Breastfeeding Attitudes of WIC Staff: A Descriptive Study

Elizabeth Reifsnider, PhD, RNC, WHNP

Sara Gill, PhD, RN, IBCLC

Patty Villarreal, MS, RN, CPNP, FAAN

Mindy B. Tinkle, PhD, RNC, WHNP

Abstract

A sample of staff members from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC program) were interviewed about breastfeeding and their perceptions of WIC recipients' views on breastfeeding. WIC staff members universally supported breastfeeding and expressed desires for more linkages between WIC agencies and perinatal education specialists in childbirth education classes, as well as with mothers during their postpartum hospital stay. The WIC staff members in this study reported on a variety of beliefs about breastfeeding held by their WIC clients, including cultural beliefs, the importance of family support, and experiences of pain during breastfeeding.

Journal of Perinatal Education, 12(3), 7–15; breastfeeding, WIC program, lactation education.

Introduction

The Special Supplemental Nutrition Program for Women, Infants and Children (the WIC program) has been identified as having an influence on the mother's feeding decision (Balcazar, Trier, & Cobas, 1995) for both bottle-feeding and breastfeeding. The WIC program is mandated to provide breastfeeding education and support for all pregnant and postpartum women enrolled in this program (Caulfield et al., 1998; Lindenberger & Bryant, 2000). However, some studies have reported that the WIC program inadvertently promotes bottle feeding because it provides an option for formula for infants (Fooladi, 2001). This paper presents a sample of WIC staff members' thoughts on breastfeeding and their perceptions of WIC recipients' views on breastfeed-

ing. In order to design meaningful interventions to promote breastfeeding among WIC-eligible pregnant women, we needed to know information mothers were currently receiving from WIC, and how that information was delivered.

Review of Literature

New mothers have indicated that support is one of the most crucial aspects of initiating and continuing breastfeed practices (Grummer-Strawn, Rice, Dugas, Clark, & Benton-Davis, 1997). In some studies, support from husbands or partners is demonstrated as paramount to promoting breastfeeding (Cohen, Brown, Rivera, & Dewey, 1999; Scrimshaw, Engle, Arnold, & Haynes, 1987). Other studies identify mothers, friends, and others in the woman's social network as important breastfeeding support resources (Balcazar et al., 1995; Bentley et al., 1999). Health care providers influence the pregnant woman's decision to breastfeed or not, with prenatal feeding advice being most influential if it is offered during the prenatal care visit (Balcazar et al., 1995). In the study by Balcazar and colleagues, non-Hispanic white women were 2–3 times more likely to breastfeed when advised to do so by WIC staff members, and, conversely, more likely to give formula when advised to do so by WIC staff. Thus, WIC staff members can be viewed as part of the matrix of health care providers that a WIC-eligible pregnant woman encounters and who can influence how she feeds her infant.

The WIC program has adopted multiple methods to increase the incidence and duration of breastfeeding among its recipients. In 2000, the United States Department of Health and Human Services published the *DHHS Blueprint for Action on Breastfeeding*, which encouraged peer counseling in the WIC program (Satcher, 2001). The WIC program has made extensive use of the practice of peer counseling. Another strategy has been the use of social marketing, as shown by the National WIC Breastfeeding Promotion Program, with

the campaign theme of “Loving Support Makes Breastfeeding Work” (Lindenberger & Bryant, 2000). Some WIC programs have used motivational videos and personalized education to promote breastfeeding (Caulfield et al., 1998). Other programs have used nurse practitioners or lactation specialists who were shown to be more effective than peer counselors (Grummer-Strawn et al., 1997). Some WIC programs have provided staff members with continuing education opportunities on breastfeeding, with the assumption that the staff, being more educated about breastfeeding, will provide more education about the benefits of breastfeeding to pregnant women receiving WIC resources. However, mere knowledge of the benefits of breastfeeding is not enough to affect behavior (Sciacca, Dube, Phipps, & Ratliff, 1995).

Methods

This study's sample consisted of the staff members from four WIC clinics in a large, southwestern city. These particular WIC clinics were chosen because they serve a largely Hispanic population (90% Hispanic) and they were all part of the same WIC project. The number of pregnant women delivering each month varied from 112 in the largest clinic to 44 in the smallest clinic. The number of women breastfeeding in the four clinics varied from 62 (58%) in the largest clinic to 19 (32%) in the smallest clinic. A total of 835 women attending the four clinics delivered during the three months of the study, and a total of 402 women breastfed, for an average percentage of 48% breastfeeding. Overall, the breastfeeding percentages varied month to month and from clinic to clinic.

No difference was detected between the responses given by the WIC staff at the clinic with the highest percentage of participants who breastfed and the WIC staff at the clinic with the lowest percentage of participants who breastfed. The WIC staff members who participated in the focus groups were largely intake clerks and nutrition aides. The sample consisted of 39 women and one man, and a majority of the staff (92%) self-identified as Hispanic and were bilingual in English and Spanish. Four of the staff members held college degrees as nutritionists, seven were licensed vocational nurses, and the remainder were public health/nutrition aides or intake clerks. The aides and clerks possessed a high school diploma or GED. The mean age of the sample

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was 32 years, with a range of 22 to 62 years of age. The majority of all the WIC staff members, including aides and clerks, had attended an introductory course on breastfeeding consisting of two or three days of focused lectures and question-and-answer sessions about breastfeeding.

Focus groups, lasting approximately one hour, were conducted with WIC staff members in order to discern their views, attitudes, and opinions regarding breastfeeding. The focus groups were conducted during lunchtime. The discussion was tape-recorded and later transcribed, verbatim, for analysis. Participants shared their views, attitudes, and opinions about breastfeeding in a non-threatening environment. Institutional review board approval was obtained to conduct the interviews, and the staff members were assured that all responses were confidential. Assent (not written consent) was required.

The researchers used a focus-group discussion guide to direct the interviews. The questions progressed from global to specific and began with the grand-tour question, "What do you think about breastfeeding?" This initial inquiry was followed by the following questions:

- What makes breastfeeding easy, and what makes it hard?
- Are there foods or substances that must be avoided while breastfeeding?
- Are there foods or substances that need to be eaten while breastfeeding?
- What do WIC participants tell you about breastfeeding?
- What have you heard from WIC participants that have shaped your views on breastfeeding?
- What kinds of things help a new mother to decide to breastfeed?
- What kinds of things help a breastfeeding mother to continue to breastfeed?
- What factors from your culture or family background influence how you think about feeding babies?

Data Analysis

The investigators reviewed the transcribed interviews for accuracy. Similar ideas from the data were grouped

together and assigned codes. Coded data were then organized into themes related to the questions guiding the research (LeCompte & Schensul, 1999). The first and second authors independently analyzed the data for trends, patterns, and themes. They then met together to compare their findings. The authors had a 98% initial agreement. When disagreement occurred, the supporting data were again reviewed and consensus was obtained. The third and fourth authors verified the themes after analysis was completed.

Results

The content of the narrative data was analyzed to determine themes. Several themes emerged from the data: the benefits of breastfeeding, barriers to breastfeeding, lack of support for breastfeeding, cultural beliefs about breastfeeding, and WIC's role in breastfeeding promotion. WIC staff members discussed breastfeeding from two perspectives: in terms of their own experiences and in terms of the WIC participants that they served.

Staff Breastfeeding Experiences

All staff members were familiar with the benefits of breastfeeding to mothers and babies. The majority of the WIC staff members attempted breastfeeding with their own children, but many encountered difficulties along the way. Most staff members felt they lacked breastfeeding support from family and health care providers. Other WIC staff members described episodes of pain during breastfeeding and the lack of adequate milk supply. Despite their personal difficulties, all staff members reported that they recommended breastfeeding to all women as the preferred method of infant feeding.

According to the sample in this study, WIC staff members' personal breastfeeding experiences were as varied as those encountered by the clients they served. Some staff members successfully breastfed their infants; others never attempted breastfeeding. Still others initiated breastfeeding, but they discontinued for a variety of reasons. All WIC staff members who had children discussed their infant feeding experiences.

Regarding her own breastfeeding experience, an LVN said, "Well, breastfeeding is the greatest. I was already breastfeeding [when I started working here], and I've learned a lot with working with the WIC program. I

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think [breast milk]—it's the best source, like they say, for the baby."

Benefits of Breastfeeding

When asked what they thought about breastfeeding, the WIC staff members universally agreed that breastfeeding is the best feeding method for an infant. An LVN said, "It's the greatest, it's the best source for the baby, and babies aren't sick as often." Another participant added, "About breastfeeding, it's very good for the mother and baby . . . it bonds them together." Still another replied, "It's natural. It's nothing to be embarrassed about. It's nothing ugly." They said that breastfeeding results in healthier babies and good weight gain for babies, and that WIC mothers were more patient with their children when they breastfed. Staff members also noticed that WIC mothers' husbands liked breastfeeding because their wives got back into shape sooner. Another participant stated, "As the child is growing up, its speech is better, it learns a lot faster, and it's just a total difference." Still another said that breastfed babies "are well behaved and it's because of the bonding with the mother. They have so much more attention."

WIC staff members described maternal breastfeeding benefits in terms of convenience. One staff member said, "[Breastfeeding] is less expensive . . . it's expensive buying the formula and bottles. [Breast milk] is already in the house and you don't have to heat it up . . . it's easier . . . you don't have to get bottles made." Another participant stated, "You don't have to worry that [breast milk] goes bad or that you can't afford it or that the store is out."

Barriers to Breastfeeding

Although WIC staff members expressed positive beliefs about breastfeeding, they stated that, just because it is best for an infant, breastfeeding is not always easy. Staff members listed returning to work, enduring a lack of family support, and experiencing difficulty with latch-on

techniques as situations that made breastfeeding difficult for women. Staff members also stated that, when women faced these difficulties, "They give up really quick, instead of trying."

WIC staff members identified barriers to successful breastfeeding, including the lack of knowledge or education about the process, pain, embarrassment, support, and hospital practices. Staff members believed that successful breastfeeding attempts need preliminary knowledge: "You know, the problem with mothers is that they have no knowledge of how to position the baby or what to do, what to expect, anything." Staff members understood that their role was to provide that knowledge to WIC participants: "Education is big, it's a big part of breastfeeding and that's what we provide." Staff members intentionally asked mothers about their infant feeding plans and provided breastfeeding literature. One WIC worker described her interactions with young mothers:

I ask them if they've thought about breastfeeding their baby when it's born. If they say, 'No,' I ask why. And then I say, 'Can you give me just two minutes of your time to let me give you the reasons why and all the things behind it?' I give them some literature to take and read. And you know, they give me the two minutes. And then they are like, 'Wow!'—because they had no knowledge of, all the pluses, that were behind the breastfeeding.

WIC staff members identified pain as another barrier to breastfeeding. Again, they discussed their personal experiences with painful breastfeeding and, then, they discussed pain issues experienced by WIC participants. One WIC staff member related:

My doctor told me, when I told him I was going to, that I wanted to breastfeed, I said, 'What do I have to do?' And he said, 'Oh, nothing. You know, just put the baby to your breast and she will do the rest.' And that's not so, it is not. And it hurt a lot.

Another staff member said, "I kept telling my mother-in-law, I said, 'How can you say that it's so pleasant, that it's so good, you know, to breastfeed when it hurts a lot?'" This same staff member also commented on the value of prenatal breastfeeding education: "I wish I would have known then what I know now, because my

daughter, when she had her first baby, she went through breastfeeding lessons, and she did beautiful.” WIC staff members related that many mothers discontinued breastfeeding because of the pain: “They give up pretty quick.”

Staff members also described misinformation that affected mothers’ feeding decisions. Some mothers decided not to breastfeed because of misinformation about foods, diet, and breastfeeding. The staff stated that many women believed they had been “good” about their diets while they were pregnant and did not want to continue following a good diet. They wanted to resume drinking alcohol, smoking cigarettes, and eating a spicy diet and “junk” food. The women believed that, if they breastfed, they would have to drink a lot of milk, they could not consume alcohol, and, if they ate salsa, it would burn their baby’s bottom. One staff member related the following perceptions conveyed by WIC participants:

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They say they cannot eat beans because the baby will get a lot of gas and colic, and the reason they are breastfeeding is so the baby won’t have colic, and that spicy food will give the baby diarrhea, or they’ll have hot stools that will burn them, and they can’t drink their sodas. They’ll say, ‘I don’t eat healthy enough, my milk is not going to be a good source. I eat too much pepper, and I like my salsa.’ They don’t want to give up liquor and beer and their cigarettes, so they’d just rather not breastfeed at all.

Lack of Support

WIC staff members discussed lack of breastfeeding support as an influence on breastfeeding success. They felt that if fathers, grandmothers, and peers did not encourage a mother to breastfeed, the mother would either not initiate breastfeeding or discontinue the practice shortly after birth. One staff member said, “A lot of times, they don’t have the family support . . . their husbands don’t

want them to [breastfeed] or their mothers don’t, so they don’t.” Another staff member related how one young girl said her boyfriend would not like her to breastfeed because “it would take time away from him.” According to another staff member, a WIC recipient said her husband didn’t want her to breastfeed because her breasts “would get all saggy.” Thus, comments were made that referred to the influence of breastfeeding on sexuality. Staff members did not offer suggestions for ways to deal with the lack of family support.

WIC staff members also discussed the lack of hospital support for breastfeeding. Once again, while recounting WIC participants’ experiences, staff members returned to their own breastfeeding attempts in order to illustrate the problems their participants faced. One staff member said, “Even though I was nursing, I’m sure [the nurses] gave [my baby] a bottle without even asking me. I’m sure they did!” Another staff member claimed that “there was no support in the hospital—I mean, the nurses didn’t support [me].”

WIC staff members believed that time spent in the hospital is critical to promoting successful breastfeeding, especially during the first 24 hours after birth. They stated that they teach their participants about initiating breastfeeding. Staff members believed that, in the hospital, mothers did not receive breastfeeding support or assistance. They felt this lack of support quickly led mothers to discontinue breastfeeding and give bottles to their babies. WIC staff members complained that all their participants were typically sent home from the hospital with a formula pack, which made it easier for mothers to give their babies formula instead of breastfeeding. Staff members reported that, when new mothers come to WIC for their postpartum certification, they request formula. One staff member said, “They want the formula. I try to explain to them that, if I give them the

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formula, they will get away from breastfeeding.” Another related, “I had one mother come in and ask for formula. I was sure she was going to breastfeed, so I asked her what happened. She said that she was told in the hospital to take the formula just in case the baby needed it, and to use it until her milk comes in.”

WIC staff members reported that new mothers are told to give their babies formula or glucose water for jaundice, or to stop breastfeeding because the mothers had a breast infection. A WIC staff member stated, “The nurses in the hospital just spend a few seconds with a new mother with problems. What can we do? They need immediate, practical help, but no resources are given.” Another staff member said, “The staff at the hospital do not help them. Mothers tell me that the nurse comes in the room, dumps the baby there, and leaves.”

Cultural Beliefs

Staff members reported another theme that addressed WIC participants’ cultural beliefs about breastfeeding. These cultural beliefs were not held by all participants; however, staff members described the most commonly related beliefs related by WIC participants. These beliefs affect WIC participants’ decisions about breastfeeding initiation and breastfeeding management. Some of the most common beliefs are described in the following WIC staff members’ descriptions of their clients’ comments:

- There’s a tea that, if the babies have colic or are not able to sleep at night, [mothers] go ahead and give them the manzanilla because it will sooth their stomach. It just looks like a bunch of dried weeds, and then you boil it. It’s the same thing as chamomile.
- One lady from Mexico told me that, if you were going to breastfeed, you had to always make sure your back was covered because you could get air that way. She said you had to cover your back with either a shawl or a blanket or a towel. It had to be covered, and your back had to be up against something because you would get air. I don’t know what that meant.
- One of our WIC participants told us that you couldn’t go to a funeral, it would sour the milk. It’s not good if you’re pregnant or breastfeeding to go to a rosary or funeral or anything, to step

in or around a funeral or cemeteries because it would sour or clog the milk. It was just bad luck.

The common view presented by WIC staff members was that some WIC participants believed that stressful or negative events, including accidents, would taint the milk. This view was extended to beliefs that a stressful life would sour the milk; therefore, if life was stressful, a mother should not breastfeed.

WIC’s Role in Breastfeeding Promotion

Finally, WIC staff members expressed another theme that concerned their conflicted feelings about WIC’s breastfeeding-promoting efforts together with the agency’s availability as an organization that provides formula to participants. Staff members said they believed that WIC should be baby-friendly and follow the UNICEF/World Health Organization’s *Ten Steps to Successful Breastfeeding* (UNICEF/WHO, 1991). They noted that their participants often ask why they should breastfeed, especially when they can get free formula from WIC. Staff members expressed frustration over working hard to promote breastfeeding and, then, being required to provide formula to participants. They stated that the formula companies had more money to advertise, and that WIC cannot afford competitive advertising in favor of breast milk. As one staff member said:

WIC is free, milk is free—you know, why bother? Maybe we can force them to breastfeed. We make it so easy for them now. You know the formula’s there, available for them, so why breastfeed when they can get formula, free?

Discussion

In this study, all WIC staff members were strong proponents of breastfeeding. Among the study’s sample paraprofessional and professional staff members, no difference was apparent in the level of support for breastfeeding. This finding matches similar results in a recent study conducted in Los Angeles County, in which 99% of WIC staff members initiated breastfeeding with their own infants and 68.6% continued to breastfeed for one year (Whaley, Meehan, Lange, Slusser, & Jenks, 2002). A significant number of the staff members who

participated in this study received breastfeeding training and participated in breastfeeding support groups based in their respective WIC offices. Therefore, staff members in this study not only received breastfeeding training at their WIC offices, but also carried out breastfeeding practices—on a personal level—promoted by the WIC program. In order to effectively promote breastfeeding, WIC agencies may need to consider providing breastfeeding education at other work sites and collaborating with employers to provide effective, on-site breast pumps.

Cultural issues and beliefs about breastfeeding (as cited here) may be specific to the regional area in which the studied WIC agency resides. In this study's WIC agency, the majority of clients claimed Hispanic ethnicity, and most clients declared Mexican ancestry. This cultural aspect is reflected in the WIC staff members' relating how some of their participants often expressed strong beliefs, such as avoiding exposure of air on an uncovered back, staying away from death and illness while breastfeeding, and drinking manzanilla tea to comfort babies. The belief that air exposure to an uncovered back may result in a chill that leads to more serious illness is similar to other folk beliefs that a upper-respiratory infection is caused by getting chilled, sitting in a draft, or walking barefoot in cold weather. Acknowledgement of this particular belief is conveyed when education about breastfeeding includes the recommendation for breastfeeding mothers to have a shawl or baby blanket handy to cover up the baby and/or mother while breastfeeding. The added cultural belief that exposure to sadness, death, and illness should be avoided is an acknowledgment that breastfeeding is hormonally mediated, and a severe shock or anxiety may decrease the milk supply. Providing education on the intricacies of milk supply and demand may reassure the WIC participant that, even if she does experience grief or anxiety, she will maintain her milk supply if she continues putting her baby to breast. Manzanilla—or chamomile—is a recognized herb that promotes relaxation and offers an anti-inflammatory activity. Hale (1999) stated that allergic reactions to chamomile and hypersensitization via breast milk could occur during lactation. However, no pediatric concerns via breast milk have been reported.

Cultural dietary beliefs are more difficult to address, especially because they are so commonly and widely upheld among ethnic groups. In America—the dominant

culture—breastfeeding mothers are encouraged to avoid smoking, consuming alcohol, and foods with low nutritional value. Some of these viewpoints have a basis in scientific reality; for example, smoking can decrease the milk supply, and alcohol can enter the breast milk (Hale, 1999). When WIC participants cite a desire to engage in unhealthy, though culturally acceptable dietary practices as a reason to avoid breastfeeding, WIC staff members may take advantage of the opportunity to introduce a helpful overview that demonstrates ways to promote the mother's health—ways that, in turn, can serve to protect the health of the mother's children. For example, if the mother smokes, WIC staff members can warn her that her children will be exposed to dangerous, second-hand smoke. If the mother eats a high-fat, nutritionally deficient diet, WIC staff members can alert the mother that all of her family members will most likely consume the same deficient food. Still, high-fat, empty-calorie diets can support lactation, especially if vitamin and mineral supplements are provided. Consumption of unhealthy, modern diets does not preclude the benefits of breastfeeding; in fact, recognizing today's modern, unhealthy eating tendencies may help induce a healthy change in a family's diet.

WIC agencies may find it useful to address the dissonance between the agency's strong breastfeeding advocacy, along with its practice to provide formula to WIC participants. In this study, staff members expressed frustrations over promoting breastfeeding and, at the same time, allowing the distribution of formula. If not addressed, this dissonance may lead to a reduction of efforts to promote breastfeeding. In order to increase their local breastfeeding rates, WIC agencies may need to use their resources to address workplace issues and other systemic barriers to breastfeeding in their communities. This, in turn, may lessen the discrepancy between advocating for breastfeeding and providing formula.

Implications for Practice

Many study participants expressed cultural and personal beliefs about breastfeeding that, if not attended to, can sabotage breastfeeding education. The impact of breastfeeding on sexuality should be addressed early in the education sessions. WIC participants should feel free to express their views on how breastfeeding will affect their sexual relationship with their partners. They should

also be encouraged to discuss these views with their partners. Open discussion about this issue during group education sessions may help those who are too shy to broach the topic during one-to-one education sessions. Factual information can be provided about anatomy and physiology, as well as discussion about practical issues such as leakage during coitus and how that may impact sexual relations.

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In this study, WIC staff members expressed frustration over breastfeeding barriers in hospitals. They recognized that the education they provided was abstract during pregnancy and that, when the baby was born, the mother needed help applying the abstract education to the reality of breastfeeding her new baby. Some steps to reduce this frustration would be for WIC agencies to collaborate with hospitals to arrange for WIC-sponsored lactation consultants or lactation educators to visit the WIC participants while they are in the hospital. If the hospital employs lactation consultants, these same professionals need to be in close communication with the local WIC agency so they can share the WIC participants' management of breastfeeding. At a minimum, lactation consultants should know the criteria for WIC eligibility so that they can refer low-income, breastfeeding women to WIC in order for these women to receive the agency's postpartum nutrition package. Lactation consultants are also encouraged to collaborate with WIC programs in order to address difficult breastfeeding motivation problems (e.g., dissuading mothers from using formula as an easy infant-feeding option).

People who staff WIC clinics—professional nurses and nutritionists, as well as paraprofessional health aides—provide nutrition education to the 7.4 million WIC participants, nationwide (Whaley et al., 2002). They listen to low-income women talk about breastfeeding, their attitudes towards breastfeeding, and the issues they face when making a decision about choosing a method for infant feeding.

In order to help foster breastfeeding, perinatal educa-

tors and community-based lactation consultants can work with the WIC agency in their community to foster breastfeeding. They can become acquainted with WIC staff and learn the details of the education offered to local WIC clients. If the situation warrants more WIC staff training than is already occurring, perinatal educators and lactation consultants can seek opportunities to become involved. They can work to coordinate with WIC programs to insure WIC mothers receive consistent prenatal breastfeeding education. Educators and consultants can also become aware of the breastfeeding barriers for low-income women in their specific community and participate in planning ways to lower those barriers, where feasible. If WIC mothers are not receiving supportive care in the hospital—as described in this article—perinatal educators and lactation consultants can advocate for establishing a feedback system so that staff nurses are aware of any negative impact their care has on breastfeeding.

The rates of breastfeeding initiation and duration will not increase in this nation unless serious attention is paid to women's issues about infant feeding. WIC staff members know these issues and can be reliable reporters for learning more about infant feeding attitudes of the population they serve.

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