pennsylvania
DEPARTMENT OF HEALTH

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Supporting Breastfeeding within African-American Communities: Evidence-Based and Research-Informed Practices

Purpose

Deciding whether or not to breastfeed is one of many decisions families face when a pregnancy occurs. The decision is a personal one, influenced by many factors in a woman's personal life and the greater social environment. The decision to breastfeed can improve and protect the health and well-being of a mother and baby over a lifetime and is a nationally and internationally recognized key to health promotion.

While the breastfeeding rates of all women have increased across the nation and in Pennsylvania, African-American women are breastfeeding at lower rates than other racial or ethnic groups. The purpose of this document is to provide guidance for agencies and stakeholders in utilizing evidence-based or research-informed strategies to address the promotion of breastfeeding within African-American populations.

This document examines the context in which African-American women make the decision to breastfeed by providing an overview of relevant research identifying barriers to initiating and maintaining breastfeeding practices. It outlines a variety of practical evidence-based or research-informed strategies stakeholders can use to build on strengths, address identified barriers, and enhance the promotion and adoption of breastfeeding within African-American communities.

Defining the Target Population

To continue encouraging breastfeeding as a healthy choice for mothers and babies, it is important to understand the status of breastfeeding and breastfeeding promotion within the Commonwealth. The Pennsylvania Department of Health (the Department) and it partners promote the decision to breastfeed through robust statewide programming engaging birth facilities through the Keystone 10 initiative, targeting initiatives in counties with low breastfeeding rates, and implementing education and training of health care professionals through the EPIC-BEST program.

The data below are drawn from Pennsylvania (PA) birth certificate and Pennsylvania Pregnancy Risk Assessment Monitoring Program (PA PRAMS) data sets. This information can assist local health departments and community-based programs to identify the characteristics of mothers who report breastfeeding, as well as those who report not breastfeeding, and to enable programs to identify target populations, the Bureau of Family Health analyzed state-level pregnancy and birth outcomes datasets. If available, local health departments and community-based providers are encouraged to analyze their own data to determine if there are additional characteristics which may help them define target populations within their communities.

Overall, the percentage of mothers that report breastfeeding has increased across all races and ethnicities. From 2009-2014, PA birth certificate data on breastfeeding reflect a statistically significant[†]

[†] Statistical significance means a result from statistical testing is not likely to occur randomly or by chance, but instead is likely to be attributable to a specific cause.

13.5% increase in the breastfeeding rate from 69.0% to 78.3%. Over this same period, a statistically significant 21% increase in the breastfeeding rate was found among African-American mothers from 58.6% to 70.9%. A similar trend is seen from 2008-2011 in the PA PRAMS data for African-American mothers reporting having ever breastfed/pumped breast milk.

PA PRAMS data indicate several factors positively influence mothers having ever breastfed. Mothers 20 years of age or older, mothers with higher levels of education, and those mothers not participating in Medicaid or WIC all report higher rates of breastfeeding. Moreover, all mothers indicate a lower breastfeeding/pumping rate when the pregnancy is unintended (69.7%) compared to those mothers with an intended pregnancy (82.4%).

Background Research / Definition of Problem

Introduction

There has been extensive research into the benefits of breastfeeding for both mothers and infants, the factors impacting breastfeeding initiation and duration, and which interventions best encourage, support and increase breastfeeding. To better understand the ways in which the Department and stakeholders can further promote breastfeeding by addressing identified barriers, the factors promoting or discouraging breastfeeding decisions within the African-American community are explored below.

Literature Review

The decision to breastfeed is a complex one involving individual, community, and system factors. There are important historical factors, such as slavery, wet-nursing, and other negative reproductive health experiences, and a general mistrust of the system influencing the reproductive and breastfeeding decisions of the African-American community. These historical factors are compounded by ongoing racism, discrimination, disempowerment, and personal biases found not only within the healthcare system but throughout the day to day lives of the African-American community.[13, 16]

Examples of Breastfeeding Barriers

Lack of Family & Social Supports

Perceived Social Norms

Unsupportive Employment

Concerns Related to Health Services

Lack of Access to Information

Cultural Competency of Health Professionals

Much of the literature regarding African-American communities and breastfeeding focuses on mothers that are identified as being low-income and/or residing within an urban setting; therefore, conclusions may not apply to all African-American mothers. Within these African-American communities, which are frequently racially segregated, many services, including those conducive to breastfeeding initiation and duration, such as childbirth educational classes and breastfeeding supports, as well as core health services are not available or are in short supply.

African-American mothers are also less likely to receive support or treatment for social, physical, or emotional needs, which can create a barrier to successful breastfeeding.[19] African-American women are disproportionately more likely to have poor perinatal health outcomes, suffer from chronic illness, stress, depression or Post Traumatic Stress Disorder which are all known risk factors for lower breastfeeding rates.[15]

The barriers to breastfeeding frequently identified by low-income minority mothers are: lack of social, work, or cultural acceptance or support; language or literacy barriers; lack of access to or inadequate or conflicting information related to supporting breastfeeding; the influence of health behaviors, such as the use of tobacco or alcohol; and a lack of advice from prenatal care providers about behaviors that promote health and wellness. [6, 16]

A consistent barrier for African-American women cited in the literature is the lack of family and community support for breastfeeding coupled with the perception that breastfeeding is viewed negatively within the community. Within African-American families it is also more likely that older generations did not breastfeed, resulting in a lack of role models within the family setting and poor support for breastfeeding.[21] This parallels data indicating African-American mothers have a much higher comfort level with formula feeding than other racial or ethnic groups.[16]

Further, due to the historical implications of wet nursing within African-American families and communities, breastfeeding may be perceived as objectification or a sign of powerlessness.[21] The literature also shows African-American mothers lacking the support of an intimate partner or the infant's father are also less likely to breastfeed.[6]

The literature defines additional barriers for low-income African-American mothers who are employed. While the Fair Labor Standards Act (FLSA) Break Time for Nursing Mothers provision mandates breaks and accommodations to support breastfeeding and pumping breastmilk, these provisions are viewed as limited and difficult to enforce or monitor.[8]

Additionally, while the commonwealth fully supports these FLSA provisions, there is no state-specific legislation in place that enhances the federal FLSA provisions. African-American women's employment is disproportionately low wage, in non-managerial positions with higher workplace stress, no flex time, limited access to leave, and no job sharing or part-time options. This racial segregation within occupations concentrates African-American women in jobs without breastfeeding protections. The Family Medical Leave Act (FMLA) does provide coverage for some individuals; however, it is still estimated that roughly 30% of African-American parents do not have access to guaranteed leave.[19]

Also, FMLA is not a universal source of support as it does not cover part-time employment, employees of small businesses, or employees with short tenure. African-Americans are more likely to work where employment-based insurance is available but are less likely to receive this coverage.[13, 14]

The literature also demonstrates bias within health care systems as a barrier to breastfeeding success. An ongoing lack of diversity in health professionals, including nurses, doctors and certified lactation consultants, as well as poor linguistic and cultural competence within the health workforce limits successful provision and promotion of breastfeeding services within African-American communities. African-American mothers are more likely to report a perceived inadequacy in the care they receive from health care providers.

Evidenced-Based, Research-Informed and Promising Practices and Strategies

Introduction

Local health departments and community-based providers are encouraged to utilize evidence-based or research-informed practices to inform their program strategies. Evidence-based or research-informed practices are interventions that have been shown to be effective in producing positive health outcomes among defined populations.

Incorporating evidence-based and research-informed practices into programs increases their efficacy and credibility, and assures that program resources are being used effectively. The following list of evidence-based or research-informed breastfeeding promotion strategies for African-American communities has been compiled to provide strategies for addressing the barriers highlighted above; it is not a comprehensive list of interventions. As noted, agencies are encouraged to identify additional evidence-based or research-informed practices if needed. When reviewing the following practices and strategies, it is important to focus on the community being served and how barriers to breastfeeding interact with and impact that community, specific needs and perceptions can vary between communities.

While implementing any one of the following recommendations may have a positive impact, the greatest success will be achieved when implementing multi-level, comprehensive approaches. Local health departments and community-based organizations should consider the following when selecting which strategies to utilize.

First, identify resources that already exist in the community and determine whether African-American families are currently able to access and utilize these services. Programs should also consider internal resources, such as funding, available staff, training needs, and space.

Second, identify which barriers, as outlined above, have the greatest impact on the population being served and consult with community members if possible.

Third, identify potential partners for implementing new strategies for promoting breastfeeding in African-American communities and ensure coordination with these partners. The most successful interventions utilize collaborations between agencies, healthcare providers, and community supports.

Fourth, in partnership with the communities being served, prioritize which barriers to address.

Finally, as appropriate, pilot strategies to promote breastfeeding. Identify measures of success and evaluate the effectiveness of each strategy with the populations being served.

The following websites may be useful when selecting and implementing strategies:

PA Department of Health (DOH) Breastfeeding Awareness [www.doh.pa.gov/breastfeeding],

The Centers for Disease Control and Prevention (CDC) Breastfeeding Support [www.cdc.gov/breastfeeding],

The Office of Women's Health's "It's Only Natural" Campaign [www.womenshealth.gov/itsonlynatural/index.html],

The Surgeon General's Call to Action to Support Breastfeeding [www.surgeongeneral.gov/library/calls/breastfeeding/index.html],

PRAMS "Data to Action Success Stories" [www.cdc.gov/prams/dta-successstories.html].

Social Support

A well-designed peer support intervention should have clear and realistic program goals, organizational support for the program, and provide adequate support for peer support workers. It should be noted training is a necessary component of peer support and should include basic breastfeeding management, nutrition, infant growth and development, counseling techniques, and criteria for making referrals.[25]

1. Educating and supporting family members and partners

   Establish programs that educate partners and family members as well as mothers.[24] This creates consistent provision of breastfeeding education and information to and between the mother and her support system. Efforts should be made to engage and utilize presenters that are African-American, and if possible from local community supports, such as churches, civic organizations, and peer support groups. Educational materials should be developed in coordination with healthcare providers, stakeholders, and community supports. When selecting programs and materials, choose those with established effectiveness with similar communities.

   a) Offer peer-facilitated, interactive, and informal classes on infant care and breastfeeding promotion for expectant fathers.[28,30] Learning from other fathers is key to engaging them.[28] Pair future fathers with trained peer mentors who are fathers of breastfed babies. The peer mentors can inform, coach and offer support. If a community does not have the resources to create a paid peer support program, try creating a volunteer program. [For more on father breastfeeding support: http://breastfeeding.nichq.org/stories/fathers-breastfeeding-support#sthash.mTDc4koE.SLCzqqO4.dpuf].
   b) Utilize culturally appropriate approaches to breastfeeding support programs. Note, the strategies listed on this site may not have been evaluated for effectiveness. [For information see: http://www.soulfood4yourbaby.org/programs/]
   c) Interventions by community health nurses which involve family members in all aspects of birthing and parenting can be essential in promoting positive health outcomes.[7]
   d) Prepare fathers for their role as the mother and baby's most important ally at the hospital; include information about the importance of exclusive breastfeeding, asking for help if the mother is struggling, clearly communicating to the hospital staff not to give the baby formula, bottles, or pacifiers, and talking points for how to address staff when they want to give the baby formula.[28]
   e) Create a task force on breastfeeding education for African-American men, focusing on developing and implementing community-based strategies to educate fathers about breastfeeding benefits as well as other infant parenting information designed specifically for dads.[28]
   f) The Office of Women's Health's *It's Only Natural* campaign offers the following tips about how to get African-American families on board with breastfeeding, such as giving the father top duties, educating the family early, identifying the mother's inner circle, and having older children help. [For more information see: www.womenshealth.gov/itsonlynatural]

2. Creation of peer support networks and peer support for mothers

Studies have shown that peer counseling (PC) interventions are successful in improving breastfeeding initiation, duration, exclusivity and positive infant health outcomes.[6] An intervention targeting a sample of low-income predominantly Puerto Rican women involved PC prenatal home visits, telephone support, daily in-house support, postpartum home visits, and free breast pumps.[6]

Another study with well-trained peer counselors—counselors trained in breastfeeding management, have experienced breastfeeding success, and work closely with women of similar demographics—positively impacted breastfeeding initiation, duration, and exclusivity.[5] The peer counselors worked closely under culturally competent lactation consultants who spoke the language of the population they were serving, understood their culture, and provided the necessary support and resources for these women to thrive. Additionally, peer counseling is seen to have a more positive impact in populations that may not qualify for the WIC program.[5]

a) Offer breastfeeding support groups, use trusted programs and community partners for referrals to services, use incentives to encourage participation, and offer the groups at meeting locations and times that are convenient for the mothers participating in the groups.[12,24]
b) Offer professional-led groups with peer exchange or ask breastfeeding professionals to attended support group meetings to provide on-site expertise to mothers.[12]
    i. The Office of Women's Health created *It's Only Natural* to offer African-American mothers the knowledge, help and support they need to breastfeed. During group sessions, mothers have an opportunity to engage with their peers in an honest and open discussion that fosters support and encouragement. [For more information see: www.womenshealth.gov/files/assets/docs/breastfeeding/itsonlynatural/leadersguide_designed.pdf]
c) The USDA WIC has launched a national initiative to institutionalize peer counseling as a core service. Many WIC state agencies already provide successful peer counseling programs, and the rest are implementing new programs as part of this national effort. After being given extensive training, peer counselors work primarily from home to provide telephone support to pregnant and breastfeeding mothers. In many programs, peer counselors also provide clinic-based counseling, make home visits during the early postpartum period, lead prenatal breastfeeding classes and postpartum support groups, and provide one-to-one support in the hospital setting.

    i. Pennsylvania Women, Infants and Children (WIC) offers breastfeeding peer counselors in many areas that meet one-on-one with WIC enrolled families to promote breastfeeding and help new moms successfully breastfeed. [For more information see: https://www.pawic.com/]
    ii. The New Mexico Women, Infants and Children (WIC) program offers peer counseling designed to train WIC program mothers to support other WIC mothers using parts of the USDA Grow and Glow curriculum. [For more information see:

https://www.cdc.gov/prams/state-success-stories/new-mexico.html and https://lovingsupport.fns.usda.gov/content/grow-and-glow-wic]

d) Build community partnerships to support recruitment and implementation of services.[12]
e) Other peer support models include peer-led face-to-face self-management programs, peer coaches, community health workers, peer support groups, telephone-based peer support, or and web- and email-based programs.
    i. The California HealthCare Foundation report provides information about implementing peer support interventions. [For more information see: http://california.foundationcenter.org/reports/building-peer-support-programs-to-manage-chronic-disease-seven-models-for-success/]
f) Establish a Black Breastfeeding Circle. (The following models may not have been evaluated for effectiveness).

    i. The Black Mothers Breastfeeding Association (BMBFA) utilizes peer-to-peer support to help women create a community-based acceptance of breastfeeding. They operate the Black Mother's Breastfeeding Club and a breastfeeding hotline. [For more information see: http://blackmothersbreastfeeding.org/]
    ii. Reaching Our Sisters Everywhere (ROSE) establishes and implements national and regional initiatives to enhance and strengthen family and community breastfeeding programs, such as breastfeeding clubs and cultural breastfeeding coalitions. [For more information see: http://www.breastfeedingrose.org/]
    iii. The Pittsburgh Black Breastfeeding Circle is an in-person and online supportive community for black breastfeeding women to meet and discuss the unique challenges they face with breastfeeding and parenting. [For more information see: http://www.sankofalactationservices.com/groups-classes and http://www.pghblackbreastfeedingcircle.org/]

3. Faith-based health promotion and education in African-American communities is a promising practice.

a) There are key elements of faith-based health promotion programs which could be used to inform breastfeeding promotion activities. [For more information see: https://www.researchgate.net/publication/6643439_Church-Based_Health_Promotion_Interventions_Evidence_and_Lessons_Learned]
b) Engage African-American churches to build community-based alliances. [For more information see: http://www.nacsw.org/Publications/Proceedings2010/ColvinASocialWork.pdf]

4. Media and Social Marketing

Using marketing strategies to promote and normalize breastfeeding can be an effective and low cost approach. It is important to note that care should not be unidirectional in promoting breastfeeding as the only option or negatively criticizing women who are incapable or choose not to breastfeed. Offering mothers a comprehensive education behind the benefits of breastfeeding, the harms of

formula feeding, and alternatives for women who are unable to breastfeed is a better approach in reframing the problem to find multiple, adaptable solutions so women can choose the best option for their families.

There is strong evidence that suggests African-American mothers engage in their own research to seek perinatal and parenting advice[2]. Most mothers are using mobile devices as they search for information. Apps that are commonly reported as being used are BabyCenter's My Pregnancy and My Baby Today, BabyGaga, and I'm Expecting. Paying for marketing targeted by zip code on these apps could be an effective way to link expecting mothers to pre-existing breastfeeding support systems in the community. Common search engines and websites that are being used are Google, YouTube, Mom365, and WebMD. Hyper-regional platforms like NextDoor, Reddit Snapchat, and Kik could be worth exploring to see if the region has pre-existing groups for mothers. [2] Mothers report mostly not reading mailings and pamphlets distributed.[2]

After birth, mothers tend to delete pregnancy apps similar to those previously discussed, but continue to use social media outlets, particularly Facebook, when they have a specific question. Having a community health worker or peer support specialist present in locations specific to mother's Facebook groups who is responsible for answering questions about breastfeeding or promoting community resources would be an excellent low cost, low effort, high impact intervention. Additionally, supporting black peer educators to form Facebook groups for black mothers locally would fill a much needed gap for peer support. Promoting pre-existing national programs that have been shown to improve breastfeeding rates, like Text4Baby, in these groups would be a low-cost strategy to link African-American mothers to existing resources.

There's a variety of outlets that could be used: Facebook groups or sponsored ads, poster campaigns, asking key informants to spread the message to their communities, or mailings. Experiment with what works for the local community, or try to model marketing methods on previously successful health promotion campaigns. The most successful social marketing campaigns are driven by the audience they intend to reach and address specific barriers identified by the community, not broad concepts.[27]

The Work Environment

Support and standard breastfeeding in the workplace with components of legislative policies supporting breastfeeding, providing designated private spaces for breastfeeding or expressing milk, permitting flexible schedules to express milk, expanding options to return to work and extending maternity leave, providing on-site child care, providing breast pumps, and offering professional lactation management services and support.

1. Employer Incentives and Resources

    a) The U.S. Health Resources and Services Administration Maternal and Child Health Bureau has launched a national workplace initiative that includes developing a resource kit for employers. *The Business Case for Breastfeeding* offers a detailed model for health professionals to follow when educating employers. [For more information see: https://www.womenshealth.gov/breastfeeding/business-case-for-breastfeeding.html]

b) The United States Department of Labor provides information on the federal Break Time for Nursing Mothers law. General guidance for employers and employees are offered along with frequently asked questions, fact sheets and employee rights cards. [For more information see: https://www.dol.gov/whd/nursingmothers/]

2. State Examples

a) Texas set forth legislation in 1995 to standardize basic components of workplace support for breastfeeding. Employers that ensure these components are in place are eligible to receive Mother-Friendly Workplace designation from the Texas Department of Health. The major components are as follows:

   i. Flexible work schedules to provide time for milk expression.
   ii. Access to a private location for milk expression.
   iii. Access to a nearby clean and safe water source and sink for washing hands and rinsing out any breast-pump equipment.
   iv. Access to hygienic storage options for the mother to store her breast-milk.

b) Louisiana (LA) PRAMS and their partners identified school and work as barriers to initiation and continuation of breastfeeding. The LA Breastfeeding Coalition proposed a bill which was passed in the legislature in 2011 requiring ten institutions statewide to construct suitable lactation areas for their employees. [For more information see: https://www.cdc.gov/prams/state-success-stories/louisiana.html]

c) New Mexico also used PRAMS data to support changes to their breastfeeding legislation. In 2007, a bill was amended requiring New Mexico employers to allow flexible break times for nursing mothers and to provide a physical private location, which was not a bathroom, for pumping. The New Mexico Medical-Legal Alliance now monitors employer compliance with the breastfeeding law and offers legal support. [For more information see: https://www.cdc.gov/prams/state-success-stories/new-mexico.html]

Growth of Culturally Informed Health Systems

When African-American women do not see themselves or their experiences reflected in the health providers that are attempting to serve them, the medical advice the providers are attempting to offer feels less applicable to them. In general, using medical staff to provide education to patients on breastfeeding is a successful strategy. However, African-American women tend to distrust medical professionals providing breastfeeding education because of historical mistreatment and traumas, which stresses the need for culturally competent providers who understand the culture of the populations they are serving, to increase effectiveness and relatability.[28]

Medical professionals should have basic training on cultural competency and basic breastfeeding management so that relevant breastfeeding education can be provided to all mothers. The only evidence-based strategy currently available is based on the implicit bias theory.[10‡]

‡ *The AAMC offers a series of trainings and curriculums based around this theory* https://www.aamc.org/initiatives/diversity/322996/lablearningonunconsciousbias.html

1. Cultural brokers can be go-betweens for a patient and what they perceive as an unfeeling health system. Here are some resources on their role and how to develop them:

    a) The National Center for Cultural Competence, Georgetown University Center, has literature on developing cultural brokers to increase access to and enhance the delivery of culturally competent care. [For more information see: https://nccc.georgetown.edu/documents/Cultural_Broker_Guide_English.pdf]
    b) *Developing Culturally Responsive Approaches to Serving Diverse Populations: A Resource Guide for Community-Based Organizations* is designed to help community-based services organizations (CBOs) define and understand cultural competency, choose interventions for diverse populations and ensure progress measurements are culturally and linguistically appropriate. [For more information see: http://www.hispanicresearchcenter.org/resources/publications/]
    c) *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease* from the Centers for Disease Control and Prevention (CDC) provides lessons learned and innovative ideas on how to maximize the effects of policy, systems and environmental improvement strategies, all with the goal of reducing health disparities and advancing health equity. [For more information see: https://www.cdc.gov/nccdphp/dch/health-equity-guide/index.htm

2. Increase understanding of implicit bias, cultural and linguistic barriers and health inequities.

    The following webinars can be used as potential awareness training tools:

    a) The University of Washington has created a webinar titled, *Challenging Implicit Bias to Achieve Equity & Justice*, which explores how implicit bias leads to racial and other inequities and how communities can implement strategies and tools to lessen the impact of implicit bias. [For more information see: https://www.youtube.com/watch?v=9YtS1ZUZ8GA&feature=youtu.be]
    b) The National Association of County and City Health Officials (NACCHO) has archived webinars addressing breastfeeding in the community, marketing and engagement, cultural humility and health inequity and structural breastfeeding barriers. [For more information see: http://breastfeeding.naccho.org/archived-webinars/]

3. Growth of culturally representative health care provider staff.

    Given that breastfeeding is a learned skill, having experienced role models as teachers is important for the success of breastfeeding mothers. This includes women who are currently breastfeeding or breastfed in the past, lactation consultants or trained peer counselors, and nurses. However, African- Americans are underrepresented in the health care professions.[23] There is some evidence that increasing representation of black women in healthcare professions, especially lactation consultants, would increase rates of breastfeeding.[15] Using this strategy may entail partnering with organizations comprised of African-American medical workers to recruit African-American women to local medical training programs. The following resources provide information about recruiting

and retaining diverse staff. Note, the strategies outlined by these community-based programs may not have been evaluated for effectiveness.

a) The Southeastern Pennsylvania Area Black Nurses Association (SEPABNA), Inc.'s goal is to bring together community and health care professionals to work together on issues and meet the demands of an ever-changing healthcare environment through education and influence of health policy. [For more information see: http://www.sepabna.org/]
b) The Association of Pittsburgh Black Nurses is committed to reducing health disparities among African-Americans and other minorities living within the Greater Pittsburgh area through education and awareness. [For more information see: http://www.pittsburghblacknursesinaction.org/index.htm]
c) The Maternity Care Coalition (MCC) focuses on providing services in neighborhoods with high rates of poverty, infant mortality, health disparities and changing immigration patterns. [For more information see: http://maternitycarecoalition.org/breastfeeding/#breastfeeding-and-doula-program]

Role of Health Systems and Professionals

1. Develop supports encouraging the continuation of breastfeeding support from delivery/hospital to community health care providers.

a) Building a seamless and reliable message about supporting breastfeeding that families receive from prenatal care through postpartum community health care services has positive outcomes for breastfeeding.[18] Support should include counseling, encouragement, and managing lactation crises; education is secondary.[18] Health care providers should provide consistent, evidence-based advice and support in-person, by telephone, within group or individual sessions, or within an office, clinic, or home setting.[18] Develop partnerships with other providers and support services in the community, creating a network that can remove gaps in care and support for a mother experiencing a breastfeeding crisis, challenge, or concern.[18]
b) Offer online or in-person training to standardize breastfeeding knowledge of community based nurses and health professionals. [For more information see: http://phpa.dhmh.maryland.gov/mch/pages/hospital_breastfeeding_policy_training.aspx, https://lovingsupport.fns.usda.gov/content/grow-and-glow-wic, http://www.paaap.org/programs/best, and http://www.birtharts.com/breastfeeding-educator-certification.htm]
    i. The Pennsylvania Department of Health's Keystone 10 Initiative is facilitating the adoption and implementation of the World Health Organization's evidence-based Ten Steps to Successful Breastfeeding within birthing hospitals and centers across the state. [For more information see: www.doh.pa.gov/keystone10]
c) Lactation consultant interventions have been proven to be effective best practices interventions in increasing breastfeeding duration and intensity.[3] Breastfeeding interventions delivered through nurses seemed to be less successful when compared to lactation counseling interventions.[6] One possible reason for more success in lactation

counseling interventions was attributed to an increased acceptance of health messages delivered by bilingual workers.[3] Being culturally aware of and building rapport with the population you serve can influence encouragement and participation in an intended intervention.[6]

d) Studies have shown that breastfeeding teams involving community health nurses, peer counselors, and lactation consultants can significantly increase breastfeeding initiation and duration rates in low-income women. [22, 29]
e) Though minority women experience a lack of access to prenatal care for a variety of reasons, prenatal pediatric visits have beneficial effects on breastfeeding decisions among urban, low-income mothers[26] who manage to receive prenatal care.
f) Group breastfeeding education sessions had a positive impact on women who had plans to breastfeed as well as for those who had planned to formula feed. It was found that individual breastfeeding education sessions also had a positive impact on those who had planned to formula feed.[17]

2. Providing culturally competent education and training for all health care professionals serving woman and children.

a) Nursing interventions should fully integrate health literacy, culture, and language. Culture and language need to be considered in any interaction designed to address health literacy for culturally diverse patients. [For more information see: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol142009/No3Sept09/Cultural-and-Linguistic-Barriers-.html?css=print]
b) Nurses and childbirth educators should have self-awareness of their attitudes toward African-Americans, empower clients for birthing, recognition of the role pregnant women's mothers play, tailor childbirth classes for African-American women, and research how racism influences pregnant African-American women's preparation for birthing.[1]
c) Effective health communication is as important to health care as clinical skills. To improve individual health and build healthy communities, health care providers need to recognize and address the unique culture, language, and health literacy of diverse consumers and communities. [For more information see: https://www.hrsa.gov/culturalcompetence/index.html

Contact Information

This document was developed by the Department of Health, Bureau of Family Health. Please contact Erin McCarty, MPH or Sara E. Thuma, MPH at 717-346-3000 with questions or requests for additional information.

Individuals or agencies who would like additional information about the PA PRAMS data provided in the "Defining the Target Population" section should contact Division of Bureau Operations at 717-346-3000.

Resource Appendices

Appendix A – Bibliography

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