

## **AMCHP 2008 ANNUAL CONFERENCE**

### **WE ARE MAKING A DIFFERENCE:**

#### **A Breastfeeding Outreach Campaign to Young African American Women**

March 1st to 5th, 2008

BRIAN CASTRUCCI: Okay. Good morning everybody. Make sure that you grab a packet. There's actually stuff in the packet. It's not just the sides. So, you get a cool CD and some parting gifts and some other stuff. Basically, for this hour-and-a-half it's me and then following me will be me, and then the third leg of the talk is a really bright person from Texas and it's me. So, were going to work through—I guess when I first applied to do a talk in AMCHP; I'm an epidemiologist by training and we're into that idea of you know 15 minute talks, and then I've read the thing a little more carefully 'cause you all know we don't really read the stuff before we submit it about the abstracts and how long, we went, "Oh my, it's an hour-and-a-half. Okay, so, how do we fill an hour-and-a-half?" And I think what you're going to get today is a really rich conversation about how we're dealing which breastfeeding in Texas and I think you're going to enjoy. And really, what I wanted to make sure is that you have materials to bring home with you. A lot of the stuff that's in the presentation is on that CD, all the radio ads and different kind of reports are on that CD. So, hopefully, that's going to be something that you can take home with you. I would throw away the rest of the packet because

we don't want to add more stuff to our luggage. You just really got to find—just that CD will give you the slides, the survey, everything else.

So, a little brief introduction of myself. My name is Brian Castrucci. I am the Director of Family Health Research and Program Development in the State of Texas, the Department of State Health Services. My unit is a unit of program staff, the Adolescence Health Coordinator, the Child Prenatal Health Coordinator, CFRT Coordinator, all of the kind, large state programs, and we have researchers. So, it's research and practice in the same unit. We have weekly battle royals to see who wins, and sooner or later we'll figure out how to all work together. But the point of the unit, the reason it was created, was to try to make sure that research and practice were working together so that we're not doing research for the sake of research. We're doing it to inform policy program and planning. And I think we've had some success with that and I think that the WIC staff, and the breastfeeding stuff that I'm going to talk about today really fit in and demonstrate how we're effectively translating some of the research into policy and practice.

So, just a brief background to start, I think if you're in the room, you're interested in breastfeeding and you know about all the benefits of breastfeeding. We've (inaudible) already AAP statements. I'm not going to go into too much depth into the background and you're just reducing maternal obesity, reducing childhood obesity, benefits of the immune system and establishing an emotional bond

between mother and child are all important benefits of breastfeeding. And many of us who are here with AMCHP and working for Title V are probably all familiar with what I think is National Performance Measure 11, if I've now memorized those point, the percent of mothers who breastfeed their infants through the first six months of life. And actually increasing this proportion is a really complicated and it requires a complex strategy that addresses several factors. So, kind of just thinking this through with my staff and doing some brainstorming, when you really think about breastfeeding at six months of age, you're talking about policy issues, social environmental issues, norms, the hospital environment, gender roles, surveillance and evaluation, and racial disparities. You know, I really—when you think about promoting breastfeeding, you really have to think of all these domains and impacting one of these areas may not be sufficient to change the breastfeeding rates in your community. So, you know, a comprehensive strategy to promote breastfeeding really needs to address each of these factors or most of these factors to really have success. And what I'm going to discuss today is how Texas really has uniquely addressed several of these domains. And in doing so, I hope to provide materials that you can take home and use in your state.

So what where doing today, we're going to start with improving state surveillance. Okay, that's the (inaudible) side of me, (inaudible) to talk about surveillance at some point. Then we want to talk about this breastfeeding outreach campaign to young African American women that we implemented in

Texas and we evaluated. Again, I think one of the strong strengths of the Title V in Texas and my unit as well is that, you know, we know we do good stuff in public health. Like, all of us can talk about our programs and that they're really effective, and then you get some epidemiologists like me coming along and says, "Well, how do you know it's effective?" And we always don't evaluate our programs. We kind of know they work and leave at that, and something that we're—and why we have, you know, the research people and the program people together is that research group is always saying, "Can we evaluate that? How do we evaluate that? Let's look at this." So, there's actually a really good evaluation as part of this African American outreach campaign. And then lastly, I want to talk about breastfeeding and disasters, which I think is an interesting take that Texas has because one of the few places that has had disasters recently and I think we had a lot of learning from that experience that I'd like to share with you guys.

So, there are going to be breaks, we're going to do questions after the each mini section because, again, an hour-and-a-half of one person speaking is a bit much. There's going to be some video, there's going to be some audio, there's going to be some fun stuff throughout the presentation just to keep things entertaining. All right, so let's start with improving breastfeeding surveillance. Let's briefly review what our objectives are for this first talk.

Okay, we want to identify sources of data on breastfeeding. We want to know the pros and the limitations of each. We want to describe the implementation of a WIC-based breastfeeding surveillance system, and we want to identify unique data points available through WIC-based breastfeeding surveillance system.

Okay, so those are our three objectives coming out of this talk. And when you think about breastfeeding surveillance you kind a think about three, you know, large datasets. Now, Pregnancy Risk Assessment Monitoring System, PRAMS, Behavioral Risk Factor Surveillance System, BRFSS and the National Immunization Survey. I know in Texas, we use an IS to fulfill our Performance Measure 11. Let's talk about PRAMS at first.

Okay, the benefits of PRAMS is it can give (inaudible) breastfeeding prevalence estimates and you can include questions other than—just “did you breastfeed?” You can get to kind of some of the social determinants, some of the (inaudible) of breastfeeding, and that's the strength of our PRAMS surveillance system.

However, there are some limitations with PRAMS. I mean the questionnaire size and breadth of the questions just kind to limits the number of questions that breastfeeding will get. I know one of the challenges in Texas, we believe, that is keeping our response rate under 70 percent is our questionnaire is really long. So, the more we have to (inaudible) about that questionnaire, you have a lot of competing interests and breastfeeding might not get as many questions as we'd like.

PRAMS is administered two to four months after delivery. So, you are not going to get that six-month time point, that's a limitation. There's a cost associated with developing new questions. Now, PRAMS, different from BRFSS, different from all a lot of the other CDC surveys, you actually need to assure that the question has been validated. You can't just have face validity, you know, this question makes sense. You can't just ask that question. It has to go to NCHS, National Center for Health Statistics, and they have to actually validate these questions. So, they pilot test it, they do very rigorous—and it cost money. And lastly, there's a CDC requirement of a 77 percent response rate which is somewhat easy to get overall, but getting it in subgroups to be able to say something about, you know, comparing Hispanics to African Americans to Caucasians. That's a very difficult response rate to get. And if you're not familiar with PRAMS, PRAMS is a mail and telephone survey. And those of us who do a lot of surveys research know that cell phones and caller ID and all these other kind of toys that are on our cell phones and our home phones are really decreasing the response rates in telephone surveys. When was the last time anybody in here picked up a unknown number on your caller ID or picked up something that said, you know, Texas State Health? Because that's—it comes up on, I know, on my phone, so I'll call my wife and she knows it's me because it says Texas Department of Health. A funny story, because I'll tell stories, but the—my wife recently joined the Health Department. And when they called her for her interview it said Texas Department of Health. So, she picked it up and went, “Hey babe, what's up?” And they went, “Hi, we'd like to offer you an interview.” So, she was a little

embarrassed. And the other limitation of PRAMS is not all states have PRAMS. And that's making it difficult for cross-state comparison.

Okay, BRFSS. Now, those of you who know BRFSS are probably thinking why is BRFSS here? It's just a general population survey, so I'm not quite sure why he's talking about it. I'm bringing out BRFSS because of how we've used it in Texas. The pros of BRFSS is that it can measure attitudes of all adults. So in 2007, Texas included about 18 questions on the BRFSS that just asked about attitudes in the general populace about breastfeeding. And the way that we're going to use that is it's going to help us in advocacy, in education.

If we find that women over 60, or people over 60, are less favorable toward breastfeeding in public, then that really just gives us a clear marker for where we need to target education. If we're—we have a right to breastfeed in Texas, okay? Any woman can breastfeed anywhere she's allowed to be. And the nuance of that bill is where you're allowed to be. I mean, you are all allowed to be here until the manager comes in and throws us all out. And we monitor experiences, we have a hotline that women can call when they've had a negative experience. And it's that kind of thing, they'll go into a restaurant, they'll start to breastfeed, manager comes over, tosses them out. And what we need to be able to educate business owners about is that people aren't grossed out by breastfeeding. It doesn't bother them. They'll still, you know, come to the business. And that's what the BRFSS questions will let us know. What are the general attitudes of

people around breastfeeding? That's an important component if we—as we start the education and we start to do some of our outreach campaigns.

Another—also included on the BRFSS were questions about breastfeeding in the workplace. Should women get 15 minutes break extra to breastfeed? Do you think it's okay for a woman who is breastfeeding to be at the workplace? Again, questions that will help all our mother-friendly work site program as it rolls out (inaudible) and it's just good information. So, while BRFSS can't give us prevalence estimates, which I know is what we want for the National Performance Measure 11, it can be a useful tool for us to understand the attitudes that people have towards breastfeeding.

Lastly, the National Immunization Survey, of course the pros are really good prevalence data at three, six and 12 months. So, multiple time points, it does drop down to the large EMSC in a lot of the States. So, that's really helpful but at the end of the day, it's only a prevalence data. You can just put it in your National Performance Measure 11 and it really—the why, we never get to the why. It's just prevalence.

So, in Texas we implemented the WIC Infant Feeding Practices Survey and it was conducted in both 2006 and 2007. I came to Texas in April of 2006. And our WIC breastfeeding coordinator, Candy, said I need your help with the survey we did in 2006. I said okay. She walks in with a sample size of about 6,000 people

which, as an epidemiologist, I get really excited. And then found out that we didn't have an IRB and I wept openly for several days knowing that we could never publish on these data. And the challenge of the dataset was the women who weren't breastfeeding were skipped out of the questionnaire. So, we really only had data on women who were breastfeeding and their experiences. Now, the final report from that survey is included on your CDs and you kind of take a look at that when you have some time and see what we're asking and see the results.

Almost immediately after Tracy left my office, the WIC breastfeeding coordinator, I said, "Okay, we're going to make this bet. Okay, if you can get 6,000 people—we have all WIC clinics in Texas willing to—and WIC sees about a million people a month in Texas. If we have this opportunity and the WIC folks are willing to do it and the local agencies are willing to implement the survey, we're going to make this better. We're going to improve the survey." So in 2007, we had an eight-page survey, and that's—you have on the right side of your binder or your packet, is our actually WIC survey, okay? And that's the one that went to the field, we pilot tested in and we worked in different clinics to make sure people understood it, it was available in English and Spanish, and everybody answers it.

And what we were able to do is between July and December of 2007, we collected these data, it's a convenience sample. But for those who, you know, if you want to bring back Biostat 101 for everybody; remember, the larger your

sample size, the more representative it is of the population. It's the central limit theorem. Remember that thing that went like this and you thought, "Why am I learning this?" It's because if you have a large sample, the need for randomization declines because it's just—it gets to a point where you don't need it. And that's—with very large convenience samples you can feel pretty good that it represents your population. We had a total of 5,291 meet the inclusion criteria out of 6,400.

Now, what's exciting for me is we went from a two-page survey and got about 6,400 people to an eight-page survey and got about 6,400 people. So, we didn't really lose sample size even though we really increased the size of the questionnaire. Now, that's probably because you're dealing with a WIC population who's pretty survey-savvy, you know, they're used to filling out paperwork, we partnered this up at their one year certification, so a time when they're filling out, you know, paperwork anyway. And I feel pretty good about the fact that we were able to keep an over 5,000 person sample size. It was limited to biological mothers only and limited to women who received WIC services while pregnant, kind of, more colloquially referred to as born-to-WIC.

The one thing to consider when—we think about the large sample size, we got a thorough questionnaire and we had some immediate practice implications, and that's the positives of the survey, when you look at Texas births, 50 percent of all Texas births were women who received born-to-WIC services, okay? So this—

so, one of the limitations is it's WIC participants only. But if you think about WIC participants only, we're talking about, again, 50 percent of the birth cohort was born-to-WIC, 70 percent of all infants will get WIC in their first year of life. And we just ran this numbers last WIC, so they're fresh. That's from the 2004 birth cohort. So even though it's only WIC participants, you're getting a fair amount of the Texas population covered in that grouping.

So, let's try to just look at some of the data that came out from the survey. The prevalence, and this again, you can get prevalence anywhere but let's just look at this, this is ever preference for breastfeeding; African American, 54 percent, White, 67 percent, Hispanic, 74 percent. I find it interesting that Hispanic women were higher than White women, that we hadn't seen that in the previous survey. And even after you adjust for (inaudible) age, education and geography, African American women had a 42 percent of lower odds of breastfeeding than did White women.

These data, however, don't really get to the why, right? We can get this off in IS, we can get this off PRAMS. What we're really interested is the why. And one of the things that's interesting for us was the hospital environment. Obstetricians and pediatricians equally encourage women of different racial and ethnic groups to breastfeed; 71 percent of White women, 68 percent of African American women and 73 percent of Hispanic women reported that their physician encouraged them to breastfeed. Similarly, no differences were found by race or

ethnicity in the proportion of women who reported receiving information from the hospital regarding breastfeeding.

Okay now, despite these similarities, so everyone, the providers (inaudible) equally, the hospitals giving out information equally, no differences there, we still see pretty stark differences in hospital breastfeeding rates. Fifty percent of African American women reported breastfeeding in the hospital, 62 percent of White women, 69 percent of Hispanic women. So, what this tells me is it's not about education, it's not about the provider message, it's not about the information you're getting in the hospital. That's not the difference between these groups. It means we have to look elsewhere. And one of the places we looked was formula distribution.

We asked women who—so, there was a question: and if you didn't breastfeed and you received your formula pack. Okay, so let's just put our minds around what the denominator is. Women who did not breastfeed and women who did receive a formula pack, they were asked, "Would you have considered breastfeeding your baby if you had you not received free formula from the hospital where you delivered your baby?" So, this is quantifying the impact of the formula distribution on non-breastfeeding mothers, okay?

What we found was that more than half of the Hispanic women said that they would have attempted breastfeeding had they not received that formula pack and

in Texas the Hispanic population is not trivial. So, that is a large chunk of women who didn't breastfeed who said they would've least considered it had they not received that formula pack. Twenty-eight percent among Caucasian women, 38 percent among African-American women, while not as high as the Hispanic group, clearly not a trivial number. And this is an opportunity loss for us. I mean, this is where, you know, these kind of data just drive you to say, "Okay, formula free," you know figuring out how to promote more baby-friendly hospitals. Texas has absolutely no breastfeeding hospitals, baby-friendly hospitals right now. I want to say there are only 64 in the country, a lot of them are in California, and Massachusetts. Title V is looking into this as a way of, you know, maybe helping with our Performance Measure 11, helping some hospitals think about how they could become baby-friendly. But these data scream at that. You know, you—just giving that formula pack, whatever it does whether it becomes just easier to do or, you know, that first day when it's a little hard or you're a little tired and you just give the formula, maybe it's access, maybe it's whatever, but we know from these data, and I don't know if there's similar data point out there that really quantifies the impact of the formula in the breastfeeding women—in the non-breastfeeding women.

So, back to work. We looked at the economic need. It was found that to be a barrier to breastfeeding, especially, among African American women. Nearly half of the African American women respondents indicated they did not breastfeed because they had to go back to work or school. Now, here's an opportunity for us

to do education because we do have a mother-friendly work site program in Texas. We know that HRSA is releasing their Business Case for Breastfeeding and doing a training around Business Case for Breastfeeding. Now in Texas, we're one of the—our Healthy Mothers, Healthy Baby Coalition, we're one of the pilot sites for that, and we're working together with (inaudible) because he told me never to move but—

UNKNOWN SPEAKER: I'm sorry.

BRIAN CASTRUCCI: That's okay. I'm never a podium speaker. It drives me crazy because I have one leg shorter than the other and I tend to do this all the time. So, but I was told, "Don't move." So, I'm trying not to move. So in Texas, we're actually partnering with the Business Case for Breastfeeding with our Mother-Friendly Worksites. We a comprehensive, you know, kind of approach is that we have people who are trained to do the business case and then when you're done with the business case and someone goes, "Wow, I really need to do this," the HRSA Program doesn't really say where to go then. It's just like, "Well, that's--we've educated you. That's cool. I'm glad you think it's a great idea. We're done." So that's where—in Texas, we're going to be able to do this transition right to our Mother-Friendly Worksite. So, when a business does get energized and charged up because of this HRSA program and the education they receive, it's an easy call to our nurse consultant in Title V who're going to help them get mother-friendly.

Interestingly enough recently; Texas A&M, the Aegis, became baby-friendly, which was a really—an excellent step. And we used that step to kind of give a call down the street in Austin to the University of Texas Longhorns and say, “Well, hmm, the Aegis are a breastfeeding-friendly worksite. Are you?” And, interestingly, they’re not. So we’re now working with UT, which is one of the largest employers in Austin, to ensure that they’re baby-friendly. And I think one of the challenges for UT as a lot of places have is it’s—I mean, UT is a gorgeous campus, very old, very gorgeous but very old, and some of the infrastructure when they built this campus back in, whenever, they didn’t have—breastfeeding-friendly was really not something they thought about. So, you know, finding ways to incorporate, you know, the need to have the privacy, the need for the rooms, etcetera, the requirements that we need to certify you as mother-friendly just—it’s more difficult. But they’re working with our nurse consultant now and that’s really encouraging for us.

Some of the stuff that we asked on the breastfeeding survey looked at social networks. We have a lot of sociologists in our crew and they are really interested in this kind of social network analysis. So, this is who encouraged breastfeeding, okay? And we really see that you’re mom, partner, grandma was there but not as much as the other two and, again, these are the folks who encouraged breastfeeding. So, let’s think about encourage. You know, the question was, essentially, who encouraged you to breastfeed? And there was a long list,

everything from rabbis, physicians, you know, mom, dad, everybody, nail salon attendant, the world. And we then followed up this question with, “Who influenced you to breastfeed,” okay? Think of that difference, you know, encouraging and influencing.

Okay, my parents do a lot of encouraging. They have no influence. My wife has influence. So saying, you know, “Oh, you know, parents of Brian, you need to tell him to do this, do this, that’s.” That’s great. You know, it’s nice. It fills up the Sunday conversation about all their encouraging but where, you know, do they really have an impact on my behavior. And that’s what influencer gets. And if you notice, you know, mom is still influencer. Partner, so look back here. Okay, so mom is a more frequently cited in the—in almost all the groups except African American. Mom was a greater influencer than the partner but then there’s some change to that—I’m sorry, greater encourager but then there’s some change with that in the influencer. You need to make sure that the influencer is also the encourager. So, the work that we’re doing now is this kind of model; figuring out, you know, influencing, encouraging and breastfeeding, or encouraging and then influencing. And how these all works together because that’s really how we need to lay out our education campaigns. And that’s what the survey allows us to do is, kind of, tease out some of these relationships.

This is very kind of preliminary data. You’ll see from the survey—again, a lot of people in here, I’m sure, are very passionate about breastfeeding and you can

look at that survey and go, “They are like 10,000 data points (inaudible) out of this survey.” You know, my personal interest is in all the hospital questions. Did the hospital staff tell you this? Did you feel comfortable doing that? Those kinds of questions, those influencer kind of stuff.

There’s a lot in there that we’re going to be analyzing and we’re hoping to present it—we’re hoping to get it into the peer review literature but also hoping to present it in the MCH EPI Conference coming up in December. So, for those of you who’ll could go to that, it’s a bit of a tease for that upcoming conference. I have to leave the Pepsi there. It fulfills my contractual obligations to Pepsi. State employee, you got to make extra money somehow, a little Pepsi deal.

Moving on to just the knowledge. We asked a host of knowledge questions. I think what’s interesting here, you have a—most people did not feel it was difficult to breastfeed, that’s positive. And again, we are talking about a WIC population so, you know, women who have been encouraged from jump to kind of breastfeed, so that’s not surprising. What I thought was surprising was more than three-quarters of our respondents said that formula-fed and breastfed babies are equally healthy. I ran over this presentation with the WIC folk and they kind of said; “Well, you know, we never really come out and say there’s a big difference or we never really say that, you know, formula feeding is worse.” So, you see there is a misconception though and they’re believing people are, you know more than three-quarters of people are believing that, you know, the formula-fed and

breastfed babies are equally healthy. So again, more opportunities for intervention, more opportunities for education.

And that's really what the purpose of this WIC survey was, is how do we expand on NIS? So, this is going to be a hallmark for the activity plan that's (inaudible) and it's part of National Performance Measure 11. You know, it's a way that we can extend our state breastfeeding surveillance. And the nice part, also, is because WIC people were there with us writing the survey, the translation to research to practice is going to be nearly seamless. We have meetings coming up next week, two weeks from now. We're all sitting around the table and figuring out what are the analysis we want? How are we going to move this to policy? What do we need to do to make this—to integrate this into practice? So that we're not just, again, doing survey for survey's sake, okay? I always encourage my research staff, if you really want to do research for the sake of research to put in the journal, you need to move out of state health. This is not where you need to be. And all of our group is really excited about being able to see how this research is going to influence real policy and practice, and we can track that in WIC because we have the WIC data that we get monthly, you can see that we're going to have some impact. And I think the next part of our talk about the African American outreach campaign will really show how data were able to move us to action in this specific case.

The other thing to note is that this state-implemented surveillance cost about \$5,000. It was the cost of printing the surveys. That was it. So, for every, “Oh, surveys are really expensive. I don’t want to do that.” Five grand. That was it. Print it, sent to the agencies. And that’s, understanding, that’s hard cost. That’s not staff time, which is probably a lot. But it’s part of our mission. It’s part of our Title V activity plan so it was already kind of budgeted, that time would be going to this project. But really, producing the survey, 5,000. You know, a really strong collaboration with WIC because this has to go into the WIC Clinics which means you have to engage the WIC directors and make sure everybody’s cool with this extra burden of work where we—anybody who completes at least 100 surveys any local agency, gets their data back analyzed just for them. So, there is a reward for each of the agencies. And what you’ll see in the report that’s on your CD is you’ll see each of kind of the local agencies and how they varied. We’re able to aggregate up regionally. It’s really—it’s a good collaboration. And it’s also, while it’s really helping practice our Texas WIC program, my feeling is this is really innovative data that no one has seen before.

So, it’s full circle. I mean, this is really one of the flagships, you know, when people say, “You went to Texas trying to get research into practice which we know no one can do and it’s impossible and they don’t speak the same language, is it really working?” This is really one of our flagships. We have something that’s going to advance the literature. We have something that the peer review journals, I mean, I think again a lot of us probably are familiar enough to say, you know,

these kinds of data, at the very least, a journal of human lactation would take up in less than a second, but pediatrics, American Journal of Public Health, those kinds of avenues will be home for this data. But then on the other side, we're also going to make some real strong policy and programmatic changes.

So, when someone says, you know, and this is—but BRFSS as well, when someone says, “Well, you know, I think that people really don't like to see breastfeeding in public.” Right now, what's our response? Well, I don't believe that. That's not what people tell me. Anecdote really moves policy and/or practice. We're going to be able to give you a number. Seventeen percent of Texans, that what I'm hoping. I'm hoping for a low number. We don't know the number yet, but some percentage of Texans said that it doesn't bother them to see a woman breastfeeding in public. So clearly, if the businesses are all saying this is a gross, disgusting thing and I can't have it in my restaurant or in my Target but the BRFSS results contradict that, then you can have a conversation because you have data and they have anecdote. When you have anecdote on anecdote, no one wins. It's a draw. But when you have data on anecdote, you're going to carry that (inaudible). So, that's why I just—I really—I'm glad we actually had an opportunity to talk about this survey as a lead-in to the African American outreach campaign. So, that's kind of a first leg of our talk. Are there any questions? Yeah?

UNKNOWN SPEAKER: I have a couple. Is this survey something that you validated (inaudible)?

BRIAN CASTRUCCI: The survey wasn't—pardon me. The survey questions were pulled from a lot of the published literature. We did face validity. We did pilot tests. We did some commutative recall, what does this question mean to you? Tell me what it means. But, I mean, a formal kind of validity-reliability assessment, we didn't do. But I don't know that that's—I think there's enough of it in the literature and pulling it right out of the literature and doing the pilot testing which gives us enough feel that this is solid data.

UNKNOWN SPEAKER: So, can we use this in our places?

BRIAN CASTRUCCI: It's public use. I'm looking over to the right corner for a nod from my third base coach. But, yeah, I mean, this—everything that's on your CD is on our Web site. So—and the questionnaire from '06 is on our Web site and the questionnaire—this questionnaire would be part of our '07 report. So, it's going to be on the Web site and people can use it, and I hope they do.

UNKNOWN SPEAKER: And tell me, did you do this questionnaire (inaudible)?

BRIAN CASTRUCCI: We piloted it. We piloted it in—this was—it went through the IRB, we did the (inaudible) kind of stuff and it didn't come back as too heavy

on the literacy. We piloted this in WIC clinics. This is probably the fourth, fifth, sixth iteration of the survey. The skip pattern has changed 10,000 different times and we never had a problem. And again, we did kind of some retrospective discussions after a woman completed it in the pilot and they're like, "Yeah, this is cool. We're find with this." So, we didn't see in the pilot an issue of literacy.

UNKNOWN SPEAKER: Because there are, of course, there are women that can't read.

BRIAN CASTRUCCI: And that's a limit—right. It's a big—that's one of your limitations. If you're—yeah, if you couldn't read, you wouldn't have completed this. But then it gets to the question of now many folks in WIC do we think, you know, really can't read or wouldn't, you know, would have a capacity to complete the survey? But with the 6,400 respondents, I don't think people were just, you know, x'ing out wherever. I mean the patterns don't appear to be random. Yeah? You (inaudible).

UNKNOWN SPEAKER: How did these (inaudible) work for your Spanish speakers? My experience is that that's not a very understandable scale. And even on the things where you (inaudible) check all the (inaudible) didn't do but (inaudible) like yes, no, yes, no?

BRIAN CASTRUCCI: Right. And the—

UNKNOWN SPEAKER: So, I'm just—I'm (inaudible) pilot testing and how (inaudible)?

BRIAN CASTRUCCI: We didn't do check all their reply because—for any number of reasons because you really want to get individualized data. Again, we—in the pilot test, we didn't--no problems were—no problems arose. We did the pilot testing for this reason so that we could say, you know, "Tell us what your issues are." And a lot of things—the biggest problem in the pilot test were the initial skip patterns because people were going all over the place and no one could understand skip patterns. I will—I can't tell you a number on the button but I can tell you that there was very little failure that followed the skip patterns. And that is a piece of evidence that I think supports the fact that this was done—that people understood it and they followed the track throughout the entire survey. So, you didn't get a lot of folks answering questions seven and question eight, if I'm recalling my questioning numbering right. But the question—the reason why you—for the women who breastfed, why you stopped; for the women who didn't breastfeed, why you never? We didn't see a lot of contamination there. So, we feel pretty confident in the instrument. In the back?

UNKNOWN SPEAKER: Would you happen to know how many Hispanic (inaudible)? Have you looked at newcomers versus (inaudible)?

BRIAN CASTRUCCI: We have a cultururation question, we have a language question but I think the sensitivity of newcomers versus folks who (inaudible) versus how long you've been here kind of steered away from those kind of questions because WIC doesn't ask or (inaudible) one those questions. But we do have a cultururation—we have some parts for cultururation, which we feel good, and those are the kinds of data that we're running. This--

UNKNOWN SPEAKER: So, you haven't done that?

BRIAN CASTRUCCI: We've done it yet. These data, literally, came available (inaudible). And since AMCHP (inaudible) a few weeks early, we only had so much time, my colleague (inaudible) so that I have something to talk to you about. But I think—because even—and let's just say (inaudible) you know maybe there are some sampling issues, maybe there are some different issues but the cool part with research is that no one has done it before. We have a lot (inaudible) conference and (inaudible) you can do. (Inaudible) we did a survey on where the people were hearing the HIV guidelines in, you know, the CDC interview (inaudible) guidelines.

So to get a sample, we actually randomly selected states and then we went to the CDC program manager to identify the clinics for us. We went to clinic manager and said, "You select for us because I'm going to answer your survey." So, you think the program manager picked the best clinics or the worst clinics?

UNKNOWN SPEAKER: The best.

BRIAN CASTRUCCI: Probably the best. And the clinic manager, do you think he picked the best councilor and the worst councilor?

UNKNOWN SPEAKER: The best.

BRIAN CASTRUCCI: The best. Is that a good sampling method? God, no. I mean, (inaudible) that you need, you know, treatment for it. However, no one has done that kind of research before. No one had looked at this question. And when everyone who wasn't doing—wasn't adhering to the guidelines, what we were able to say was the best of the best didn't adhere to the guidelines. What do you think the worst of the worst did? And that (inaudible) STD. When you're driving in a new area, when you're trying to produce some of these new knowledge, and I think the formula stuff on the non-breastfeeding mothers is a good data point that no one has. You (inaudible) a little leeway because, again, you know, breastfeeding just—the large surveillance of breastfeeding is most that. It's just pure surveillance. And this really gives us a lot of stuff to play with from socio-cognitive perspective. Yeah?

UNKNOWN SPEAKER: Could you talk a little bit about the development of the survey itself, who was on the team, how you made decisions about what would be included, was that contentious?

BRIAN CASTRUCCI: It's actually, you know, there was a job interview (inaudible) once, about the program. I had a job interview once. And it said—they asked me—they said, you know, "Tell me about the time you had a tremendously contentious situation that you to deal with. And, you know, I got to my (inaudible) you have a lot of contention. Somehow, (inaudible) really a good point with the research and programs staff. And so, what we did to get this thing working was I had my child health coordinator and one of the researchers just (inaudible) the literature. You find every question that was reported, put it in a table and let's look at that. I mean, let's see what people have asked. These people have asked it; let's, you know, that's a good source for questions and then we can figure out what we want to do. So, we probably had something, you know, (inaudible) thick when it was all said and done, and then we got the WIC branch manager, the breastfeeding coordinator, child health coordinator, was mine, more of my researchers all sat around the table and just started going through it. What's important? Answer the question, what's important to you? What's important to you? What are you going to do with these data?

You know, this little like esoteric question over here was really interesting to me but we have to cut the questionnaire now. I mean, I'm grateful and fortunate that

we got as many responses as we get. A group of us who understood the risks with an eight-page questionnaire that this thing could've blown up because people were not going to fill it up. So, there was an inherent risk there when you had (inaudible) at some point and say, you know, "This just can't be there." So, a lot of it was (inaudible) by the WIC needs because, ultimately, this is a practice in (inaudible) survey for WIC. So, we were though able to kind of guide it so that it was—that it is publishable and then we can get something to advance the literature and also meeting the goal.

So—and again, next week's meeting where we start to talk about how we we're going to analyze this, it's WIC, it's our (inaudible), it's me and my crew, so we all can start to say what's important, you know, because I know WIC has a different—I know some purports that WIC wants and (inaudible) soon are considered are, I can say, the reports that I want and on the same timeline. So, we're going to negotiate that. But I think one of the style that we've been able to adopt in my (inaudible) is to kind of, you know, we get data (inaudible) and then we move on. We're just finishing a large parts of the CDC where we produce five manuscripts in less than a year and it was just—(inaudible) kind of (inaudible) style which helps us a lot because when I have data question, then my colleagues are also working on the same data and I could get a much cleaner analysis. And when things come up in our analysis, (inaudible) it's been useful. But it's 100 percent collaboration with WIC. And this is really—when you think about how to get data to action, you need that collaboration. The longer we stay

inside of those, the longer we're not going to be able to move this stuff. Other questions?

UNKNOWN SPEAKER: You may be answering this. Can you talk about (inaudible) how do you influence those social network (inaudible) months later?

BRIAN CASTRUCCI: The African American outreach campaign actually did targeted social networks. And we're going to see some of that right now if there are no more questions. Are we all good? Do we need a break? Are we dying? Are we okay? Oh, more questions.

UNKNOWN SPEAKER: Did you involve your (inaudible)?

BRIAN CASTRUCCI: We didn't involve the—in which part?

UNKNOWN SPEAKER: In the development of the survey.

BRIAN CASTRUCCI: In the survey? No. This was a very much (inaudible) Title V WIC or a division of family community health services project. You know, I learn more and more everyday that, you know, you always forget some partner at the table. And it's a learning experience to think, you know, "Oh, you know, we should've had them and we should them." And that's kind of our list we keep running for next year. You know, we're—this used to be an annual survey. We're

going to rest it for a couple of years because it just makes no sense to do this every year and put the burden on the WIC clinics. But, you know, every couple of years, we'll do it with the same questionnaire so can get some trend data going but we are learning, "Oh, got to involve so-and-so who's over there." So, there are so many—so much of MCH, and I find MCH to be a challenge because you either can be an MCH division unit, etcetera, or as some states do, they kind of take it apart and (inaudible) it out over everywhere, which means just the need for us to collaborate is so strong because, you know, I'm doing an obesity study. Well, I need to make sure I get the obesity people. And I'm doing this other but, you know, because when it's children, it's kind of yours and Title V, but it's—you just risk so hard to remember all the partners that need to be at the table because they have vested interests as well.

UNKNOWN SPEAKER: And there are (inaudible).

BRIAN CASTRUCCI: In the back.

UNKNOWN SPEAKER: Oh, I'm just a little unclear. Did the client self-administer the survey or did the WIC staff go over (inaudible)?

BRIAN CASTRUCCI: The WIC staff went over the consent form with the client. It was passive consent which was approved by IRB, and then they actually were just—they were self-administering it after a review from the staff.

UNKNOWN SPEAKER: The clients themselves?

BRIAN CASTRUCCI: The clients would read through the survey and (inaudible) it off and that's how we piloted it as well. And it's really interesting to see our first version of the survey to the version that we have now. And the pilot testing, which I don't know was necessarily on our radar at first, we were kind of—we're all sitting in a room one day and said, gee, we got this thing done early, let's take it out and let's make sure this works and huge, hugely helpful, to, I think, really improve the quality. And just again, that face validity stuff, I'm seeing the data coming back again as solid data. We're seeing questions, you know, your answer to question four and your answer to question seven are similar, you know? They make sense. And one the challenges in the old survey was just the skip patterns—you just see everybody answering everything and you would actually, in the 2006 survey, we went back and imposed appropriate skip patterns. So if you breastfed, even though you answered question A and question B even though you're suppose to skip question B, we artificially skipped you out of that. In this survey, we didn't see a lot of that. So, that's really encouraging. Okay, let us go on to the effects of a breastfeeding outreach campaign. Yeah?

UNKNOWN SPEAKER: One of the—so, a couple of weeks now (inaudible) you can't read and you can't (inaudible).

BRIAN CASTRUCCI: You didn't fill it right.

UNKNOWN SPEAKER: I'm just wondering if that also (inaudible) so do you think you're missing that group of people?

BRIAN CASTRUCCI: You're going to miss a whole bunch of people. There's no doubt that there are people within the WIC population who didn't fill it out whether they were, you know, too tired or it was too long or they couldn't read or the dialect of Spanish that we used was not in congruence with, I mean, I sat through many, many meetings talking about how you actually say breastfeeding in Spanish. There are several different ways. I didn't know that. I don't speak Spanish. And so, that was, you know, what does WIC use? What is more colloquial in different places? So, inherently, there are going to be challenges with this type of survey. That's a tradeoff a bit when you're not doing, you know, the large, randomized trials and the, you know, the telephone-based surveying and all the, you know, maybe the gold standard methods. And that's okay because what we can counter that with is data that no one has and never has had and a big, old sample size. And, you know, a big, old sample size gets carried the day often. So, it's a huge—I think, again, just from a state planning perspective, nothing gives us these data. How are we, again, a lot of our breastfeeding planning, how we are doing it? You know, these data will help us move to an evidence-based strategy to address breastfeeding. And that's what's exciting, you know, because that's why have the research people paired up with

the program people to ensure that the evidence is created for the needs of the program and then on the back end, to ensure that there's fidelity and that the evidence that we created is used appropriately in planning the program. So, this kind of circle of, you know, research practice, for me, is very exciting.

Okay, the average American breastfeeding outreach campaign. Our objectives for this talk, we're going to identify some key components of a successful outreach campaign. We're going to describe the impact of the outreach campaign on African American women in rural counties in Texas. We kind of already went through the benefits. We all know the benefits. But when you really think about some of the disparities and the complex biological, social and economic factors that go into creating these racial disparities; when you look throughout all of the health indicators, this disparity between African Americans and Caucasian and Hispanics—when you have something like breastfeeding; which is free and, you know, has tremendous health benefits, it's just such a need to target and eliminate the self disparity because there's no, you know, it's not an access issue. It's not insurance issue. It's not a where-you-live issue. It's just—it's really—it's an issue within the woman and her socio-cultural context.

So, to help women and get the benefits that breastfeeding provides, this is clearly an area that we need to target and we need to be effective. So, Texas WIC decided to attempt to increase the breastfeeding rates among African American women who were currently using WIC and they did this through a multifaceted

media campaign. However, prior to the construction of the campaign, they actually conducted focus groups that would help form the creation. So, these focus groups provided qualitative data. It included interviews with 43 African American women who were expectant mothers, new mothers ages 17 to 25 and who were currently receiving WIC, and with 15 healthcare providers so that you could start to understand some of the knowledge and the beliefs about breastfeeding from the women, some of the barriers and (inaudible) influences from the health care providers.

Okay, so these were the base data. This is what we got from the focus groups. And it's a little small but you have it in your packet and you actually have the slides on the CD, so you could see this later. But some of the stuff that people said were, you know, "it's good for the child, you should try to do it, I tried on my own but I couldn't." And those kinds of ideas were kind of boiled down because, again, with focus group data, you get a lot of ideas, right? It's not a quantitative data, which is everything is nice and in it's box, and it's easy to analyze. Qualitative data is much more difficult.

So, you need to take all these information that people give you and kind of come up with a coding system and then come up with a theme. Okay. And ultimately, that—some of those first statements ended up under the theme of training, "he didn't want me to breastfeed, she wouldn't eat." Those are training issues. In the second theme which actually came out with support, "I'm afraid, I'm intimidated, I

gave him the bottle, they recommended that I pump but then they ran out of pumps.” So, those are kind of—those are support issues, okay? Issues of support. That’s the overall theme. And then lastly, it was just, “my mother and my grandmother, my boyfriend all talked to me about breastfeeding, my husband was convinced that if I breastfed, he wouldn’t get to feed the baby,” which is, you know, that can be an issues. And these were all issues of family and professional issues.

And it was those, it was these three themes upon which the intervention was developed, okay? So we needed to address in this outreach campaign issues of training, issues of support, and issues of family and professions. Are you with me? Okay. The intervention rolled up again in January 2004 and lasted through September 2004, recognizing the need to tailor the campaign to maximize the effectiveness in the target population. WIC relied on subject matter expert reviews and one-on-one interviews to identify barriers to breastfeeding and important—the narrative influences to determine the health promotion measures within the rural communities. And that’s what these focus groups were. They actually got in there and said, you know, “Tell me about it. Tell me what your barriers are. Help me understand the messages you’re getting.” So, that was all incorporated into this campaign.

This was all purchased media. And when I did this last week, I just said media and the WIC folks said, “Make it clear. This was purchased media.” So, this

wasn't the donated media that comes on at two in the morning between the (inaudible) ad and then up all night. So this was, you know, real primetime media, the radio spots. This was all purchased media. It included newspaper columns that were in local news outlets like community newspapers, etcetera, and magazine advertising. So, to kind of give you a sense for this campaign because I can talk but it doesn't give you the flavor for it. I'm going to play some of the radio ads and I'm going to play the TV ads. So, this is the radio spot for the WIC dad and, hopefully, it's going to play.

UNKNOWN SPEAKER: Being a dad is new for me. It's got me scared sometimes. (Inaudible) my son his whole life ahead of him and I just want to give him the best (inaudible) I can. I want to be a great, you know, do things right. And that's not always easy. There's a lot to learn. I've been raised with all the things a baby needs to grow healthy and strong. One surprise is learning how to do the (inaudible) for the baby.