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Karen Marie Robinson

Marquette University, karen.robinson@marquette.edu

Leona VandeVusse

Marquette University, leona.vandevusse@marquette.edu

Jamarrah Foster

Wheaton Franciscan - Saint Joseph Hospital Milwaukee

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Reactions of Low-Income African American Women to Breastfeeding Peer Counselors

Karen Robinson

College of Nursing, Marquette University, Milwaukee, WI

Leona VandeVusse

College of Nursing, Marquette University, Milwaukee, WI

Jamarrah Foster

Wheaton Franciscan–Saint Joseph, Milwaukee, WI

Abstract

Objective

To examine the influence of breastfeeding peer counseling on the breastfeeding experiences of African American mothers who participated in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Design

Qualitative study using focus groups.

Setting

Two WIC clinics in Southeast Wisconsin were used for recruitment and data collection.

Participants

A convenience sample of nine African American mothers participated in one of two focus groups.

Methods

The women responded to a series of open-ended questions about their breastfeeding experiences and the effect of breastfeeding peer counselors (BPCs). Content and thematic analyses were used to analyze patterns related to the influence of BPCs on breastfeeding.

Results

Four themes were categorized: *Educating With Truth*, *Validating for Confidence*, *Countering Others' Negativity*, and *Supporting With Solutions*. Mothers in this study expressed positive reactions to educational, emotional, and social support from BPCs. The mothers noted that the contact they had with BPCs had a direct positive influence on their breastfeeding experiences. However, the contact from BPCs varied between the two WIC clinics.

Conclusion

The findings demonstrate the positive effects of BPCs on breastfeeding experiences among African American WIC participants. Findings from this study can guide future explorations using BPCs. Interventions are needed to develop standardized guidelines to bring about homogeneity of, better access to, and greater use of BPCs.

Keywords

African American, Breastfeeding, Peer Counselors, WIC

Nationally, breastfeeding initiation rates have risen, and overall rates have reached the Healthy People 2010 objectives (Centers for Disease Control and Prevention [CDC], 2014a). Data indicated that 76.7% of new mothers in the United States initiated breastfeeding in 2010, which met the stated national goal of 75% at that time (CDC, n.d.). In the same year, 47.5% of new mothers in the United States continued breastfeeding at 6 months, coming close to meeting the Healthy People 2010 objective of 50% (CDC, n.d.). Despite national progress in reaching breastfeeding initiation and continuation objectives established for 2010, the United States continues to face major racial breastfeeding disparities. Recent data indicated that African American women continue to have lower initiation and continuation rates than women of other races and ethnicities. Results from the 2010 National Immunization Survey (CDC, n.d.) showed that only 63.3% of African American women initiated breastfeeding and that 36.1% continued to 6 months. These rates, which have remained statistically unchanged since 2004, fell well short of national objectives.

The Healthy People 2020 breastfeeding objectives (81.9% initiation and 60.6% continuation at 6 months) may further widen the gap between African American mothers and new mothers of all races (CDC, 2014a). The U.S. Surgeon General's 2011 Call to Action acknowledged the need for a national

commitment to close the racial gap in breastfeeding initiation and continuation (U.S. Department of Health and Human Services, 2011). Improving initiation and continuation breastfeeding rates, especially for African American women, is vital to improving other disparities that exist in maternal–child health. According to the most current data from the U.S. Department of Health and Human Services Office of Minority Health (2013), the infant mortality rate among African American infants in 2010 was 2.2 times higher than the rate for White infants. Bartick and Reinhold (2010) concluded that if 90% of all U.S. mothers breastfed exclusively for 6 months, there would be 900 fewer infant deaths per year in the United States. Analyzing a large national database from 1988 with representative samples of postneonatal infant deaths, Chen and Rogan (2004) were able to better control for confounding variables. They projected that a national increase in the continuation of breastfeeding could decrease the infant mortality rate by 720 deaths each year with minimal risk or cost. It is highly likely that increasing breastfeeding initiation and continuation rates in the African American population would lead to improved infant outcomes.

Review of the Literature

Women enrolled in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) have lower breastfeeding initiation rates than the total U.S. population of breastfeeding mothers (Evans, Labbok, & Abrahams, 2011). The WIC program is a federally funded grant program that provides nutritional services and counseling for more than 50% of low-income families who have children from infancy to age 5 years (Evans et al., 2011). In samples from the 2012 and 2013 National Immunization Surveys (CDC, 2014b), 72% of the women who participated in WIC initiated breastfeeding. Only 38% continued at 6 months. This national dataset did not specify race/ethnicity for WIC participants, making it impossible to determine initiation and continuation rates specifically among African American WIC participants.

However, researchers have identified racial disparities that exist within the WIC community regarding breastfeeding initiation (Ma, Brewer-Asling, & Magnus, 2013). This disparity may be related to the difference in breastfeeding advice given to African American WIC participants. In a quantitative comparative study on breastfeeding advice, Beal, Kuhlthau, and Perrin (2003) reported that African American women were significantly less likely to receive breastfeeding advice from their health care providers (48% vs. 53%, $p < .001$) and WIC counselors (56% vs 64%, $p < .001$) than White participants. In addition, African American women were significantly more likely to receive recommendations to formula feed from WIC counselors (65% vs 55%, $p < .001$; Beal et al., 2003). Evans et al. (2011) found that in North Carolina WIC clinics, African American women were significantly less likely to be offered breastfeeding support services ($p < .05$). These findings suggested that African American women using WIC services received limited information regarding infant feeding options. Furthermore, Evans et al. (2011) found two confounding factors that contributed to the low breastfeeding rates in the population: being a WIC program participant and being an African American mother.

Various strategies have been implemented to improve breastfeeding rates among low-income women, specifically African Americans, and researchers have shown that role modeling has a positive influence on breastfeeding initiation and continuation for African American mothers (Robinson & VandeVusse, 2011). Promoting the use of breastfeeding support services such as those more recently offered through WIC programs, including additional food packages to support nutrition for breastfeeding

mothers and use of breastfeeding peer counselors (BPCs), was essential to shifting from formula feeding to breastfeeding among low-income African American women who participate in WIC (U.S. Department of Agriculture [USDA], Food and Nutrition Service, 2014).

Frequent exposure to education and encouragement about the substantial benefits of providing breastmilk for infants have been successful strategies to increase breastfeeding rates among African American women who are WIC participants. The WIC program provides BPCs for educational, emotional, and social support for new breastfeeding mothers (Campbell et al., 2013, Evans et al., 2011, Hedberg, 2013, Rozga et al., 2015a). The BPCs are mothers who have experience with breastfeeding and who are able to provide emotional support and key information about how other mothers can successfully breastfeed (USDA, Food and Nutrition Service, 2010). The basic requirements established for WIC BPCs are that they must contact (a) WIC enrollees at least once during their pregnancies; (b) a new mother every 2 to 3 days within the first 7 to 10 days postpartum; (c) any woman within 24 hours if she reports breastfeeding difficulties, and BPCs must make suitable referrals if difficulties still persist; and (d) postpartum mothers weekly through the first month and then monthly throughout the infant's first year of life (USDA, 2010).

The BPCs have had positive effects on increasing breastfeeding initiation and continuation for African American mothers enrolled in WIC (Arlotti and Cottrell, 1998, Baumgartel et al., 2013, Campbell et al., 2013, Caulfield et al., 1998, Gross et al., 2009, Olson et al., 2010, Rozga et al., 2015a). In a study conducted at a WIC clinic in Baltimore, Caulfield et al. (1998) determined that BPCs in addition to motivational videos doubled breastfeeding continuation rates in African American mothers at 8 and 16 weeks postpartum compared with mothers who did not receive any breastfeeding interventions. Campbell et al. (2013) found that WIC participants who were breastfeeding for the first time were more likely to initiate breastfeeding when they had contact with BPCs during pregnancy, in the hospital, and after discharge than those without such contact. Olson et al. (2010) analyzed the effectiveness of BPCs in Michigan among WIC participants. In their quasi-experimental study, they found that use of BPCs increased breastfeeding initiation by 27% and increased continuation time by 3 weeks. In a randomized controlled trial, researchers (Pugh et al., 2010) found that use of BPCs increased breastfeeding continuation rates at 6 weeks postpartum from 56.9% to 66.7% (*OR*, 1.71; 95% CI [1.07, 2.76]; *p* = .03). Using secondary analysis of 5,886 WIC charts of low-income breastfeeding women, Rozga et al. (2015a) evaluated components of a WIC peer counseling program in Michigan to support breastfeeding women. They found that WIC participants who received optimal in-person contact from the peer counselors were more likely to continue breastfeeding at 6 months compared with those not receiving optimal contact. The researchers noted that identifying what is *optimal* remains a challenge.

Pugh, Milligan, Frick, Spatz, and Bronner (2002) studied a community health intervention to encourage breastfeeding and examined its possible cost effectiveness. In their cost-benefit analysis, these researchers found that mothers who received breastfeeding support from a community health nurse and a BPC reported fewer infant visits to providers for illness compared with mothers who did not receive support. Furthermore, they noted that the cost of the intervention "was partially offset by cost savings on formula and health care" (p. 95). The authors cautioned that the limited 6-month time frame of the study was insufficiently sensitive to include intangible benefits of breastfeeding for

mother and infant or to monitor long-term health benefits. Recognizing the resource limitations among peer counseling programs, Rozga, Kerver, and Olson (2015b) examined the WIC charts of 12,923 breastfeeding women for prioritization of services. Most of the sample were non-Hispanic White women (59%), compared with 27% non-Hispanic Black and 14% Hispanic women. In this secondary analysis, the researchers found that enrolling women into the program during the prenatal period was a better use of resources than later enrollment (e.g., 4 weeks postpartum) (Rozga et al., 2015b). In identifying and working through potential and real breastfeeding-related obstacles during pregnancy, interaction with peer counselors may increase the likelihood of breastfeeding initiation and continuation.

Few researchers have examined the effectiveness of breastfeeding peer counselors on breastfeeding initiation and continuation from the perspectives of participants in a supplemental nutrition program.

Few researchers have examined the effectiveness of BPCs on breastfeeding initiation and continuation from the perspectives of WIC participants. Meier, Olson, and Benton (2007) conducted six focus groups (three with WIC participants and three with BPCs). They found that mothers who received breastfeeding assistance from BPCs were pleased with the support. T. T. Gross et al. (2015) examined the perceptions of BPCs who provided breastfeeding support to African American WIC participants. The 23 BPCs discussed factors that they believed influenced decisions to initiate breastfeeding, and the BPCs noted that the support they provided was critical to the success of breastfeeding among these women (T. T. Gross et al., 2015). For example, the BPCs stated that some women reported that BPCs were the sole supporters of breastfeeding in their lives. The BPCs also expressed the importance of meeting mothers where they were by accepting any form of breastfeeding, whether exclusive or partial. Rossman, Engstrom, and Meier (2012) conducted individual interviews with 17 health care providers (nurses, neonatologists, and dieticians) to examine their perceptions of the effectiveness of BPCs in the NICU. They found that across disciplines, providers believed the BPCs to be a vital asset. The BPCs were viewed as role models who empowered the mothers they supported.

Our study was intended to directly examine the perspectives of African American WIC participants about BPCs. Our study addresses a lack of qualitative studies exclusively focused on the perspectives of these mothers who were breastfeeding.

Methods

Sample and Procedures

We obtained human subject approval through the institutional review board of Marquette University. The primary researcher met with the clinic directors at two WIC sites in Southeast Wisconsin to discuss study recruitment procedures. It was determined that the BPCs would approach eligible women to participate in the focus groups. African American WIC participants who were currently breastfeeding or had breastfed during the last 6 months, were 18 years or older, and spoke and read English were eligible for this study. The primary researcher obtained written consent from participants before the start of each focus group. The participants were asked a set of guided questions that gave them the opportunity to openly discuss their feelings about breastfeeding, their experiences, and how their BPCs influenced them (Table 1). Two African American researchers conducted the focus groups. One

facilitated while the other took notes, which included observing the nonverbal cues of the participants, such as their vocal tones, facial expressions, and body language. The focus groups were audiotaped, and the tapes were transcribed verbatim for detailed analysis. Each participant was asked to complete a sociodemographic questionnaire. Data gathered from the questionnaire included each participant's involvement in the WIC program, marital status, income, level of education, parity, and ages of children. Limited data to reduce participant burden were gathered on the demographic forms and did not include prenatal complications, birth method, delivery site, or length of time postpartum.

Table 1. Focus Group Discussion Items

Number	Questions and Statements
1	Describe your experiences with your breastfeeding peer counselor.
2	What kind of advice would you have liked to receive but didn't get from your breastfeeding peer counselor?
3	What kind of advice did you find beneficial during your experience with your breastfeeding peer counselor?
4	Overall, how would you describe your experience with breastfeeding?
5	How do think your experience would be different if you didn't have a breastfeeding peer counselor?
6	Describe how family and friends responded to you breastfeeding.

Data Analysis

To ensure the accuracy of the qualitative findings, the observational notes of nonverbal cues and the audiotapes from the focus groups were transcribed verbatim. The first and third authors independently reviewed the verbatim notes and transcripts. We listened to the audiotapes and compared them with the transcripts for accuracy. We read and reread the transcripts and independently coded the data into sets of like patterns of statements, phrases, and outliers. Next, we shared our content analyses and coding after discussing what we saw as common categories and as outliers. We continued this process until no new themes emerged (Taylor-Powell & Renner, 2003). As a final step of analysis, we consulted a qualitative expert (second author) to review the notes, transcripts, and other data. On further analysis and discussion with the second author, an additional theme was identified to adequately represent all findings.

Results

Nine mothers participated in one of two focus groups (first group, $n = 4$; second group, $n = 5$). See Table 2 for demographic data. The mean age of the participants was 26 years ($SD = 3.72$; range, 22 to 31 years). All women in the sample had intentions to breastfeed, and one intended to breastfeed and formula feed. All but one of the participants were still breastfeeding at the time of the focus groups. Four infants, two of whom were born between 34 and 36 weeks gestation were still breastfeeding at the time of this study. The women breastfed beyond the number of months they reported having contact with their BPCs (Table 2).

Table 2. Demographics of African American Women in Focus Groups ($N = 9$)

Characteristic	<i>M</i>	<i>SD</i>	Range	<i>n</i> (%)
Age, years	26.0	3.7	22–31	
Living children, <i>n</i>	2.2	1.0	1–4	
Gestational age at birth, weeks	37.8	2.0	34–40	
Months planned to breastfeed	10.5	2.8	6–12	
Months have been breastfeeding	7.6	7.6	0.8–19.2	
Months worked with BPC	4.4	3.5	0.5–10.0	
Marital status				
Single/divorced				6 (66.7)
Married				3 (33.3)
Education				
High school				1 (11.1)
Some college				4 (44.4)
College graduate				4 (44.4)
Yearly income				
≤ \$20,000				4 (44.4)
\$20,001–\$40,000				3 (33.3)
\$40,001–\$60,000				2 (22.2)

Studying the BPCs directly was not the focus of our study. However, the two WIC clinic directors provided general demographic information about the BPCs at their clinics. According to the WIC directors, the BPCs demographically mirrored the women they supported (race, age, socioeconomic and educational levels, marital status, and parity). Both BPCs had been WIC peer counselors for a minimum of 1 year and had breastfed their infant(s) for at least 6 months. They received BPC training through Loving Support Through Peer Counseling: A Journey Together, a BPC training program federally funded through the USDA Food and Nutrition Services (USDA, Food and Nutrition Service, 2011). To receive the designation of WIC BPC, both BPCs completed the 12-module formatted curriculum developed through the Loving Support program. The BPCs were employed half time or less through WIC.

The BPCs had direct access through WIC to the participants in our study. During pregnancy, once a participant informed a WIC nutritionist of her desire to breastfeed, the nutritionist placed the woman with the BPC at her clinic. The BPCs followed the guidelines noted earlier (USDA, 2010). The program included various types of contact with BPCs: clinic visits, telephone calls during the pregnancy and postpartum time periods, and in-hospital and in-home visits. Specific data on the frequency and types of contacts with BPCs was not asked on the questionnaire but was gathered from what participants indicated during the focus group discussions. The WIC directors indicated that there were limited resources for BPCs, which affected their availability for outreach services.

Four themes emerged from the focus group analyses after the women were asked about their perceptions of the educational, emotional, and social support they had received from BPCs: *Educating With Truth, Validating for Confidence, Countering Others' Negativity, and Supporting With Solutions.*

Theme 1: Educating With Truth

The mothers reported receiving valuable breastfeeding information from their BPCs. They were informed of the benefits of breastfeeding for themselves and their infants. They stated that the counselors gave them critical information and “helped with my breastfeeding education ... that I needed. Like how breastfed babies are more advanced ... all the nutrients and vitamins, and how it helps fight off infections.” One participant noted that the BPC “informed me of how much better it [breastmilk] is and they have all these charts showing you.” Another reported learning about “the closeness” and bonding fostered by breastfeeding. Still another commented that it was the “least expensive way for me to feed my baby [she was smiling] because I’m a single mother.” The mothers expressed their trust in the truthfulness of the information they received from their BPCs: they “tell you what it’s [breastfeeding is] really like.”

The truthfulness perceived by the participants was related to the lived breastfeeding experiences of the BPCs: “It’s good to have someone who cares and who have been through it [breastfeeding].” Another mother stated, “She [BPC] is willing to give advice because she went through it. So, it’s like someone who says, ‘OK, I went through it; here’s what I did.’” The information was valid to the participants because the BPCs had “breastfed for a long time.”

Theme 2: Validating for Confidence

Lack of confidence and emotional and social support have been reported as barriers to breastfeeding initiation for African American women. The mothers in our study voiced that their BPCs were “real reassuring” and validated the choice to breastfeed. The counselor’s “advice allowed me to be sure about my breastfeeding decision.” One woman reported her counselor’s advice: “Your body knows; trust in your body and your baby.” Relative to breastfeeding in public, one participant stated, “Even if other people [around] ... are uncomfortable ... [baby’s] gotta eat.... I’m not gonna starve my child; I’ll cover up, that’s fine.”

The breastfeeding experiences of low-income African American women were positively influenced by their interactions with breastfeeding peer counselors.

Some mothers decided to breastfeed but had doubts related to perceived physical limitations: “I was skeptical I would be too big; [BPC] put me in a comfortable state and I was like, ‘I can do this.’” Many of the mothers spoke of their increased confidence in defending their infant feeding decision to family and friends: “Once I had the knowledge, it was easy for me to tell people this is the reason [I chose to breastfeed].” Another said, “If you’re outspoken you can say, ‘This is my decision even [if] you accept it or not.’”

One participant reported a hospital situation in which her infant was not latching on well. When the nurse planned to give formula if the infant was not feeding by a certain time, the woman responded confidently:

I told her [the nurse], “If you come in here and try to give my child a bottle, we gonna have a problem. I told you I was breastfeeding and that’s what I’m gonna do.” You have to kind of stand your ground.

Theme 3: Countering Others' Negativity

As the women's confidence about breastfeeding increased, they reported instances when they would behave like their role models, the BPCs: "I even got one of my cousins to breastfeed! She's younger than me. My cousin said, 'I look to you as a role model ... and if you can do it, I can do it.'" Several participants reported negative comments from key persons in their lives and noted that sisters, husbands, and friends believed that breastfeeding was "nasty" or "weird." One woman stated,

I had a lot of negative people around me; my mother-in-law wanted me to give the baby the bottle. So I took her to the classes [conducted by BPC] so she could see how beneficial [breastfeeding was] and she started supporting me.

One husband reportedly changed his mind: "He's all for it because now he sees that it's working." To counter others' negative assumptions, one woman explained, "I still get freedom; your [breastfed] baby gets on a schedule.... Now I can be gone for 2½ hours and the more they grow, the less they'll need [breastmilk]."

Another participant advocated BPCs for women to create emotional and social support around them when it did not exist: "People who don't have a support system, to have a [BPC] to come back and tell you things [is good]." One woman described:

Need to get the BPC out in the community to the young ladies. I mean I didn't even know about [them] until after I delivered. I might have questions early on in the pregnancy; like my breasts started to hurt before I had her.

One woman stated:

This is your baby! Take the time, 3, 6 months. You don't have to do it [breastfeed] forever, but those first 3 months, the system, W-2 [a local, non-entitlement program that assists low-income parents with employability; Wisconsin Department of Children and Families, 2014] even, helps you stay home with your child.

Theme 4: Supporting With Solutions

When common breastfeeding problems arose for mothers in our study, their BPCs helped them find solutions: "If I did have a question or was wondering something or got stuck, she's right on time [answering my questions]." For another, her "BPC would ask ... 'How are things going? Do you have sore nipples?'" and explained "They would do home visits if you needed the extra help; [BPCs are] really hands-on." One mother who described her "really small nipples" concluded she "loved the advice they [BPCs] gave me" which included using nipple shields, pumping, and storing breastmilk.

Some of the women described problems encountered and the assistance and educational, emotional, and social support they received. One participant who gave birth prematurely shared how the BPCs helped her initiate breastfeeding: "My baby was born prematurely and didn't have suck reflex and I got help from the BPC. They teach you the best way to position and stuff like that." One participant spoke of enduring painful thrush with the help of her counselor. "I lasted through it [thrush] 'cause my peer counselor said, 'You can do it.' She told me, 'You made it through all that [birth].'" The counselors were noted to influence breastfeeding continuation: "I probably wouldn't have lasted as long because it

[breastfeeding] was kind of difficult. So I would say I would have probably switched to formula if I didn't have my BPC.”

Discussion

The four themes identified in our study showed the positive effects of BPCs on the breastfeeding experiences of African American mothers who participated in WIC. The mothers noted that their contact with the BPCs, specifically the information and verbal support each counselor provided, had a direct effect on their breastfeeding experiences. From the mothers' perspectives, the BPCs were influential to breastfeeding success. The findings in our study reinforced the results reported in the current literature that use of BPCs had a positive effect on breastfeeding outcomes among low-income women who participate in WIC. Those who received support from BPCs had greater breastfeeding initiation rates than those who did not receive support (Campbell et al., 2013, Gross et al., 2009, Pugh et al., 2010). Furthermore, BPCs had positive effects on breastfeeding continuation, especially if initial contact was made prenatally (Rozga et al., 2015a, Rozga et al., 2015b.)

Lack of breastfeeding role models and lack of self-confidence in breastfeeding were noted as barriers to breastfeeding initiation and continuation among low-income African American women (Hedberg, 2013, Robinson and VandeVusse, 2011), and researchers found that African American women expressed the need for breastfeeding support from other African American women (Lewallen & Street, 2010). Mothers in our study openly discussed how BPCs helped bolster their confidence in breastfeeding, and increased self-confidence contributed to breastfeeding initiation and continuation despite obstacles they encountered (e.g., negative feedback from others, common breastfeeding issues). In addition to the direct benefits of BPCs identified by the participants in our focus groups, the fact that the women themselves brought the information about breastfeeding to friends and families further widens the influence by changing attitudes and cultural norms about the topic.

Although there is evidence of the positive influence of BPCs on breastfeeding initiation and continuation rates among African American WIC participants, BPCs are used inconsistently. For example, at one of the WIC clinic sites in our study, in-home visits were not part of routine counseling services. Most WIC BPCs provided breastfeeding support through phone contact or face-to-face meetings at the WIC clinics, but few if any provided routine home visits (Bronner, Barber, Vogelhut, & Resnik, 2001). In their randomized controlled trial, Pugh et al. (2010) found that use of a standardized breastfeeding support model increased breastfeeding rates in the intervention group compared with the control group. Inconsistent use of BPCs may be related to the lack of financial resources in WIC to support them: 0.6% of WIC's budget is allotted to breastfeeding programs (Baumgartel et al., 2013). In a cost–benefit analysis, Frick, Pugh, and Milligan (2012) found that the costs of BPCs and community health nurses to support breastfeeding WIC participants were “partially offset by reducing medical care utilization and formula feeding costs” (p. 144).

Nurses can advocate for better integration of breastfeeding peer counselors into the health care system to improve breastfeeding health-related outcomes.

Limitations

Our study was limited by a convenience sample of nine African American women who self-identified as successful breastfeeding mothers interested in participating in focus groups from two WIC clinics in

southeastern Wisconsin. The women who self-selected to participate may have been highly motivated to explain the positive effects of BPCs in their breastfeeding successes. Because we did not explicitly collect data on the exact types of contacts (e.g., phone or in person) the participants had with their BPCs, relevant comparative data were unavailable. Also, our study focused exclusively on low-income women, so our findings may be quite different compared with those for all breastfeeding women.

Nursing Implications

Our findings have implications for nurses who provide maternal–child care for African American women participating in WIC, a population that historically has low rates of breastfeeding initiation and continuation. Nurses are uniquely positioned to work with BPCs in an effort to provide holistic breastfeeding support. Research has shown that community health nurses who collaborated with BPCs in providing breastfeeding support to WIC participants contributed to reduced needs for health care services and costs of formula feeding (Pugh et al., 2010).

Furthermore, nurses have great opportunities for interdisciplinary collaborations with WIC personnel to expand and enhance current WIC BPC programs. Nurses and other providers can play instrumental roles in advocating and lobbying for programmatic changes within WIC that could result in better integration of BPCs within the health care system. With increased funding, more recruitment and preparation of women from low-income backgrounds to work as BPCs could further expand their positive effects among African American women.

Conclusions

The improvement of perinatal outcomes is a national public health goal. Identifying how to specifically increase the rate of breastfeeding among African American women entails more research about which interventions are key to initiation and continuation. Using BPCs to promote breastfeeding can result in improvements in health outcomes and contribute to reduced health disparities for African American infants.

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