby Café sites at strategic locations throughout the region. Baby Cafés are free, drop-in lactation centers where mothers can receive support from professionals, Certified Lactation Counselors® (CLCs), and peers. To support the establishment of Baby Café sites, the FLBP engaged additional partners, hosted CLC trainings to increase the capacity of the available workforce, and implemented a social marketing campaign to promote breastfeeding as a social norm.

Results/project outcome: Through this project, the FLBP trained 22 CLCs, established six Baby Café sites, hosted 70 group meetings for 532 attendees, and provided 1,212 one-on-one support encounters with mothers. A key to sustainability was incorporating Baby Café staffing into the regular job responsibilities of health department employees trained

as CLCs through the grant. The FLBP engaged a range of partners, including libraries, churches, and community groups not traditionally involved in public health programming. Community support for breastfeeding and the shift to a more breastfeeding-friendly environment also played a role in long-term project sustainability. Mothers are now asking to be trained as CLCs to staff additional Baby Cafés, and more businesses and community partners are engaged in the efforts of the FLBP and S2AY. Finally, according to local health department data, breastfeeding initiation rates (any human milk fed at hospital) have been steadily increasing for the region, from 75.1% in 2012 to 78.3% in 2016 (see Figure 1).

Conclusion/implications: Lessons learned from this project include the importance of engaging a broad range of stakeholders and identifying and addressing community needs. Not only were partners integral to establishing Baby Café sites, but they are now involved in other FLBP efforts, such as adopting breastfeeding policies, promoting education, and bringing in allied programs. In response to low participation rates during start-up, some Baby Café locations and meeting times were changed to better serve participants. Although the overall project goal was to increase breastfeeding support for low-income mothers, the continuous promotion of breastfeeding as a social norm helped with initiating crucial conversations with partners, recruiting mothers, and changing community dynamics and dialogues about the importance of breastfeeding in the Finger Lakes region.

Support on the Go: Integrating Breastfeeding Into the Monroe County Community

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Motivation/problem statement: In 2014, the breastfeeding initiation rate for the Monroe County Health Department, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) was 69.5%, which was lower than the national and New York State averages, at 82.5% and 84%, respectively. Through funding from the National Association of County and City Health Officials (NACCHO), Monroe County WIC aimed to enhance services by increasing access to breastfeeding peer education and support during pregnancy and postpartum. The aim was to improve breastfeeding rates in zip codes known as “the crescent,” whose demographics included predominately low-income minorities, including African Americans. Peer counseling services

were provided at eight different community settings, including hospitals, obstetrician (OB) offices and pediatric offices, and public libraries.

Methods/approach: By leveraging NACCHO funds with the National Institutes of Health/University of Rochester grant, The Breastfeeding Partnership, Monroe County WIC was able to expand services by increasing breastfeeding peer counselor reach and hours to integrate services with health-care providers and establish community drop-in support groups and events. A needs assessment was conducted to determine the most convenient support group locations targeting pregnant and new mothers. Peer counselors partnered with OB and pediatric offices to co-locate services by participating in Centering Pregnancy[®] groups and by establishing “office hours” to provide immediate breastfeeding education and support to interested patients during routine appointments. An additional partnership was established with the Nurse-Family Partnership to support mutual clients.

Results/project outcomes: Through the systemic change of moving from a decentralized peer counselor model to a “support on the go” model, Monroe County WIC increased the number of women serviced both prenatally and postpartum. Establishing partnerships with healthcare providers increased referrals to the Monroe County WIC peer counselor program and promoted early enrollment in WIC. Moreover, requests for breastfeeding education increased in Centering Pregnancy groups, which led to an expansion of peer counseling services to five additional offices. Overall, Monroe County WIC served 516 women through one-on-one and group support. As a result of the aforementioned successful drop-in groups, Monroe County WIC has expanded from three to five locations, including an additional OB office and hospital setting. In addition, the Monroe County Health Department/University of Rochester has secured funding from the New York State Department of Health, the Creating Breastfeeding-Friendly Communities grant, and will transition the drop-in groups to the Baby Café model (see Figures 2 & 3).

Conclusion/implications: Integrating and co-locating peer counseling services into settings beyond WIC clinics and into community settings to essentially “meet women where they are” is a recommended strategy. It enables the strengthening and reinforcing of standardized breastfeeding messaging across healthcare professionals at the start of pregnancy, immediately at birth in the hospital, and postpartum. However, the use of this strategy requires establishing partnerships and creating environments that are mutually beneficial to all partners. The presence of a breastfeeding peer counselor in provider offices enables immediate breastfeeding education and support to mothers, which can lead to an increase in breastfeeding rates and set the stage for improved health outcomes.

Black Health Matters: An African American Breastfeeding Movement Reaching Our Sisters Everywhere, Inc.

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Problem statement: While national breastfeeding rates are on the rise, there remains a 17% disparity gap for African American women. The state of Georgia ranked 45 out of 53 in the 2013 Maternity Practices in Infant Nutrition and Care Survey results, with a subscore of 47 of 100 in facility discharge care for referrals to breastfeeding support (Centers for Disease Control and Prevention, 2014). Based in Decatur, Georgia, Reaching Our Sisters Everywhere, Inc. (ROSE) mitigates inequity-based health disparities through culturally competent, evidence-based lactation education and intervention. ROSE is focused on developing and implementing strategies for African American communities to reclaim a tradition of breastfeeding through community-based initiatives.

Methods/approach: ROSE provides research-informed, community-based breastfeeding peer support training to African American women called ROSE Community Transformers (CTs). CTs increase access to evidence-based breastfeeding resources by providing peer support to expectant and breastfeeding mothers and lead breastfeeding support clubs in their own communities. In addition, ROSE conducts professional breastfeeding support training, the ROSE International Board Certified Lactation Consultants[®] (IBCLC) Prep Course, for individuals seeking to become IBCLCs. The training course is a means for individuals to increase their knowledge and certification status in the field, with a specific emphasis on women of color. Participants from the course serve as a referral source for the ROSE network of CTs. Furthermore, ROSE staff, CTs, and prep course attendees then serve African American families throughout the Southeast/Greater Metropolitan Atlanta area. ROSE also establishes a network of resources for evidence-based breastfeeding support between community-based organizations, hospitals, and health departments, whose network size grows exponentially.

Results: By leveraging funds received from the National Association of County and City Health Officials, currently, 271 CTs have been trained across eight states with 97 CTs residing in the Greater Metropolitan Atlanta area. Moreover, the ROSE IBCLC Prep Course has trained 30 individuals, and 18 have taken the IBCLC exam. Last, monthly breastfeeding clubs, led by ROSE CTs, are held in three locations, serving predominantly African American families. Overall, 4,132 predominately African American mother–infant dyads have been reached through this initiative (see Figure 4).

Conclusion: The next phase of impact will involve the construction of a national breastfeeding blueprint, which aims to provide a realistic picture of the current breastfeeding landscape. ROSE will collect and generate academically rigorous information, which will be used to target problem areas in underserved communities. To this end, ROSE will continue to provide evidence that a community-based approach to improving access to breastfeeding support is achievable.

Innovative Online and School-Based Breastfeeding Support Project in Pine Hills

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Motivation/problem statement: Children's Home Society (CHS) of Florida, the oldest and largest statewide organization in Florida serving children and families, implemented a multi-approach program specifically designed to meet the needs of pregnant African American women and their families living in the Pine Hills Community in Orange County, Florida. Several barriers face breastfeeding mothers, including no Baby-Friendly Hospitals, no breastfeeding-friendly early care education facilities, and no formal workplace breastfeeding support policies. Moreover, there was only one part-time, professional lactation support provider located in the local Special Supplemental Nutrition Program for Women, Infants, and Children office. Last, transportation was an additional barrier to accessing services in rural areas, especially for pregnant teens.

Method/approach: Pine Hills, an underserved community particularly in areas relating to pregnancy, infant mortality, and postpartum support services, has a rural low-income population with more than 50% of its residents being African American. Upon receiving funding from the National Association of County and City Health Officials (NACCHO), CHS implemented two major activities. The first, leveraging funds from NACCHO and other grants, was used to launch the Peer and Online Lactation Support Program (POLs). POLs delivers peer support services via community health workers employed in the CHS Pine Hills Wellness Program. Through a combination of face-to-face encounters and mobile solutions, pregnant and new mothers can access professional lactation consultants for questions and support. Pine Hills Wellness community health workers are trained as Certified Perinatal Educators using the Community Outreach Perinatal Education Program. This training allowed the community health workers to provide breastfeeding education and formula-feeding risks and teach nurturing techniques between mothers and infants that are associated with longer durations of breastfeeding. The second program component

included the implementation of a school-based lactation support program. CHS developed a breastfeeding support program at Evans High School to provide educational, emotional, and social support to teen mothers in the prenatal and postpartum periods.

Results/outcome: CHS, in partnership with the Orange County Public Schools and the high school leadership, established a "No-Judgement Zone" lactation room, equipped with a hospital-grade breast pump, within the high school building where the student mothers could pump and store breast milk during the school day. Additionally, a new lunch program was introduced for pregnant and breastfeeding students to receive additional healthy foods to meet the increased nutritional needs of pregnant and breastfeeding mothers. Overall, CHS has improved the breastfeeding landscape in Pine Hills by changing systems and strengthening partnerships to create a more breastfeeding-friendly environment. CHS support services have become a signature initiative that is well attended by pregnant and postpartum teen mothers and fathers. CHS extended their breastfeeding services to two additional community providers that serve teen and adult mothers. CHS has also expanded their program to another high school within a predominately African American and underserved population.

Conclusion: In order to improve the Pine Hills breastfeeding landscape, developing a series of community partnerships that allowed for expansion and reach to additional women in the community was key. It was also important to address community needs, such as availability and accessibility of services by target population. To address transportation and time constraints, CHS chose to implement the online support that could be accessed at any time and the school-based program, meeting teens where they already were during most of their days.

Bridging the Breastfeeding Gap Through Community Partnerships in Oakland County, Michigan

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Motivation/problem statement: Through this project, we addressed the lack of diversity among skilled lactation providers and disparities in access to breastfeeding support services for African American and underserved populations. The aim was to improve breastfeeding rates by implementing culturally relevant drop-in lactation care services called Meet Nurse Love (MNL) at the Mother Nurture Club. African American and underserved mother-infant dyads were referred from a variety of community settings, including the Special

Supplemental Nutrition Program for Women, Infants, and Children (WIC). Participants were also referred by multiple hospitals, healthcare providers, businesses, and community members.

Methods/approach: Based on the findings from an extensive needs assessment, MNL was established in collaboration with community partners, including a countywide breastfeeding coalition, a local hospital, service organizations, and the health department. MNL offered both group and individual lactation services to provide continuity in care from prenatal education to postpartum support. Bi-monthly drop-in lactation services were offered at a local hospital on the south end of the county and monthly services provided at a community action agency on the north end. Each MNL group was facilitated by a WIC breastfeeding peer counselor and/or a skilled lactation support professional, which allowed for both peer and one-on-one support as needed. Moreover, services were delivered and leveraged through two International Board Certified Lactation Consultant® (IBCLC) candidates, who gained experience through mentorship and clinical hours as students of the Mother Nurture Lactation College. Candidates received mentored hours while gaining experience working on the labor and delivery and neonatal intensive care units at the partner hospital, St. John Providence Southfield, and the MNL support group. Each IBCLC candidate was provided with 500 mentor hours, didactic information, study materials, and technical support, which allowed them to work toward eligibility requirements for the IBCLC credential. Overall, this project leveraged an existing initiative by the local WIC program to support and increase breastfeeding initiation and duration in underserved populations. At the same time, the partner hospital was interested in expanding breastfeeding support services for their patients.

Results/project outcomes: Over the 17-month project, 83 mothers received at least one support service, including peer and professional support in group and individual settings. Sixty mother–infant dyads were referred by WIC. The target population made up more than 50% of MNL participants, many of whom were repeat attendees. Community needs were addressed by providing meals and support for transportation, diapers, and breastfeeding support items. A key component of MNL was the intentional involvement of the entire family to normalize breastfeeding at home and in the community. Shifts were made to ensure that the needs of the family were met. For example, when the lead referral source for the north MNL group took a leave of absence, the number of participants attending that location declined. Services were adjusted by merging the two groups in order to continue providing support to MNL families. As a result of this project and sustainability efforts, community partnerships were built and fortified. MNL continues to offer drop-in lactation support in partnership with a local business that offers free space to support groups throughout the community. In addition, the

local health department continues to partner with the project to expand reach through a commitment to hold groups and offer services in each county office location.

Conclusion/implications: Project partners listened to the specific needs of the community and discovered that there were significant barriers to accessing culturally competent care services. By offering a safe space for husbands/partners, older children, as well as food and other incentives, families felt supported and engaged in services. Additionally, having peer and skilled breastfeeding support and education by professionals who reflected the community served was a key driver in the group's success.

Enhancing the Breastfeeding Landscape in Gadsden County Through Education and Integration in Home Visiting

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Motivation/problem statement: In Gadsden County, Florida, there is a limited availability of breastfeeding support services. In addition, there are disparities in breastfeeding rates among Black and White women. From 2011 to 2013, 76.6% of White mothers initiated breastfeeding compared to 47.2% of Black mothers.

Methods/approach: The Center for Health Equity administered a pre-implementation community survey designed to gain insight into the community's awareness, beliefs, and practice of breastfeeding. From the results, the Center for Health Equity presented findings to local partners, including Healthy Families, Florida State University–Early Head Start, Florida Healthy Start, and Home Instruction for Parents of Preschool Youngsters to enhance the breastfeeding efforts. Survey results were also shared with the Florida Department of Health, state-level Healthy Start office. Additionally, the Center for Health Equity developed educational materials for the target population and provided breastfeeding awareness events throughout the county to both men and women. Moreover, breastfeeding education and support were incorporated into the home visiting program of the Gadsden Federal Healthy Start Program, providing 8 hours of training to home visiting staff. The Center for Health Equity also used grant funds to train two staff members to become the first Certified Lactation Counselors® in the county. Support groups for women and their families were also implemented during the project. Last, a breastfeeding workplace policy template and introductory letter to local business were created that included the *Creating a Breastfeeding Friendly Worksite* guide. These documents assisted businesses with understanding current breastfeeding laws and benefits to both employed mothers and employers.

Results/project outcomes: As a result of this project, the Center for Health Equity had an overall improved system of care. The provision of breastfeeding education and support to mothers and their support system is now part of the standard home visiting service model. The program's data collection forms and data system were modified to include questions regarding a mother's plan to breastfeed and the subsequent breastfeeding activity at initiation and 3, 6, and 12 months. The implementation of these changes enhanced the Center for Health Equity's ability to report on breastfeeding activity and assess trends over time. This will enable the organization to modify services as needed to meet participants' breastfeeding needs and demonstrate increased breastfeeding activity. Overall, every pregnant and parenting mother receiving case managed services also received breastfeeding education and support from the Center for Health Equity staff and Certified Lactation Counselors during their home visits. Over the course of the project, 117 mothers and 119 infants were served through home visiting and support groups. Furthermore, discussions with the local library led to the creation of private breastfeeding rooms in three Gadsden County libraries. The Center for Health Equity will continue to use the countywide breastfeeding assessment survey results, the breastfeeding workplace letter, and the *Creating a Breastfeeding Friendly Worksite* guide to raise awareness and support for breastfeeding in the community. Last, the Center for Health Equity partnered with WIC on several community education events, which brought a wider audience to the events. Due to this effort, WIC increased its education on breastfeeding.

Conclusion/implications: When providing breastfeeding services, engaging the participant's support system is vital to sustain breastfeeding. In addition, a lesson learned from this project was that one size does not fit all and the utilization of a variety of approaches (home visiting, outreach events, events at local WIC offices, social media, and surveys) to deliver breastfeeding information is key to engaging broad audiences.

Reducing Disparities in Breastfeeding Using the Nurse-Family Partnership Model

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Motivation/problem statement: Philadelphia has significant challenges related to breastfeeding initiation and duration rates, especially among African American women. Only 66.9% of African American mothers in Philadelphia initiate breastfeeding (Philadelphia Department of Public Health,

2016). African American infants in Philadelphia are at significantly higher risk of death than infants of other races, with an infant mortality rate of 13.8 per 1,000 live births (Philadelphia Department of Public Health, 2016). Breastfeeding has proven to increase health outcomes and decrease the risk of infant death. Barriers that stand in the way of increasing breastfeeding rates among African American women include lack of provider support, barriers to adequate prenatal care, and lack of anticipatory guidance and peer support.

Methods/approach: Neighborhoods most frequently served by the Philadelphia Nurse-Family Partnership (PNFP) have the lowest breastfeeding initiation rates in the city (Philadelphia Department of Public Health, 2016). In response to the disparity in breastfeeding rates, the PNFP implemented several initiatives. Peer lactation counselors were trained to facilitate breastfeeding support groups and provide in-person and telephone counseling to expectant and breastfeeding mothers. Approximately 50% of nurse home visitors were supported through study groups and trained to sit for the International Board Certified Lactation Consultant® (IBCLC) exam. Additionally, breastfeeding support capacity was increased by contracting with private practice IBCLCs. Expanded community outreach included the initiation of breastfeeding support groups. All nurse home visitors attended breastfeeding trainings and collected data related to breastfeeding initiation and duration rates.

Participants/setting: The Nurse-Family Partnership is a national home-visiting model that partners a registered nurse with first-time mothers prior to the third trimester of pregnancy until their child turns 2 years old. Each year, PNFP serves approximately 600 families. According to data from assessments performed by the Philadelphia Department of Public Health, the majority of PNFP mothers live in neighborhoods that report high rates of poverty, teen pregnancy, homicide, unemployment, and school truancy. Predominately African American women (72%) ranging in age from 15 to 35 years, 60% of whom are teen moms, are served by the program. The average annual household income for families in the program is \$7,500. Healthy People 2020 (2012) reports that low-income status and age are reflective of poorer percentages of breastfeeding initiation and duration.

Results/project outcomes: As a result of the interventions implemented over a 1-year period, 3,100 one-on-one breastfeeding support interactions were recorded, breastfeeding initiation rates reached 89%, six peer counselors were trained, 10 community breastfeeding support groups were held, and 120 hours of IBCLC support were provided to clients free of charge. Additionally, 11 nurse home visitors passed the IBCLC exam. The IBCLCs who were supported through the

grant in their certification can now provide expert support to the collaborative and client population. These IBCLCs have formed a committee entitled LATCH, which will continue the momentum started by the work from the National Association of County and City Health Officials grant.

Conclusion/implications: Breastfeeding success of mothers in our target population needs to be a healthcare priority. Women need multi-level support in order to initiate and sustain breastfeeding. Addressing breastfeeding early and throughout prenatal care, hospital discharge, the postpartum period, and pediatric care is essential to ensure that women are receiving continuous support. All providers need to be adequately trained and aware of the peer and professional breastfeeding resources available to women. Assisting women to establish consistent personal and professional breastfeeding relationships may have a profound effect on increasing duration rates. LATCH is intent on addressing the breastfeeding needs of PNFP clients and advocating for structural changes to the maternal and infant care network in Philadelphia. LATCH has begun to develop partnerships with community- and hospital-based IBCLCs and breastfeeding peer counselors in Philadelphia to address areas of improvement.

Integrating WIC Peer Breastfeeding Support Into the Hospital and Community

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Problem statement: The Edgar Mills Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinic has the lowest rates for initiation and sustainment of breastfeeding of the seven WIC clinics in Broward County, Florida. The Edgar Mills WIC clinic is in an area characterized by high poverty rates, poor health outcomes, and high rates of health disparities. In 2014, the Edgar Mills WIC clinic had a breastfeeding initiation rate of 78%, while the Broward County average was 82%. Moreover, the 6-month duration rate at the Edgar Mills WIC clinic was 24% and the Broward County Agency average was 34%. The purpose of the Broward County Reducing Disparities in Breastfeeding through Peer and Professional (Lactation) Support project was to increase the initiation and duration of breastfeeding among WIC participants in a primarily African American community known for low breastfeeding rates.

Methods/approach: The Florida Department of Health, Broward County (DOH-Broward) WIC program identified a need to close the gap between community partners and

hospitals, expanding the WIC Breastfeeding Peer Counseling program into birthing hospitals and community partners in Broward County to close the gap between delivery and breastfeeding support after discharge. The program was presented to community hospitals, with four entering a memorandum of agreement with the DOH-Broward. In March 2015, Broward Medical Center, a community hospital serving the Edgar Mills WIC clinic, implemented a Memorandum of Agreement to provide support by peer counselors to WIC mothers after delivery. A job description, scope of practice, and training curriculum were created by DOH-Broward WIC. A community partnership was also established with Broward County Healthy Mothers and Healthy Babies and the Urban League of Broward County to provide breastfeeding promotion, education, and support within the targeted community. Peer counselors also participated in prenatal programs within these partner sites and a local church. The WIC breastfeeding peer counselor in the hospital and in the community provided encouragement support and basic breastfeeding education. WIC peer counselors received a cell phone for providing after-hours breastfeeding support. If breastfeeding support was needed beyond the peer counselor's scope of practice, a referral was sent to the WIC program's International Board Certified Lactation Consultant®. Peer counselors assisted mothers in establishing breastfeeding and developing feeding plans and arranged discharge follow-up as needed. Breast pumps were provided for mothers with infants in the NICU. The peer counselors continued support after discharge until breastfeeding was well established.

Results: As a result of this project, the initiation rates in the targeted WIC clinic increased from 83% to 87.3% between March and December 2015. Similarly, the duration rate increased from 19.9% to 28.52% in the same months.

Conclusion: This project enabled DOH-Broward WIC to identify gaps in WIC breastfeeding support after discharge. Hospital peer counselors closed the gap between discharge and the next WIC clinic appointment by providing support during this critical period, as evidenced by the high initiation rates and low duration rates. The collaboration between DOH-Broward WIC and Broward County hospitals led to the successful partnership for the *Baby Steps to Baby Friendly Hospital Initiative*. DOH-Broward WIC is now a key stakeholder with Broward Health Healthy Mothers and Healthy Babies and the Urban League of Broward County. This program has proven to be successful, as evidenced by additional hospital requests for peer counselor coverage and requests from community partners. DOH-Broward WIC will continue to leverage funding received for the Loving Support through Peer Counselor Program to support this project and will continue to seek additional funding to expand to other community hospitals.

Looking In, Lifting Up, Reaching Out: Development of Curricula, Workforce, and Programs to Build a Black Breastfeeding Community

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Motivation/problem statement: In 2012, 92.1% of African American (AA) women in Alameda County initiated breastfeeding (California Department of Public Health [CDPH], 2012), but only about 15% continued breastfeeding at 3 months postpartum (CDPH, 2014a). For impoverished AA women, especially adolescents or those with less than a high school education, these numbers were even lower (9%-12%; CDPH, 2014b).

Methods/approach: The Alameda County Public Health Department (ACPHD) engaged the community to increase organizational understanding of lactation support service gaps in East Oakland and of the challenges associated with sustaining breastfeeding. Community needs were assessed through informal mother gatherings and a comprehensive engagement plan was developed. The target population included at-risk mothers and infants in East Oakland who lacked access to breastfeeding education and support. The ACPHD worked with the African American Breastfeeding Cultural Outreach Taskforce (BCOT) and East Oakland Health Center (EOHC), a Federally Qualified Health Center serving a low-income and largely AA community, to facilitate peer and professional support. During the 1st year of the project, the ACPHD implemented a three-part strategy to build community access to breastfeeding education. First, a community input to enhance the CDPH Black Infant Health curriculum with culturally relevant breastfeeding messages was used. Second, 12 AA community members, including one man, were trained as peer counselors using the Special Supplemental Nutrition Program for Women, Infants, and Children Loving Support curriculum. Two AA International Board Certified Lactation Consultants® from the target community led the trainings. Third, the ACPHD developed and delivered a breastfeeding group facilitation training for 24 community health workers and peer counselors. Moreover, the 2nd year of the project focus was on implementing peer support programs and increasing access to professional support by expanding the successful West Oakland Black Mothers Group, Breast Friends, to East Oakland. All of the peer counselors trained in Year 1 contracted with the EOHC to implement outreach activities to diverse community agencies, co-facilitate support groups, and provide direct support.

Results/project outcomes: As a result of the program, 63 mothers received 435 one-on-one support sessions and 170 attendees participated in support groups. Training was also

provided to 36 community residents and/or paraprofessionals to promote and support breastfeeding, and three peer counselors became Certified Lactation Educators™ and gained permanent employment with local programs. Moreover, the intensive outreach to providers and community service and faith-based organizations in East Oakland resulted in 109 community partnerships and increased community knowledge of the importance of breastfeeding and awareness of available services and resources. The breastfeeding culture in the community has changed, as evidenced by the rise in referrals for lactation support by community agencies and local providers. In 2016, 95.5% of AA clients at the EOHC initiated breastfeeding, and 38% of these mothers continued to exclusively breastfeed their infants at 3 months postpartum (EOHC, 2017).

Conclusion/implications: Foundational to the success of the project were key partnerships with the BCOT; Black Infant Health; the Special Supplemental Nutrition Program for Women, Infants, and Children; First 5; Alameda County Maternal Child Health; West Oakland Health Council; and the EOHC. However, true change and success in reaching AA mothers required program input by mothers, leadership development and mentorship of AA peer counselors, and intensive outreach to mothers and community organizations. Last, assessing internal and external challenges and using partnerships to push the traditional limits of programs and budgets enabled the ACPHD and EOHC to uplift AA mothers. In the same manner, the ACPHD and EOHC used methods, staffing, and outreach to bridge gaps that would not be crossed without multi-organizational support.

Addressing Community Needs to Increase Lactation Support in African American Women

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Problem statement: Sutter Delta Medical Center (SDMC) serves a high percentage of African American women in East Contra Costa County (East County), a geographic area with high rates of poverty, few community resources, limited public transportation, and low breastfeeding rates. Persistent lactation challenges exist for African American and low-income women delivering at SDMC. In 2014, 86% of the hospital deliveries were African American infants, yet the facility had one of the lowest in-hospital breastfeeding rates for African Americans, ranging from 56% to 65%. The Contra Costa County Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) has worked for years to improve breastfeeding rates in an effort to address adverse health trends. While efforts resulted in positive outcomes in certain

communities, low rates of exclusivity and duration persist in East County. Many Medi-Cal eligible women in East County receive prenatal care at Contra Costa Regional Medical Center Health System (CCRMC) but elect to deliver at SDMC due to easier accessibility. The absence of a care coordination system to transfer patient care from SDMC back to CCRMC resulted in many women not receiving post-discharge breastfeeding services. Other challenges included inadequate breastfeeding training for SDMC perinatal staff and poor access to low-cost hospital-grade breast pump rentals. Through the Reducing Disparities in Breastfeeding through Peer and Professional (Lactation) Support project, WIC aimed to create a coordinated system to improve patient care by enhancing breastfeeding support services at SDMC.

Methods/approach: Breastfeeding continuity of care challenges were addressed through a comprehensive partnership between WIC and SDMC. The partnership, documented by a memorandum of understanding, established in-hospital support by a WIC-funded African American International Board Certified Lactation Consultant® (IBCLC). In an effort to increase staff cultural competence and capacity, WIC also coordinated breastfeeding training for SDMC perinatal staff and other East County healthcare providers. In addition, WIC instituted a free pump rental program for clients delivering at the hospital. Finally, a system to coordinate post-discharge support and transfer patient care between SDMC and CCRMC was established.

Results/project outcomes: The 2016 in-hospital breastfeeding rates for African American women delivering at SDMC were 86% for any breastfeeding and 61% for exclusive breastfeeding. This reflects a 5% improvement in the rate of any breastfeeding and a 22% increase in the exclusive breastfeeding rate since 2010. The services of the African American IBCLC proved so indispensable that the hospital created a permanent position for her post funding. Moreover, through a coordinated WIC training effort, all nursing staff will receive 20 hours of the recommended breastfeeding training for the Baby-Friendly Hospital Initiative by March 2018. In addition, some physicians will receive a 3-hour live and/or online breastfeeding training. Since establishment of the free pump rental program, two to five WIC clients per week have participated. Furthermore, through the improved post-discharge system developed jointly by the SDMC and CCRMC, it is protocol that all CCRMC mother–infant dyads are scheduled appointments at newborn clinics within 2 days of discharge. Overall, the observations helped WIC and SDMC staff broaden their perspectives on community breastfeeding challenges.

Conclusion: The National Association of County and City Health Officials grant provided seed money to offer breastfeeding services that sustained and strengthened hospital community ties. Addressing community needs is critical to

the success of this type of program. While verbal agreements with partners can be initially effective, written agreements, such as memorandums of understanding (MOUs), are necessary to facilitate project sustainability. To demonstrate, SDMC perinatal staff training continued after funding ended, and staff continue to participate in the breastfeeding coalition as active partners to improve breastfeeding rates among African American and low-income women in East County.

#RVAbreastfeeds: Cultivating a Breastfeeding-Friendly Environment

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Problem statement: A person's ability to successfully breastfeed is influenced by the environment, policies, and systems that surround them. Changing the local environment is a complex and long-term endeavor that involves interaction and intervention at multiple levels, including raising public support, influencing systems and policies that enable people to breastfeed, and building capacity within organizations that serve pregnant and postpartum families.

Methods/approach: In 2011, the City of Richmond undertook an initiative to improve the breastfeeding environment with an emphasis on reaching marginalized citizens. With support from the mayor's office, diverse stakeholders were recruited, including community members; public health; for-profit businesses; health systems; academia; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and faith-based institutions. A multi-sectoral breastfeeding commission was created, charged with developing recommendations to improve the local environment. Funding was obtained using the recommendations to conduct research with African American WIC participants and establish a breastfeeding coalition. From 2013 to 2017, the #RVAbreastfeeds coalition sponsored multiple activities, including two citywide breastfeeding awareness campaigns, partnerships with a transit agency for staff training and placement of print and audio breastfeeding advertisements, and two symposiums to foster relationships with care providers, advocates, and citizens to identify local breastfeeding barriers, gaps, and opportunities. In 2015, leveraging funds received from the National Association of County and City Health Officials, the initiative expanded to the provision of direct breastfeeding support services through partnership with a community agency. A member of the original breastfeeding commission, Healthy Hearts Plus II, was chosen for their innovative approach that included culturally relevant peer-to-peer breastfeeding guidance and other forms of educational, social, and material support for low-income African Americans.

Results: The #RVAbreastfeeds coalition: Public Support for Breastfeeding

- Sponsored Latch On community events.
- Conducted social media campaigns utilizing strategically placed larger-than-life-size cutouts of local breastfeeding women, which generated approximately 100,000 impressions, and provided opportunities for direct interaction with the public.
- Developed signage for the interior and exterior of Greater Richmond Transit Authority (GRTC) buses and broadcast a public service announcement on Virginia's public breastfeeding law 30 times a day on GRTC buses.
- Placed campaign images on a digital billboard along a high-traffic corridor, resulting in over 500,000 impressions.

Influencing Systems, Policies, and Organizational Capacity

- Produced and distributed a handout to 450 GRTC employees outlining how to respond to complaints about breastfeeding on the bus.
- Trained 110 providers from 35 organizations on the Ready-Set-Baby curriculum.
- Hosted a symposium that explored the impact of racism on breastfeeding with 206 attendees. A 2-month follow-up survey ($N = 71$ out of 198 potential respondents) indicated that 69% of respondents had changed a behavior or practice as a result of attending the symposium.
- Conducted outreach resulting in 90 businesses displaying a "Breastfeeding Welcome Here" decal and informing staff of breastfeeding-friendly practices.
- During January 2015 to June 2016, 297 direct support encounters and 27 support groups were provided by Healthy Heart Plus II.

Conclusion: Early and ongoing establishment of collaborative partnerships allowed the agency to effectively leverage resources to develop informed policies and practices, connect with and support community organizations that serve pregnant and postpartum families, increase public awareness of the importance of breastfeeding, and contribute to the cultivation of a more breastfeeding-friendly community.

Mommies, Bellies, Babies, and Daddies: A Community-Based Model for Improving Breastfeeding Outcomes

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Motivation/problem statement: The infant mortality rate in Richmond, Virginia, has declined in the past years; African American infants have a rate of 12.8 deaths per thousand births, compared to 8.3 per thousand in White infants in 2013 (Virginia Department of Health, 2013). Recognizing that breastfeeding is associated with reduced mortality and that African Americans have increased barriers to breastfeeding success (Wafaie, 2016), Healthy Hearts Plus II (HHPII) partnered with the City of Richmond to address breastfeeding as a key strategy to improve Richmond's infant mortality rate. Through this partnership, HHPII received funding from the National Association of County and City Health Officials (NACCHO) in March 2015 to further implement their community-based program.

Methods/approach: HHPII designed the Mommies, Bellies, Babies, and Daddies community-based approach to offer a suite of services to engage pregnant and postpartum women in making healthy choices around prenatal and postpartum care, parenting, healthy eating, finances, education, and employment. HHPII serves women and families in public housing. The majority of women served are African Americans between the ages of 14 and 46. The ABC's of Breastfeeding is the program curriculum, developed by HHPII to empower and educate pregnant women about the benefits and management of breastfeeding and to connect new pregnant and postpartum women with experienced mothers in a peer-to-peer support model entitled Sister Circles. The curriculum was designed as a holistic life-skills approach, providing hands-on training, education, and authentic support for breastfeeding and parenting success. Expectant mothers are empowered to A—Appreciate themselves, B—Bond with their baby, and C—become a better Caretaker of themselves and their babies. Based on the understanding that women need to be empowered socially, psychologically, and economically, the overarching Mommies, Bellies, Babies, and Daddies model includes health topics beyond breastfeeding education and management. The program also provides community-based workshops on self-care; nutrition education to prevent chronic diseases, including cooking classes and access to a mobile food pantry; and exercise classes. Furthermore, it includes topics addressing basic needs, such as finances, employment, domestic violence, housing, education (GED/diploma/college/technical schools), and professional development. Mothers-to-be also are offered doula services and breastfeeding supplies, such as breast pads, and assistance in accessing free breast pumps. HHPII partners with non-health community agencies to leverage resources. For instance, the workshops and services are delivered at the public housing space.

Results/project outcomes: A total of 297 one-on-one service encounters and 27 group sessions were facilitated during the grant period. Of all the women who completed the ABC's of Breastfeeding program during NACCHO funding,

62 mothers reported initiating breastfeeding after birth. At 3 months postpartum, 26 mothers reported continued breastfeeding and 15 mothers reported exclusively breastfeeding. Moreover, at 6 months postpartum, 12 mothers reported continued breastfeeding and 5 mothers reported exclusively breastfeeding. Last, at 12 months postpartum, 9 mothers reported continued breastfeeding.

Conclusion/implications: Hard-to-reach African American pregnant women engaged in culturally designed breastfeeding programs are more likely to make the choice to initiate breastfeeding at birth and exclusively breastfeed longer. Increasing Richmond's breastfeeding rates is an overall priority for local nonprofits like HHPII and public health officials. Through continued partnerships with state and local public health agencies, public housing, academic institutions, managed care organizations, and other nonprofits, the Mommies, Bellies, Babies, and Daddies model continues to leverage local resources to better serve economically disadvantaged women in Richmond. The model engages mothers, fathers, grandparents, and extended family members who influence breastfeeding decisions. The ABC's of Breastfeeding curriculum has been used as the community-based breastfeeding strategy for funded projects in partnership with Richmond City Healthy Start and Virginia Commonwealth University. The curriculum is currently being evaluated by researchers at Virginia Commonwealth University.

Integrating Breastfeeding Support Into Social Services Programs

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Background: Rates of breastfeeding in the state of Indiana fall short of the Healthy People 2020 goals. There is also a disparity in breastfeeding rates among African Americans and Caucasians in the state. The Indiana Breastfeeding Task Force developed a plan of action that aligns with and supports the goals of the U.S. Breastfeeding Committee, the Indiana Perinatal Network, and the American Academy of Pediatrics. These goals are to (a) assure access to comprehensive, culturally appropriate lactation care for all families, (b) ensure that breastfeeding is recognized as the normal and preferred method of feeding young children, (c) ensure that federal, state, and local child welfare and family laws support the importance of breastfeeding, and (d) increase protection, promotion, and support for breastfeeding mothers in the workforce.

Methods: Parkview and its community partner, Stop Child Abuse and Neglect (SCAN) Healthy Families department, provided evidence-based prenatal breastfeeding education and support to pregnant and postpartum mothers, with the

goal that more African American mothers initiate and continue breastfeeding in Allen County, Indiana. The targeted area was southeast Fort Wayne, a designated Medically Underserved Area, which includes a large African American population. Professional and peer breastfeeding support were provided through support groups, individual counseling, and home visits. With funds from the National Association of County and City Health Officials (NACCHO), two African American social workers were trained as Certified Lactation Specialists (CLSs). The CLSs were recruited from the SCAN existing staff and were familiar with the community and connected to the families. Experience has shown that new mothers and families are more likely to listen to and heed advice from someone who is perceived as part of the community.

Results: As a result of this project, Parkview Health increased the provision of breastfeeding services from one support group per week to nine groups per month within the targeted area. In addition, home visits were provided to mothers who were unable to attend the group session because of medical conditions. Furthermore, Parkview developed several culturally sensitive breastfeeding education and marketing materials. The materials feature photos of families and infants of color, with information on breastfeeding benefits for mother and infant and also contact information for local support and resources, including the CLSs. Over a 12-month period, from March 2015 to February 2016, a total of 97 breastfeeding support groups were hosted, which included a total of 626 face-to-face encounters with mothers engaged in the breastfeeding program. The women who received support were primarily White and African American. Overall demographics were 232 White, 194 African American, 100 Hispanic, 45 Asian, 8 American Indian, and 47 of other races (see Figure 5).

Conclusion: The NACCHO funding increased Parkview Health and SCAN's organizational capacity to provide breastfeeding support. Lactation support has been incorporated into job responsibilities for the program to be sustained. The increase in attendance at the breastfeeding support groups and the additional home visiting requests have led this initiative to develop a new registered nurse position, who will be trained in lactation management. Last, the nine support groups per month have been maintained, with approximately 8 to 10 women in attendance per session. As this program continues, the goal is to close the breastfeeding gap in Allen County.

Reaching Teen Moms With Breastfeeding Education and Support

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Motivation/problem statement: Adolescents face unique challenges with pregnancy and parenting. Because of their age, many Teen Outreach Pregnancy Services (TOPS) clients have shared that adults have not taken them seriously in their commitment to breastfeed. Furthermore, they also may lack support from their family, school, or community, which makes them more vulnerable to poor health outcomes. Historically, adolescent mothers have lower breastfeeding rates than adult mothers. The most recent data from the Centers for Disease Control and Prevention's 2014 *National Immunization Survey* indicate that 58.6% of women younger than age 20 initiate breastfeeding, which is significantly below the national average of 80% for all women. Breastfeeding duration also represents a challenge among teens. Roughly 29% of women surveyed nationally reported breastfeeding for 12 months, but among those younger than age 20, the breastfeeding rate was less than 5%.

Methods/approach: The goal for this project was to educate adolescents, ages 14 to 21, who were pregnant or parenting, living in Metropolitan Phoenix and Tucson about the health and emotional benefits of breastfeeding and encourage them to make educated, healthy decisions about what is best for them and their newborns. Funding received from the Reducing Disparities in Breastfeeding through Peer and Professional (Lactation) Support project of the National Association of County and City Health Officials substantially increased the ability of TOPS to positively impact the breastfeeding rates of this underserved population. To increase breastfeeding support, TOPS goals were to increase organizational capacity by increasing the number of staff with International Board Certified Lactation Consultant® (IBCLC) credentials and provide weekly breastfeeding support groups and drop-in lactation services. Support services were also offered on an on-call basis with a specific focus on the first 2 weeks postpartum. TOPS also sought to normalize breastfeeding by updating education materials, enhance staff capacity, and build community partnerships to strengthen care continuity. Updating policies through formal memorandum of agreements allowed for enhancement of partnerships with community agencies. Partner hospitals assisted with flyer distribution, patient referrals to TOPS lactation consultants, and provision of meeting space for TOPS pregnancy and childbirth classes. These policy and system shifts enabled TOPS and the Special Supplemental Nutrition Program for Women, Infants, and Children to develop a mutually beneficial partnership that increased interagency referrals.

Results/project outcomes: During the grant period of January 2015 to June 2016, TOPS enrolled 388 clients.

Additionally, TOPS held 192 breastfeeding support groups and completed 491 one-on-one encounters to provide adolescents with the peer and professional support needed to reach their breastfeeding goals. Four TOPS staff members were certified as an IBCLC and provided lactation support throughout the region. Ninety percent of clients initiated breastfeeding in the hospital, outpacing the 2013 national average of 79% for adult women and the state average of 59.7% of women younger than 20 years. Active weekly support groups allowed clients access to IBCLCs and peer support. Additional results included hosting an annual breastfeeding celebration to recognize client achievements. The TOPS curriculum was enhanced to better serve the clients and included breastfeeding education earlier in pregnancy. Last, sustainability plans include maintaining IBCLC presence, continuing breastfeeding support groups, maintaining drop-in lactation support, and providing professional breastfeeding development opportunities for all staff.

Conclusion: Creating systemic sustainability of breastfeeding support for the underserved adolescents in the community was the paramount goal when undertaking this project. The TOPS goal to reduce the disparities in breastfeeding rates of teen mothers was initiated and enhanced through this grant. All of the changes to program operations ensured that breastfeeding education and support were interwoven throughout the adolescents' time in the program. This is vital, as research shows that the adolescent brain requires a message to be sent multiple times, in various ways, to be effective. With education and support, adolescent mothers can successfully breastfeed.

Laying the Infrastructure for Breastfeeding Partnerships in Lee County

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Motivation/problem statement: In 2014, the average breastfeeding initiation rate was 75.8%, yet among African Americans, the rate was 59.9%. Lack of diversity in the lactation workforce, a lack of coordinated breastfeeding efforts, and no formal community-wide discussions may contribute to this inequity.

Methods/approach: With funds from the National Association of County and City Health Officials, the Florida Department of Health, Lee County (FDOH Lee) aimed to improve the county's environment to support breastfeeding through the establishment of a strategically developed breastfeeding coalition and through the provision

of advanced training to women within the targeted, underserved community. FDOH Lee focused on establishing formal partnerships to support the development of a local breastfeeding coalition. The first steps of this newly established, diverse, community-wide breastfeeding coalition were to identify effective strategies to address breastfeeding inequities in the community. Furthermore, the need for a higher level of support was identified in both hospitals and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which resulted in a collaboration between the FDOH and the local hospitals to establish five scholarships to provide professional lactation training to women within the targeted underserved communities. The scholarship consisted of online breastfeeding training and a paid mentorship and was awarded to three hospital staff and two WIC staff who had little to no formal breastfeeding training. In addition, the project included hospital staff providing breastfeeding classes and one-on-one support in WIC clinics and WIC staff providing breastfeeding support at the hospital. FDOH Lee believed that the bi-directional training between the hospital and WIC was imperative to address continuity of care. The goal was to have WIC and hospital staff become exposed to each other's practice setting to broaden perspectives and understand challenges faced with breastfeeding initiation immediately post delivery, as well as issues faced post discharge.

Results/project outcomes: As a result of this project, there is an improved continuity of care for low-income, African American and Hispanic families in Lee County. There is now a policy allowing hospital staff to work with WIC clients. Due to the short time frame of the grant, FDOH Lee was unable to establish a policy for WIC staff to work in the hospital at the bedside; however, this is an opportunity for future projects. There is now a pathway for professional lactation education in the community as well as additional staff with advanced training available for support during "teachable moments" at the hospital bedside and in the WIC clinic. In addition, breastfeeding messaging is accurate and consistent, which is a result of the improved communication between partners. Furthermore, the stand-alone breastfeeding coalition is growing and building momentum for lasting environmental changes and future policy. Breastfeeding has been included as a health and nutrition improvement goal into the strategic plan for the community. The breastfeeding coalition is now moving breastfeeding into the policy arena with participation in the Infant Mortality Taskforce.

Conclusion/implications: This project significantly improved the breastfeeding conversation within Lee County. The breastfeeding coalition has grown to 15 community partners and has identified four strategies to improve the

breastfeeding support community-wide. The advanced training allowed for an increase in the potential staffing pool for future program growth and development. Another significant project outcome was the development of a strong partnership between the county's three local hospitals and FDOH Lee. These newly formed partnerships have reduced barriers for clients between the hospital and WIC offices. This grant facilitated opening lines of communication that will improve breastfeeding support and reduce barriers along all racial, ethnic, and economic fronts.

Increasing Lactation Support in the North St. Louis African American Community

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Motivation/problem statement: Between the years of 2006 and 2010, Missouri had an average infant mortality rate of 15.0 per 1,000 for African Americans, and 6.2 per 1,000 for their White peers. Recognizing that breastfeeding is associated with reduced mortality and that African Americans have increased barriers to breastfeeding success, the St. Louis Breastfeeding Coalition (SLBFC) sought to strategically increase breastfeeding supportive services for African Americans with the hope to consequently reduce infant mortality rates in St. Louis. Subsequently, there was an interest in breastfeeding among African American mothers and a lack of supportive services in North St. Louis.

Methods/approach: The SLBFC conducted focus groups with African American mothers in the community to discuss adequate breastfeeding support. The importance of implementing a model that would be culturally competent, flexible, and nonjudgmental was the result of the conversation. Therefore, I AM: Breastfeeding (I AM) was created and carried out by a team of African American breastfeeding mothers, with support and guidance from the SLBFC. The goal was to adopt a self-sustaining model. For that reason, an assessment was conducted of African American-led breastfeeding support groups in cities similar to North St. Louis, finding low attendance and little to no home support. The result ended with I AM creating a new model from which they were trained as peer lactation counselors.

Results/project outcomes: I AM serviced African American and underprivileged mothers in group settings, as well as individually, using nontraditional methods such as phone, email, and social media. Group support, focusing on meeting the health needs of African American women, was held in the community setting at the Ferguson Public Library

and Community Birth and Wellness Center. Between April 2015 and June 2016, I AM provided direct support to approximately 75 mothers. Once funding from the Reducing Disparities in Breastfeeding through Peer and Professional (Lactation) Support project concluded, I AM became independent of the SLBFC and, with their continued support, applied for 501c3 status. I AM is actively meeting the needs of breastfeeding families through peer support from a team of mothers who are all volunteers, work full-time, and utilize personal finances and donated funds for travel, food, and supplies. The service structure has grown to include group homes and hospitals (see Figure 6).

Conclusion/implications: Starting I AM to increase awareness of the importance of breastfeeding support in African American communities has shown that there is a need for more culturally sensitive lactation training. There are several models that assist breastfeeding mothers, but the majority are not led by women of color and do not captivate the African American community. I AM observed within the community that African American women are attempting to breastfeed, yet a large number are not expected or encouraged to breastfeed. Moreover, when interest is expressed, they do not always receive adequate or accurate support from medical personnel. An increase in African Americans becoming peer counselors and birth workers and gaining lactation certification, such as Certified Lactation Counselor[®] and International Board Certified Lactation Consultant[®], can help close the breastfeeding gap between African American and White mothers. I AM has yet to obtain funding, so sustainability is not guaranteed; however, the organization will continue to provide services and conduct outreach to increase breastfeeding rates in North St. Louis.

Peer Counseling in the Arkansas Delta: Integrating Services With Other Public Health Projects

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Motivation/problem statement: Arkansas has one of the lowest breastfeeding rates in the United States. According to the Centers for Disease Control and Prevention's (2016) *Breastfeeding Report Card: United States 2014*, the Arkansas breastfeeding initiation rate is 67.1% and duration is 32.3% at 6 months. With Healthy People 2020 goals at 89.1% for initiation and 60.6% for duration at 6 months, it is evident that breastfeeding gaps exist in the state. Furthermore, Desha County, located in the Arkansas Delta, has an African American initiation rate of 28%, while their White counterparts have a rate of 69%, which is higher than the Arkansas state initiation rate. At the beginning of the Reducing

Disparities in Breastfeeding through Peer and Professional (Lactation) Support project, there were no peer counseling services available in the Delta region of Arkansas, which is very rural and consists of primarily low-income individuals, with half being African American.

Methods/approach: Pre-implementation, the Arkansas Breastfeeding Coalition, local health unit, Arkansas Department of Health's Minority Health and Health Disparities division, and hospital staff collaborated to offer input on service needs to improve breastfeeding rates in Desha County. One strategy was to integrate breastfeeding education into other public health programs in the area. The second was for the Arkansas Breastfeeding Coalition to provide basic breastfeeding training for the local health unit and hospital staff. The third strategy was to hire an African American peer counselor to provide breastfeeding education in Desha County to pregnant and/or breastfeeding women. Services were provided in the local health unit and hospital, at home visits, and remotely by phone calls or text messages. The peer counselor was integrated into the Say Yes to Best safe sleep program, which provided infant safety items, including a Pack and Play and other infant items, to pregnant women in the program for a 1-year period. Registration for the program was through the peer counselor, which offered an added incentive for families to become educated about breastfeeding. The strategy to hire a peer counselor reflective of the community was aimed at addressing the very low breastfeeding rate among African American women in Desha County. In addition, the peer counselor participated in two trainings: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Loving Support peer counselor and Certified Lactation Counselor[®] certification. During the 1st year of the project, the peer counselor provided education and support to almost all pregnant women engaged in services at the local health unit. After Say Yes to Best ended, the percentage of pregnant women enrolling in the project decreased.

Results/project outcomes: As a result of this project, the hospital and local health unit increased their capacity to support breastfeeding mothers. The peer counselor, now a Certified Lactation Counselor, was hired by WIC in Desha County and continues to provide lactation support services.

Conclusion: The Arkansas Breastfeeding Coalition was aware of the limitations of serving women in a very poor and rural community, where many did not have transportation and cell phones prior to the project. The solution to eliminating barriers was to hire a peer counselor who was able to connect with a hard-to-reach population. Moving forward, having a trained minority breastfeeding peer counselor available will continue.

An Integrated Health Center-Based Program to Improve Breastfeeding Rates Among Latina Women in Chicago

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Motivation/problem statement: Esperanza Health Centers (Esperanza) is a Federally Qualified Health Center serving a primarily Latino population in Chicago's southwest area. Among patients served, 96% are $\leq 200\%$ of the federal poverty line, 60% are enrolled in Medicaid, 25% are uninsured, and 12% have commercial insurance. Most patients prefer care delivered in Spanish (71%), and 95% are younger than age 65. Evidence has shown that in the Latino population living in the United States, with higher degrees of acculturation, there are lower rates of breastfeeding. In addition, it is a common practice for many Latina women to provide both human milk and formula, known as *las dos*. This is consistent with breastfeeding practices among patients at Esperanza.

Methods/approach: Esperanza enhanced its existing Healthy Tomorrows Program, which was launched in 2014. By leveraging the organizational infrastructure and previous funding, a peer support component was integrated into the Healthy Tomorrows Program with extended training to support staff. The program consisted of bridging the obstetrics and pediatric practices by providing care coordination and education at eight unique points of contact, starting at the prenatal visit through the 1st month of birth. The electronic medical system was updated to ensure that breastfeeding intentions, education, and support encounters were recorded in the patient's file. Through funding from the National Association of County and City Health Officials, Esperanza implemented weekly peer lactation education in Spanish and hosted support groups in-house and in the community at a library. The group was open to pregnant and postpartum women and provided peer-to-peer social support, breastfeeding education, and guest speakers to provide education on other health topics. The Esperanza pediatric nurse practitioner, who is also an International Board Certified Lactation Consultant[®], held a learning session for medical assistants on the frontline of patient care and positioned to connect patients to peer counselors during their initial appointment intake.

Results/project outcomes: From 2015 to 2016, 100 peer support sessions were held and 218 unique women attended. Nineteen medical assistants attended the breastfeeding



Figure 1. S2AY Baby Café group photo.

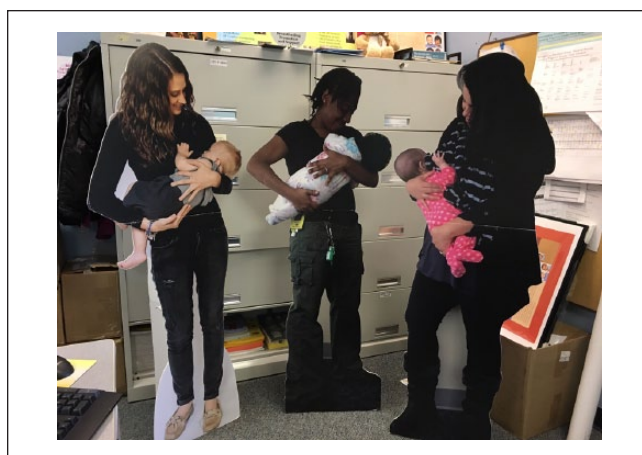


Figure 2. Monroe County Public Health's larger-than-life-size cutouts.



Figure 3. Monroe County Health Department, educating pregnant women.



Figure 4. Reaching Our Sisters Everywhere team.

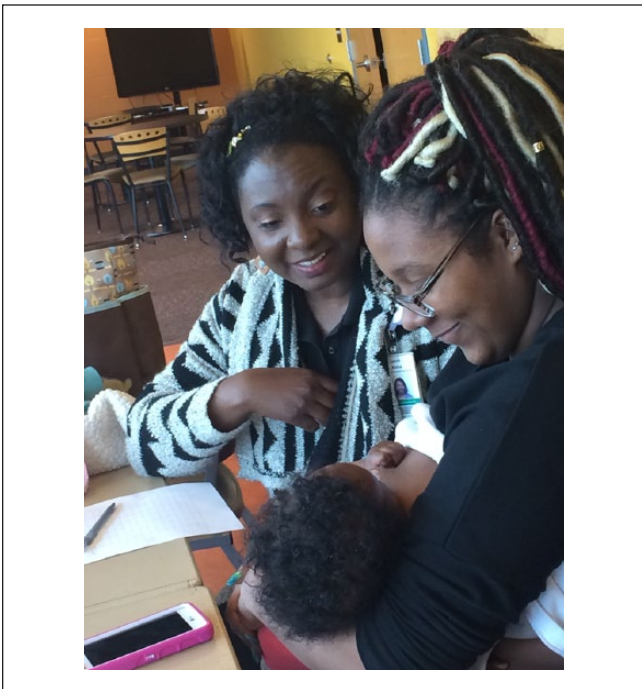


Figure 5. A mother breastfeeding at a Parkview Health breastfeeding support group.



Figure 6. I AM: Breastfeeding group picture showing the significance of family support.

workshop and increased their base breastfeeding knowledge from 7.63 to 9.52 post workshop. Overall, the program reported an increase in breastfeeding duration at 6 months from 33% to 43.1% and a decrease of formula-only feeding from 57% to 45% at 6 months. By shifting internal policies and systems and integrating breastfeeding support into other existing, culturally appropriate, population-based services, Esperanza was able to sustainably increase breastfeeding continuity of care.

Conclusion/implications: Obtaining policy and programmatic buy-in from both the obstetric and pediatric practices was instrumental for an institutional-wide program adaptation. Coordination and implementation of the program was effortless because of the clearly defined goals and structure, patient openness to the program, the initiative and interpersonal skills of the peer counselor, and strong support from staff, including clinic leadership. Although the initial goal was to increase breastfeeding exclusivity and reduce the practice of *las dos*, there was only a nominal change in that area. Ironically, the program increased the practice of *las dos* by reducing the number of women exclusively formula feeding.

Authors' Note

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention. The authors prepared the article within the scope of their employment with the National Association of County and City Health Officials.

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