

Common Evidence Based Challenges in Maternal and Child Health

*The Intervention Works but There
is More Adherence/Uptake in Some Populations
The Case of Breastfeeding*

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OVERVIEW

The purposes of this case study are to:

1. *Identify the key characteristics of this type of evidence-based challenge and the problems that fall into this challenge category,*
2. *Discuss potential courses of action when dealing with this type of challenge,*
3. *Identify strategies to overcome the challenge,*
4. *Identify recommendations for action that might apply across programs/interventions.*

This case study was developed for use in ***Leadership, Legacy, and Community: A Retreat to Advance Maternal and Child Health (MCH) Scholarship and Practice***. The Retreat was hosted by the MCH Program at the University of Illinois at Chicago School of Public Health, in Chicago, July 2008. This is one of four case studies developed for the Retreat. We encourage you to use this case study, as well as the others, to engage in a group dialogue around the many evidence-based challenges we face in our work related to MCH.

Each case study was designed to be used in a 3-hour workshop that may include two full-group discussions and two rounds of small group discussions. In the initial whole group discussion, you may choose to discuss the characteristics of this challenge and how to know when an agency/organization is experiencing this challenge. You may also choose to generate a list of issues/problems that characterize this type of challenge (Purpose #1). We encourage you to follow-up this discussion with 2 rounds of small group discussions (8-10 people per group). Each small group discussion should be 30 minutes and focus on a different set of questions designed to address and achieve purposes #2 and #3. Lastly, you may conclude your workshop/discussion with a large group discussion to identify recommendations to address this particular type of challenge across interventions/problems, purpose #4. All discussions can be guided by the set of **Discussion Questions on page 7**. The questions provided for each round are to be used as guides to focus the discussion, with an eye toward having the focus be distinct but complementary across rounds. ***If you identify other key questions for that round's focus, that is wonderful.***

Disclaimer: We believe that these case studies will produce insightful and useful information. Therefore, we encourage you to share any information and recommendations/strategies that you identify with the UIC Maternal and Child Health Program. With your permission, we will post this information on our website at www.uic.edu/sph/mch. Please contact Kris Risley at kyrisley@uic.edu.

Note About Working With This Case Study

As a participant in a discussion about this evidence based challenge, we ask you to take a look at your colleagues and note the different disciplines as well as the different generations present and be willing to learn from, discuss, and create with all participants. Whether you have a lot or a limited amount of experience with the particular issue on which this case is based, you have much to offer in helping the field of MCH identify a process to address this type of challenge.

The Intervention Works But There is More Adherence/Uptake in Some Populations *The Case of Breastfeeding*

A wealth of literature documents the multiple benefits of breastfeeding for the physical and psychological health of infants as well as for the maternal-infant relationship. As such, maternal and child health professionals recommend breastfeeding as the best approach to feeding infants. Despite the clear evidence in support of breastfeeding, it is not always the preferred method for women (or their partners). There are potentially many reasons that breastfeeding is not always the preferred method of infant feeding including: myths about breastfeeding; lack of support from peers and partners; lack of support from the medical and nursing staff in the hospitals immediately following delivery such as the separation of infants from mothers and the provision of free infant formula to new mothers; lack of training of providers during medical/nursing school highlighting the importance of breastfeeding; policy issues related to insufficient leave time and insufficient support for breastfeeding in the workplace; and, lack of breastfeeding support after returning home.

Nevertheless, the rates of breastfeeding have increased in the last two decades. Between 1993-2006, the percentage of infants ever breastfed increased from 60% to 77%. Among African American women, the percentage of infants ever breastfed increased from 36% to 65%. Although breastfeeding rates are increasing among African- American women, there are still widespread disparities in breastfeeding initiation and duration by race/ethnicity (79% of Non-Hispanic white infants were ever breastfed and 80% of Mexican American infants ever breastfed vs. 65% among African American infants) and by socioeconomic status (i.e., breastfeeding rates are lower in low income non-Hispanic White and non-Hispanic African American homes). Interestingly, breastfeeding rates did not differ by socioeconomic status in Mexican-American homes.

While interventions to promote breastfeeding are most often focused on changing individual knowledge, attitudes behavior and decision-making, in the U.S., whether women choose breastfeeding or bottle-feeding is deeply embedded in a culture which supports easy, non-messy, technological solutions to issues, and which is minimally supportive of parenthood, and provides little support for working mothers. Furthermore, the decision to breastfeed or not to breastfeed is heavily influenced by a powerful lobbying group, the formula companies who provide free formula samples for women at hospital discharge and who spend millions of dollars annually on both TV and print media to encourage bottle-feeding. (The number of TV and print ads for formula marketing increased from 7000 in 1999 to over 10000 in 2004.

Women who choose to breastfeed often have to overcome numerous cultural and structural obstacles to do so. Consequently, the decision to breastfeed may be easier for women with more resources, life opportunities, and support. Therefore, as breastfeeding promotion interventions continue and as increasing numbers of women initiate and maintain breastfeeding through six months, it is possible that the disparities between racial/ethnic/class groups associated with breastfeeding will continue or even grow if there is continued differential uptake of breastfeeding across groups.

Breastfeeding Historical Timeline—

- 1880s:** Women began to supplement their own milk with cows' milk shortly after giving birth and to wean their babies from the breast before 3 months of age.
- 1912:** In an issue of JAMA, doctors indicated that breastfeeding rates had been steadily declining since the mid-19th century.
- 1930s-1970s:** Mothers were supplementing breast milk with cows' milk and weaning infants in the first few weeks/months of life. More and more mothers were not breastfeeding at all.
- 1948:** The American Academy of Pediatrics (AAP) recommends breastfeeding.
- 1971:** Only 24% of mothers in the US initiated breastfeeding.
- 1970s:** The feminist-inspired women's health reform movement rekindled interest in Breastfeeding.
- 1984-1989:** Breastfeeding initiation rates decreased from 60% to 52%.
- 1989:** Joint WHO/UNICEF statement "Protect, Promote and Support Breastfeeding" A special role for maternity services. The introduction of the Ten Steps to Successful Breastfeeding.
- 1989:** WIC re-authorization is passed and includes for the first time, \$8 million for breastfeeding.
- 1990:** The Healthy People 2000 Goals for the Nation contain goals for breastfeeding.
- 1992:** The Breastfeeding Promotion Act of 1992 is signed by President Bush.
- 1994:** States begin passing legislation to protect a breastfeeding couple's right to breastfeed in Public.
- 1995:** Breastfeeding initiation rates return to 60%.
- 1997:** Healthy People 2010 national health objectives contain goals for breastfeeding. AAP recommends exclusive breastfeeding until infant is 6 months old.
- 1998:** H.R. 3531 The New Mother's Breastfeeding Promotion and Protection Act introduced into Congress. 29% of White mothers and 19% of African American mothers breastfed at 6 months postpartum.
- 2000:** *HHS Blueprint for Action on Breastfeeding* is released from the Office on Women's Health.
- 2001:** Breastfeeding initiation rate is 69.5%.
- 2002:** Ad Council, renowned for its ability to alter human behavior and attitudes, announces they will formulate a campaign to convince Americans of the importance of breastfeeding.
- 2004:** National Breastfeeding Awareness Campaign launched.
- 2005:** The AAP publishes a Policy Statement on the benefits of breastfeeding for infant, mother, and community.
- 2005-2006:** The percentage of infants **ever breastfed** exceeded the HP 2010 target of 75%, however, the percentage of non-Hispanic black infants ever breastfed (65%) is much lower than the percentage of Mexican-American (80%) and non-Hispanic white infants ever breastfed (79%).
- June 2008:** CDC releases first-ever survey of breastfeeding practices at hospitals and birthing centers nationwide in the Morbidity and Mortality Weekly Report. The report indicates that a substantial proportion of hospitals and birthing centers engage in practices that interfere with successful breastfeeding. 70% of hospitals and birthing centers surveyed provided women with infant formula samples upon discharge.

DISCUSSION QUESTIONS

Whole Group Discussion (30 minutes) (Purpose #1)

- What are the key characteristics of this type of problem (evidence-based challenge)?
- What other programs/interventions/problems fit this profile?

Round I (30 minutes): **Given the potential for differential uptake of interventions across race/ethnicity and class, particularly for interventions focused on changing individual decision-making and behavior, what are our *Course of Action* options?** (Purpose #2)

- If continued promotion of an intervention (or set of interventions) has the potential to widen racial/ethnic and class disparities in outcomes, is it ethical to continue to support the intervention in its current form?
- Is there sufficient evidence to explain differential uptake of the intervention? If not, what should be the focus of evidence generation?
- What are key ingredients to developing support within non-majority communities/cultures for the adoption of any public health intervention?

Round II (30 minutes): **Given the potential that promoting an intervention or interventions has for increasing disparities between populations due to differential uptake, how can we reframe the intervention within a new paradigm to meet the needs of a variety of populations and decrease/eliminate differential uptake?** (Purpose #3).

- Are there ways to “intervene” on behalf of the intervention, developing approaches which take the onus off of individual behavior and put the onus on provider and system changes that support individual behavior change?
- What are the pressures/constraints in trying to refocus/retool/re-image interventions in communities that currently have been less likely to embrace them?
- What are the essential strategies that can lead to a paradigm shift with respect to any public health intervention within non-majority communities/cultures?

Whole Group Discussion (45 minutes): **Given what we have learned from this case, how can we take what we’ve learned and apply it to other programs/interventions/problems that fall into this challenge** (those identified in the beginning of session)? (Purpose # 4)

- Given the challenge presented today, what are the recommendations/approaches to addressing the challenge that are universal in nature (ie, apply to other issues/programs/problems that fall into this challenge)?
- What is the role of the MCH field in meeting this type of challenge to evidence based practice?
 - Practice professionals?
 - Academic professionals?

DISCUSSION GUIDELINES

The Ultimate Purpose of this Session is to **Identify Global Recommendations and Strategies to Address this particular evidence-based challenge**. The guidelines presented below were adapted from the World Café model: www.worldcafe.com.

- 1) **Focus** on what matters!
- 2) Contribute your thinking.
- 3) Speak your mind and heart.
- 4) Listen to understand.
- 5) Link and connect ideas.
- 6) Listen together for insights and deeper questions.
- 7) Have fun!

Our assumption:

You have within you the wisdom and creativity to confront even the most difficult challenges. Given the appropriate context and focus, it is possible to access and use this deeper knowledge about what's important – the lives of the women, children, and families you serve.

FACILITATOR INSTRUCTIONS

Initial Whole Group Discussion: Discussion Questions, See Page 7

1. **Main facilitator introduces the Case and leads the participants into a group discussion that addresses purpose #1 (See page 4).** Main Facilitator also reviews World Café guidelines prior to beginning any discussion (**See page 8**).
 - i. **Facilitator identifies a participant** to take notes on flipcharts for any discussions involving the entire group. (The note-taker should pay special attention to comments resulting from the question: What other health status problems/issues fit this profile? [we will return to this question in the final group discussion]).

NOTE: You may use additional note-takers to keep up with group discussion.

ROUND 1: Discussion Questions, See Page 7

Ask each Small Group to identify 2-3 Take-Home Messages from this round that they will then share with the entire group.

2. **Main facilitator asks participants to break into small discussion groups of 8-10 people.**
3. **Main facilitator asks each table to identify an individual to facilitate the small group discussion for that round (*table facilitator*).**
4. **Main facilitator asks each table to identify a *table note-taker* who will take notes about the discussion.**
5. **Following the completion of that round (25 minutes), main facilitator asks each *table facilitator* to share the 2-3 take-home messages that were identified from the round.** This should last no more than 5-10 minutes.

NOTE: EACH DISCUSSION SHOULD LAST APPROXIMATELY 25 MINUTES AND BE FOLLOWED UP BY A WHOLE GROUP DEBRIEF THAT LASTS NO LONGER THAN 5-10 MINUTES.

ROUND 2: Discussion Questions, See Page 7

6. **Main facilitator asks individuals to move to a table with new people for the Round 2 discussion.**
7. **Main facilitator asks each table to identify a new individual to facilitate the small group discussion for that round (*table facilitator*).**
8. **Main facilitator asks each table to identify a new *table note-taker* who will take notes about their discussion .**
9. **Following the completion of that round (25 minutes), main facilitator asks each *table facilitator* to share the 2-3 take-home messages that were identified from the round.** This should last no more than 5-10 minutes.

Final Whole Group Discussion: Discussion Questions, See Page 7

The purpose of this final session is to identify several, tangible strategies/recommendations to address this particular type of challenge. They may be related to practice or academia.

10. **Main facilitator leads the entire group in a discussion to address the final Whole Group Discussion questions (See page 7).** Please leave about 45 minutes for this section.
 - i. Identify a note-taker to take notes during this session.

NOTE: You may choose to take a 10-15 min break between rounds 1 and 2 or round 2 and the final discussion.

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