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Community Health Workers: Collaborating to Support Breastfeeding Among High-Risk Inner-City Mothers

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Abstract

Background: Low breastfeeding rates persist as a health disparity among high-risk inner-city mothers. We sought to obtain input of community health workers (CHWs) in preparation for a breastfeeding intervention.
Subjects and Methods: We conducted audiotaped focus groups with CHWs of the Cleveland (OH) Department of Public Health's MomsFirst™, a federally funded Healthy Start program, which addressed interest in breastfeeding, positives and negatives of breastfeeding, perceived barriers, and an intervention concept. We used notes-based and tape-based analysis with a previously developed theme code modified for breastfeeding relevance.
Results: Seventeen (50%) of 34 actively employed CHWs participated in two focus groups. Issues that emerged were as follows: (1) breastfeeding is "hard" for young mothers, with multiple obstacles identified, including lack of support at home, pain with nursing, extra time required, incompatibility with medications and lifestyle, body image concerns, and "no equipment" (breast pumps); (2) expected supports such as postpartum hospital care have not been helpful, and in-home help is needed; (3) many CHWs' personal breastfeeding experiences were difficult; (4) CHWs requested additional breastfeeding education for themselves; and (5) while strongly endorsing "making a difference" in their clients' lives, CHWs worried that additional curricular mandates would create burden that could become a disincentive.
Conclusions: CHWs who make home visits are in a unique position to impact their clients' breastfeeding decisions. A targeted intervention for high-risk inner-city mothers must meet the educational needs of the teachers (CHWs) while minimizing administrative burden, address issues identified by the clients (mothers), and provide hands-on help within the home.

Introduction

The Healthy People 2020 goal for breastfeeding initiation is 81.9%, with the additional goals of 46.2% and 25.5% exclusive continuation of breastfeeding at 3 months and 6 months, respectively.[1] Risk factors for low rates of breastfeeding include African American race, younger age, lower educational level, lower socioeconomic status, and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) eligibility and participation.[2] We initiated partnering with the Cleveland (OH) Department of Public Health's MomsFirst™ Project, a federally funded Healthy Start initiative, to identify additional interventions to increase breastfeeding rates among high-risk inner-city mothers. A series of target population focus groups were conducted to pinpoint barriers to breastfeeding initiation, continuation, and exclusivity among expectant and delivered mothers served by MomsFirst, which delivers comprehensive services including twice-monthly community health worker (CHW) home visits prenatally through 2 years postpartum to high-risk mothers in Cleveland with a mission to reduce health disparities in infant mortality and improve birth outcomes among African American women in Cleveland. Most MomsFirst participants are enrolled in WIC, and participants have multiple risk factors for choosing not to breastfeed. Data from 2009 revealed a rate of any breastfeeding at 1 month postpartum of just 46% (L. Matthews, personal communication, April 2010). CHWs provide in-home education and support to the mothers enrolled in MomsFirst using a curriculum-based approach with the books *Baby Basics*[3] (from The What to Expect Foundation) and *Partners for a Healthy Baby Home Visiting Curriculum Manual for Expectant Families*[4] (from Florida State University), both of which are appropriate for expectant and delivered women of low health literacy. CHWs cover topics that include, for example, safe infant sleep practices, good nutrition, smoking cessation, substance abuse prevention and treatment, and depression screening and referral. Breastfeeding education materials currently in use are those

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embedded in the *Baby Basics* and the Florida State curricula. Our objective was to obtain input, opinions, and ideas of CHWs in preparation for a targeted breastfeeding support intervention to augment this ongoing breastfeeding education.

Subjects and Methods

Study design

The study used a series of nine focus groups in an approach called "broad involvement design" that includes both the target audience (mothers) and other audiences (e.g., family members, health providers).[5] Results of the two focus groups conducted with CHWs are reported here. The study was approved by the University Hospitals Case Medical Center (Cleveland) Institutional Review Board.

Recruitment and participants

MomsFirst contracts with nine Community Agencies within the City of Cleveland to provide client services; the lead administrator at each Community Agency is the Case Manager. Case Managers are degreed professionals, and MomsFirst CHWs either have a degree or are engaged in higher education working toward a degree. Recruitment for the focus groups was initiated by the MomsFirst Project Director and Administrative Officer, who invited Case Managers to offer participation to the CHWs employed at their Agencies. A goal of recruitment was to include at least one CHW from each Agency, and CHWs were permitted to participate in both groups if another CHW from their Agency was not available. CHWs were aware of the focus group topic (breastfeeding and infant feeding choice) and previewed the informed consent document prior to deciding whether to attend; participation was completely voluntary. A pizza meal and $10 gift card were provided to each participant; transportation was available if needed.

Conduct of groups

The groups were held at a local health center in June and October 2009 and were moderated by a International Board Certified Lactation Consultant with experience serving high-risk women. Participants signed a written informed consent document prior to participation, and the groups were audio-recorded with the participants' knowledge. An assistant took notes throughout. Participants knew each other from their day-to-day work and from training workshops for MomsFirst but were asked to commit to confidentiality for the focus group discussion; the study team committed to full anonymity for all opinions expressed. A script (available on request) was used by the moderator to facilitate discussion. Each group lasted 90 minutes, and participants were able to step out if needed to respond to urgent phone calls.

Data analysis

Raw data included (1) a written summary of the discussion created by the moderator (C.D.) immediately after the session, (2) notes taken by a study assistant during the session that documented the discussion as it occurred, using a schematic of the seating with participants numbered to identify individuals and their comments, and (3) a tape-based transcript created directly from the audiotapes (by L.F.). We proceeded on two paths and included both a question-based pragmatic approach and a theme-based theoretical approach to the data. The pragmatic approach identified and collated CHW responses to specific questions from the moderator regarding the CHWs' and their clients' (the mothers') views of breastfeeding and of a potential intervention package. The CHWs stayed largely on task in responding directly to the moderator's questions, with responses following directly from moderator queries. The theoretical approach categorized CHW responses by assigning them to domains and subdomains in order to search for themes within the discussion. The template for analysis was adapted from The University of Texas Southwestern Medical Center Focus Group Analysis Guide, Factors Influencing Beliefs schema.[6] This framework was created to assist a lay community planning group in analyzing focus group data for a human immunodeficiency virus intervention in a low-income high-risk community setting.[6] Students (Angela North and Elizabeth Banks) had previously collaborated to flexibly redefine the Factors Influencing Beliefs schema for breastfeeding content.[7] Domains and subdomains were therefore previously defined with inclusion/exclusion criteria. The process of quotation assignment for CHW focus groups was conducted by L.F., using serial review to confirm domain and subdomain applicability, with triangulation to literature on breastfeeding peer helpers/peer counselors to verify context and content.

Results

Population

Eleven CHWs participated in the first focus group and 10 in the second focus group; four CHWs participated in both groups. All nine Community Agencies contracting with MomsFirst were represented at each group, and of all 34 CHWs actively employed at the time of the study, 17 (50%) contributed to one or both groups. All participants were women; other demographic data were not collected.

Summary of question-based analysis

As an "icebreaker" question and in order to provide context for the dialogue, the moderator asked, "What do you enjoy most about being a CHW?" CHWs uniformly and warmly endorsed their commitment to their work and their clients and felt they are able to make a difference in their clients' lives. They reported enjoying their relationship with the mother, including earning her trust, providing her with support, education, and resources, "seeing a light bulb go on" for her, empowering her in her choices, and "knowing I made a positive impact." Other comments included, "My favorite thing is the birth of the baby," "I am humbled that people share with me …," "When you see a healthy outcome [for the baby], that is a huge gratification," "Don't you think there is always something to teach?," and "You see a progression to self-sufficient. …"

When asked if mothers are interested in breastfeeding, CHWs' responses were mixed. Comments included, "… it depends if she is willing to make sacrifices [drinking, smoking, eating, being there for baby]…they [mothers] be go, go, go…back to the streets," with several comments that mothers who are interested in breastfeeding are more likely to be in a stable relationship with the father of the baby, to have a stable home life, to be "progressed in other areas [of their life]," and

to have expressed a commitment to a healthy baby. "The moms that have already decided to breastfeed have dads with them [at enrollment into MomsFirst]…these are the ones that continue." One CHW reported that most of her clients say they will "try" breastfeeding, but the "critical period" is coming home from the hospital. CHWs described their efforts to interest mothers in breastfeeding, using strategies such as explaining the importance of neurological development from birth to age 3 years ("the baby is a person"), "make them [the mother] aware this is the best start," citing that LeBron James and Michael Jordan [professional basketball players] were breastfed, and noting benefits such as "burning 500 calories a day," "best for bonding," and "jumpstart the immune."

Regarding what seems too hard about breastfeeding, CHWs rapidly listed "lots of things [that] make it hard." These included return to work and school, the time it takes to breastfeed, the anticipation of pain, and needing an electric breast pump and not having one. Additional personal obstacles included taking medications that would make breastfeeding contraindicated, "breasts are going to sag," and lifestyle conflicts ("bad habits").

When asked why mothers discontinue breastfeeding, CHWs reported that pain with breastfeeding was a major factor, with not enough support at the hospital and no support at home. The challenge of engorgement with no milk flowing was a major obstacle, and the experience of "being rejected" by the baby who could not latch on to the breast was deeply felt. Regarding the home to hospital transition, one CHW stated, "In the past not a lot of information [was] available…if people can hone in on problems [with breastfeeding]. …" Another CHW added, "No one ever came back," indicating that if breastfeeding is not supported early on, the mother will discontinue and begin formula without retrying breastfeeding.

CHWs shared their own personal experiences with breastfeeding, which included many challenges. One CHW who had been able to breastfeed said she was "… 17 years old, in the hospital, crying…I was young and depressed. I kept doing it [breastfeeding] because of a woman from [gives name of a parenting program]." Another CHW had tried to breastfeed her third child but was unable: "… [I was] young…depressed…and it hurt. I had a 10 month old and a new baby. It was overwhelming…I had back to back babies and it was terrifying." Grandmothers and in-laws weighed in on the breastfeeding question: "My mom didn't breastfeed. My mom said, 'That's the nastiest thing—it's crazy stuff …,'" "My grandmother told me, breasts are for men," and "My in-laws left the room when I started to breastfeed the baby." Other CHWs recalled intense uterine cramping with initial breastfeedings ("my stomach hurt bad"), which caused them to discontinue before leaving the hospital, combined with a self-described prior lack of basic information ("Then…I didn't know the milk doesn't come out right away") and lack of personal and institutional support ("We [were] not encouraged to breastfeed" and "the hospital pushed formula"). Several noted postpartum depression had been a personal obstacle and that their postpartum period was a blur. Despite sharing moving and poignant personal narratives, CHWs strongly endorsed breastfeeding as a good health choice for the baby and thought that "propaganda" was now coming "full circle" with new acceptance that "breasts are made to feed the baby not made for men" and that breastfeeding was no longer a sign of poverty but rather of personal choice and pride.

When asked what would make breastfeeding easier for their clients, CHWs focused on breast pumps and education. If a mother who wants to breastfeed could easily obtain an electric breast pump, CHWs thought she could be coached to "problem solve" and balance the competing needs of school, work, the baby, and her other children. For example, they suggested, she could breastfeed at night and pump milk during the day, and one mother who had done so was cited by her CHW; several voices responded, "[but] she was committed." CHWs thought that talking in person with someone who has "pumping experience" would be important to success with the breast pump. Support bras were also mentioned as a breastfeeding need. CHWs said that education earlier in the pregnancy, a connection with the hospital and WIC, and "troubleshooting information" ahead of time so women "go into it knowing" are all needed because "we lose them between 0 and 3 weeks." More education would include discussion of "myths and misinformation…what is colostrum…and talk about benefits [because] most clients don't want to breastfeed." A parallel to education about infant sleep position was drawn: CHWs instruct clients about the importance of "back to sleep" and infant sleep safety and believe that literature should be addressed not just to the mother but also directly to the maternal grandmother and aunt in order to have an impact. CHWs raised the issue of a conflict between co-sleeping, which might make breastfeeding easier, and the need for infant sleep safety, which is a curricular mandate in their work with mothers. Finally, CHWs discussed the role of a financial or gift incentive to encourage or reward breastfeeding, but a consensus was not reached on this topic.

When asked what mothers need for breastfeeding, the first identified need was "to choose to breastfeed," and the second was additional personal support: "We need a campaign…need a visual not just a verbal…what do you do when hurting or clogged…show me…go beyond the paper…maybe someone can come into the home in the first week." CHWs echoed the need for a "visual" to learn for themselves, too. Personal support would ideally come not just from the CHW, but from the mother's family and her partner ("she needs to hear from friends and family"). However, CHWs recognized that they were the sole support for many of their clients, not just regarding breastfeeding, and that clients did not always readily accept the education offered ("[some] visits are me against her"). At this point, CHWs circled back to ideas for promoting breastfeeding, including having a workshop or event for a group of mothers, showing them "kangarooing" (skin-to-skin care), the possibility of gift incentives, and "talking up" relevant benefits of breastfeeding. These included "better brain development," saving money, and the concept that breastmilk is "specially for you while formula is manufactured." One CHW said, "… tap into that mother thing…nurturing…guilt them…babies who aren't held grow up to not be able to have relationships."

The moderator asked what the CHWs themselves would like to or need to know in order to support breastfeeding for their clients. Responses endorsed or offered by more than one CHW included information about how to help with common breastfeeding problems (specifically latch and sore nipples), more "resources" for breastfeeding help, better understanding of the long-term benefits of breastfeeding, specific information on how the father can help, and resolution of the issue of co-sleeping (to facilitate breastfeeding) versus "back to

Table 1. Representative Quotes by Themes

Theme	*Representative quotes*
A. Risk Appraisal	
Stereotyped beliefs/misconceptions	"… Gotta eat right, vegetables, fortified diet…and have good behaviors."
Problem hierarchy	"Is mom willing to make sacrifices?"
Pain	"It hurts to breastfeed."
Lack of knowledge	"Latching on is a problem."
Fatalism	"Most moms have already decided [how to feed the baby]."
Illusion of invulnerability	"She won't ask me [CHW] or the father for help."
Perceived benefits	"Breastmilk is made for your baby…formula is manufactured and they vomit it."
B. Self-Perceptions	
Self-efficacy	"Let her know she can impact her baby's development [with her milk].""Help her problem solve with babies and school [and breastfeeding]."
Self-esteem	"She feel[s] rejected [when engorged, hurting, and no help]."
Intentions	"You need to keep asking her about breastfeeding."
Expected outcomes	"Need to focus on more education about benefits.
Ambivalence	"I'm a selfish person [re additional program burden]."
C. Relationship Issues and Social Influence	
Communication/negotiation/relationships	"The ones who breastfeed are more stable."
Cultural norms re sexuality	"[People] think breasts are a sexual organ."
Gender roles	"My husband would put my son on my breast while I was asleep."
Interpersonal power dynamics	"My mother told me, don't do that—it's nasty."
Group norms	"Women of color used to have a necessity to breastfeed…it was a class thing…propaganda goes full circle…used to think of single mothers as shameful…now think of them as strong."
Social support	"[Mom has] no support at home.""She needs to hear from her friends [about breastfeeding]."
D. Structural and Environmental Factors	
Environmental barriers or facilitators	"[She] needs follow-up help when hurting."
Social policies/information environment	"Need more education earlier in pregnancy. …""Need a better connection with WIC and the hospital."
Social inequalities/individual access	"The critical period is going home from hospital…nobody came to help.""Need to be able to loan an electric breast pump."
Sense of community	"We need to know more to help mom."
Social capital	"A CHW is only one person [who can provide motivation]."

CHW, community health worker.

sleep" for safe infant sleep. The moderator posed the possibility of the client (the mother) inviting a "support person" such as a family member, close friend, or partner to join the mother at home visits with the CHW, with the express purpose of learning about breastfeeding, to become the in-home support postpartum that seems missing for many women. CHWs had mixed responses and felt it could be positive or negative, depending on whom the mother chooses: "She needs to choose someone reliable…the right person." The possibility of the mother having a "falling out" with her support person was raised, as well as worry about repercussions if the support person "sees something" in the home (i.e., abuse or neglect) and reports to Children and Family services. One CHW said, "… our clients are not consistent and reliable …" with concern that the support person the mother chooses would not be able to be consistent. Another CHW said, "… she needs someone who will be supportive …" and gave the example of a client whose sister thought breastfeeding is "nasty." The possibility of the mother identifying two support persons was also raised, with the idea that one person might be at work or school at the visit time. This potential for scheduling conflicts, leading to more work for the CHW, as well as the need to track and document the support person's attendance, brought up concerns about additional burden for the CHWs. Several CHWs were concerned about taking on additional curriculum on behalf of their clients and about more paperwork and educational mandates and thought an incentive for the CHWs should be considered if there are new responsibilities.

Summary of theme-based analysis

The primary theme domains in the Factors Influencing Beliefs framework relevant to breastfeeding issues include Risk Appraisal, Self-Perceptions, Relational Issues and Social Influence, and Structural and Environmental Factors. Breastfeeding-focused definitions for these domains and their subdomains were previously described.[7] A summary of the theme-based analysis is presented in Table 1, with example quotes.

Conclusions

CHWs who visit the home are in a unique position to impact the health decisions of their clients, including breastfeeding decisions. While reporting great job satisfaction with empowering and making a difference for their clients, CHWs expressed frustration with the challenges of motivating young

mothers to choose breastfeeding, and many described difficult personal breastfeeding experiences, echoing issues and barriers reported by their clients about breastfeeding. Overall, CHWs perceived breastfeeding as "hard," thought that doctors and hospitals do not provide enough support to mothers, and thought that a lot more support would be needed in order for their clients to choose and persist with breastfeeding. Many CHWs acknowledged need for additional breastfeeding education and access to resources for themselves and were concerned about the additional administrative burdens and educational mandates a breastfeeding initiative might entail. The perception of breastfeeding as difficult or "hard" by the CHWs, who provide direct service to expectant mothers, is an important barrier to breastfeeding promotion in this setting.

Breastfeeding peer helpers or counselors optimally receive specific training and support in order to provide qualified and accurate breastfeeding advice. Achieving Certified Lactation Counselor certification is one method of achieving expertise. The World Health Organization "gold standard" for breastfeeding peer counseling includes 40 hours of training with a hands-on component.[8] There is evidence that peer counselor support, compared with standard care, increases rates of breastfeeding initiation among WIC enrollees.[9] Especially among low-income women, the role of breastfeeding peer support has received national attention, and several studies have documented improved rates of breastfeeding initiation and continuation.[10–13] The breastfeeding peer helper program is a core component of the National WIC Breastfeeding Promotion Program's breastfeeding initiative, Loving Support™.[14,15]

By definition, CHWs are members of the communities in which they serve, provide health-related information and advocacy beyond simple peer support to hard-to-reach or underserved populations, and are individuals with a shorter training than that of professionals.[16] CHWs can serve to improve selected health outcomes in underserved populations, but the evidence related to maternal–child health outcomes is mixed, and the effect of CHWs not specifically trained in breastfeeding support on the health outcome of breastfeeding in the United States has not been reported.[17] The CHWs participating in these focus groups differ from CHWs as broadly defined because most either have a degree or are currently in pursuit of a degree. These CHWs also differ significantly from breastfeeding peer counselors or helpers in that they have not received extended training in breastfeeding support or physiology and were not selected based on their successful breastfeeding experiences or an interest in providing breastfeeding support to their clients (peers). However, there is evidence that interventions including lay support significantly increase rates of short-term exclusive breastfeeding, as well as rates of any breastfeeding in both the short and long term, and that lay support is more effective than professional support.[18] There is also evidence that multiple prenatal and postnatal contacts with face-to-face counseling, which the CHWs in this study practice, are more effective in promoting breastfeeding than fewer contacts and phone contacts.[11]

Overall educational attainment of breastfeeding counselors is not a significant predictor of support skills and techniques.[19] On the other hand, duration and content of initial training and the availability of ongoing curricula do appear to impact counseling techniques, suggesting a potential benefit for standardized training to improve breastfeeding support.[19] For example, peer counselors with longer training duration and ongoing training were more likely to provide hands-on help for latch, observe a breastfeeding, help the mother position the baby, and refer for assistance to an International Board Certified Lactation Consultant.[19] Although desired, it is impractical to expect that public health agencies will be able to bear the time, cost, and logistical burden of extended topic-specific CHW education and training in content areas such as breastfeeding.

The strengths of this study are several. We used qualitative methodology to obtain input regarding breastfeeding support and promotion; this permits exploration of old themes and identification of new themes without the limitations of a questionnaire or structured interview study design. The use of focus group methodology permits interactions between the moderator and the participants, and between the participants themselves, which gives opportunity to highlight and expand on themes that were of high interest. The focus group participants were CHWs who are currently serving a population of high-risk expectant mothers, so their views and comments provide an honest and undiluted picture of the realities of their work. We used both note-based and tape-based analysis to examine the data, and this combination of techniques provides moderate to high rigor with a low rate of error.[20] We did not use a transcript of the audiotapes for analysis, and this is a limitation of the study. However, although transcript-based analysis is considered the most rigorous method of analysis, both context, including participant interactions and conversation flow, and emotional intensity, communicated by voice tone and other clues, can be missed with a transcript-based approach, and the goal of this study was to capture not only the content but the nuances of the CHWs' perceptions. It is an additional limitation that one investigator reviewed and assigned comments to domains and subdomains; however, triangulation to the literature was used, and the question-based analysis was not impacted by this approach. Although only two focus groups were held, both budgetary considerations and respect for MomsFirst staff time were factors in this decision, and, most important, theme saturation appeared to have been well reached by the end of the second group as judged subjectively by the moderator and objectively by repetition of participant comments in the abbreviated transcript. Finally, it is a possible limitation of the study that four CHWs were participants in both focus groups. This occurred for pragmatic reasons because with re-recruitment CHWs were permitted as repeaters owing to staff availability, and we deferred to MomsFirst regarding the final roster. However, we do not believe this impacted the discussion or analysis because (1) the focus groups were held 4 months apart in time and (2) CHWs are used to training together on a variety of topics and to respecting each others' input, so that, although imperfect methodologically, the data and analysis do not appear to have been compromised. In the moderator's opinion no one individual or individuals "drove" the discussion. The overall purpose of the focus groups was to obtain information to aid in design of a breastfeeding support intervention to augment the ongoing curricular efforts of MomsFirst. The input of the CHWs was valuable and highlighted the challenges of collaborating with CHWs. We conclude that a targeted intervention for high-risk inner-city mothers will need to meet the educational needs of the teachers (CHWs) while minimizing administrative burden, address issues identified by the clients (mothers), and provide hands-on help and support within the home.

The planned intervention resulting from and following these focus groups includes a CHW-oriented curriculum and availability of a new dedicated MomsFirst breastfeeding peer helper (a former CHW now trained as a Certified Lactation Counselor) who makes pre- and postpartum calls and is available for home visits, with referrals as needed to a WIC International Board Certified Lactation Consultant. CHWs will receive ongoing in-service training regarding breastfeeding promotion but will not undergo specific training to become peer helpers. Utilization of CHWs who are not dedicated breastfeeding peer helpers to promote breastfeeding among underserved high-risk women in the United States has not yet been studied. This new intervention approach has the potential to augment and enhance the ongoing fieldwork of the MomsFirst CHWs and also the breastfeeding promotion efforts of the local WIC program. Coordination among providers, including the CHWs, the Certified Lactation Consultant, and WIC, will be critical to elimination of communication gaps, and the program will require careful outcomes study to examine feasibility and effectiveness.[20]

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Disclosure Statement

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