Community Engagement and Dissemination of Effective Breastfeeding Programs

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AS GAINS IN EVIDENCE THAT SUPPORT the efficacy of breastfeeding interventions and effectiveness of breastfeeding programs and practices accrue, the priority shifts toward dissemination. While gaps in both efficacy and effectiveness remain and ongoing research and evaluation are still needed, federal, state, and local initiatives increasingly emphasize and fund efforts to disseminate effective programs. Dissemination of individual programs commonly relies on single funding streams and commitments of organizations or groups (e.g., Special Supplemental Nutrition Program for Women, Infants and Children [WIC] breastfeeding peer counselors; Baby-Friendly Hospital Initiatives).

When viewed through the lens of the social ecological model, this approach is inadequate to create sustained and sustainable change. As with most dissemination, success hinges on what happens at the local level, where unique attributes, capacities and resources, and history must be taken into account. Breastfeeding is no exception. Like most health promotion initiatives it is multifaceted, warranting involvement and coordination across different components of the healthcare system, human services, and community-based and volunteer organizations along with government, business, and industry. Accomplishing this warrants a community-based approach that looks comprehensively at multiple levels: policy, institutional, community, and inter- and intra-personal.¹ Community engagement is central to the success of this approach.

Community engagement is variously defined and an area of increasing interest and attention. It is viewed as essential to sustainable improvements of a community's health.² Increasingly, federal and state agencies fund consortiums, coalitions, and other like entities to listen to, work with, and otherwise involve the community in the work of health promotion. Community-based participatory research (CBPR) is one commonly utilized framework, even if the goal is not full implementation of all of CBPR's principles.³ Regardless of the framework being used, making community engagement operational presents significant challenges.

Common to these approaches is establishing a coalition or consortium typically populated with representatives of agencies whose missions align with or whose resources are needed to support the effort. For breastfeeding, this typically involves healthcare organizations (e.g., hospitals, provider practices), human service organizations (e.g., WIC), volunteer

groups (e.g., La Leche League), insurers, and businesses in addition to healthcare professionals or lay workers who either care for infants or women of childbearing age and/or who have specialized training in breastfeeding support. Some coalitions include among their membership, breastfeeding mothers or those of childbearing age, or may include others who may influence the decision to start or sustain breastfeeding (e.g., father, grandmother). In some cases members, based on their personal experience, are expected implicitly or explicitly to both represent their organization and be the voice of the breastfeeding mother or childbearing woman. This dual role can create confusion and may subvert or muffle the voice of the childbearing mother and family or only represent the breastfeeding mother and not others such as grandmothers or fathers who are also part of the equation. Bringing the voice of the community into this dialogue may be limited further for pragmatic reasons to create a group of manageable size.

A National Institutes of Health-funded research project using CBPR methods is focusing on increasing breastfeeding among low-income women from an upstate New York urban community. Our interventions are across the community involving providers, hospitals, and other health and human service organizations along with community messaging. A Community Council, organized and chaired by a community-based organization, drew its ethnically diverse membership from women of childbearing age (not just mothers) and other influencers, including males and older women. No agencies or organizations are represented on the Council but rather are involved in the project as members of the research team (e.g., WIC, hospitals) or its working subgroups (e.g., providers, insurers). Research team members provide input into the overall Council agenda, and several participate on the Council (including the Principal Investigator), but they are in the minority. The community-based organization recruits, convenes, and structures the agenda and follows up on monthly meetings. Issues warranting more in-depth exploration are addressed through focus groups. Transportation, child care, and food are provided at each meeting, and members are paid for their participation. The Council discusses and debates the issues surrounding infant feeding and helps shape proposed evidence-based interventions to the local context and interprets local breastfeeding data.

While still maturing, the Council has contributed to the project in key ways through both their involvement with the

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project's development and lessons learned regarding community engagement. The latter include:

- Our initial plan to include a broad range of ethnically diverse individuals proved both important and challenging. We sought mothers who had and had not tried breastfeeding, a range of childbearing-aged women, including teens (who may or may not have been mothers), and males who may or may not be or have been fathers.
- Engaging and retaining individuals presented difficulties, particularly among those who not only are raising a young family but also have school and/or work commitments that compete for their time and attention.

What we have learned so far to inform our project both affirmed and challenged our understanding of breastfeeding in our community:

- Negative or ambivalent attitudes about breastfeeding among professionals working with low-income women continue. Their actions in support of breastfeeding remain key; however, messages are inconsistent and contribute to confusion for the breastfeeding mother.
- Knowledge that breastfeeding is best is generally known, but specifics are lacking. Helping members understand the subtleties proved difficult (e.g., how breastfeeding affects pediatric obesity or that it is allowable for mothers who smoke to breastfeed).
- Beliefs about infant feeding, beyond the commonly held myths, were identified. That a child could actually not have multiple ear infections was viewed with skepticism.
- Systems and policies or practices within and across organizations serve to subvert one another and negatively impact breastfeeding among low-income women.
- Need for support to sustain breastfeeding is not limited to low-income women.
- Family relationships can, but may not always, play a significant role particularly in sustaining breastfeeding (be it supportive of or serve to undermine breastfeeding).
- Living situations are complex and complicate breastfeeding. The breastfeeding mother may feel vulnerable and need protection while breastfeeding even in her home.
- The cost of formula did not figure prominently as a motivator to breastfeed or as a reason to not use formula, as it was available for free.
- In the context of their lives, formula feeding was seen as convenient, whereas breastfeeding was not.

- Teens and young mothers were identified as a key target group for intervention.
- Local attitudes do not map perfectly onto national attitudes (and hence the need to listen to local voices).
- While the optimal choice is breastfeeding, low-income women make suboptimal choices everyday. Why should decisions about infant feeding be any different? How risky a choice is formula feeding in the context of their lives?

Our work to date has reinforced the importance of looking at breastfeeding promotion and support from a systems perspective, moving away from a focus on "blaming the mother."

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