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The National Connection for Local Public Health

[FACTSHEET]
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Shifting the Care Paradigm: Cultural Humility in Breastfeeding Care

BACKGROUND

In 2014, NACCHO, in partnership with the Centers for Disease Control and Prevention (CDC), Division of Nutrition, Physical Activity, and Obesity (DNPAO), implemented the Reducing Disparities in Breastfeeding through Peer and Professional support project to increase breastfeeding rates among African American and underserved populations. The effort supported the implementation of 72 community-level peer and professional breastfeeding support programs by local health departments (LHDs), community-based organizations (CBOs) and hospitals in 32 states and territories from January 2015 through May 2016. Grantees provided direct breastfeeding support, based on recommendations of the CDC Guide to Strategies to Support Breastfeeding Mothers and Babies while addressing families' challenges to accessing services.

At times, grantee organization staff believed the stereotypical ideas that lactation support providers needed to be the same race or ethnicity as their clients to better relate to them and provide culturally-appropriate care; that clients will not take advice from someone from a different background, which is usually not true. While there is an urgent need for a more diverse workforce among providers, there is also substantial work being done towards lactation workforce equity, not only to remove barriers to the profession for people of different races, but also different nationalities, genders, and providers from different socioeconomic statuses.

This factsheet describes the training in cultural humility provided to all grantees during Year 1 of the project in 2015. This training was presented at the 2016 National Head Start Conference, the 2016 California WIC Association, and also requested for 2018 Arizona WIC Conference.

INTRODUCTION

Cultural humility (CH) is a lifelong process of self-reflection, used to better understand the multi-dimensional identities of clients in order to establish and maintain respectful, healthy, and productive relationships. It analyzes root causes of suffering and gives a more inclusive view of the world.[1] CH is used in public health as a framework that contributes to the ultimate goal of working with all populations with a sense of equity and respect. Trainings in cultural competency, address only static constructs, such as race, nationality and religion, and do not factor in the worldview that the provider brings to the interaction. CH takes into account financial, emotional and marital status, oppression and privilege, mobility, sexual orientation, provider approaches, as well as race and ethnicity and the individual's self-identification of race, gender, generation, and multiple cultures of an individual, providing a more dynamic methodology[2]. Cultural humility recognizes the personal culture of every individual.

Cultural humility is likely to have a positive association with working alliance between provider and client because the client is likely to develop a sense of trust and safety with a provider who engages with his or her cultural background with an interpersonal stance of

openness rather than superiority. Results of a study exploring important skills wanted in a therapist by clients showed that cultural humility demonstrated from the therapist was one of the most important skills– more so than other factors such as racial similarities, gender, years of experience, and content expertise. Further, the results showed that clients' perceptions of their therapist's cultural humility was positively associated with developing a strong working alliance and improvement in therapy. [3]

> *"Mothers are looking for help, but it is important to meet them where they are first and find even the smallest connection to establish and maintain a working relationship".* \Stephanie Hidalgo, Breastfeeding Peer Counselor)

CULTURAL HUMILITY PRINCIPLES

Cultural humility includes a set of principles that guides the thoughts and actions of individuals and institutions that seek to address inequity in access to healthcare services such as breastfeeding support. [1]

Lifelong commitment to learning and self-reflection: Remaining humble and flexible allows for the provider's rejection of ethnocentrism and personal ideas of "normal" breastfeeding[4]. It requires providers to conduct a critical, on-going self-evaluation to remain aware of their own biases and limitations and continuously seek out additional resources that will enhance the understanding of their client's worldviews and behaviors.[1,5]Failure to develop this self-awareness can become an additional barrier to mothers accessing breastfeeding support services, despite how knowledgeable the provider is.

Desire to fix power imbalances within provider-client dynamic: Lactation support providers should act as students of their patients, who hold the expertise of their personal story. Providers should actively immerse themselves in the community history, traditions and norms to create a balanced, collaborative environment with pregnant and breastfeeding mothers[5]. When providing breastfeeding education and support, providers should suspend the prescribing authority language of "this is what you should do," instead they should allow ample space for mothers and their families to voice their questions, beliefs or concerns about breastfeeding[6]. Asking for familial opinion provides more insight into a mother's personal goals and helps identify options that work for her family. This encourages patient empowerment and self-efficacy or belief in her ability to breastfeed[1]. Patient-centered care and motivational interviewing are some of the counseling methods that are in line with cultural humility principles and are appropriate to develop a strong working relationship and conduct effective counseling with a client who is culturally different[7], where the provider must be able to overcome the natural tendency to view one's own beliefs, values, and worldview as superior, and instead be open to the beliefs, values, and worldview of the diverse client[1].

Institutional accountability & mutual respectful partnership based on trust: Cultural humility goes further than the individual self. Accountability is also required within the institutions that aim to provide culturally-appropriate support through educational programs. There should be engagement in social justice and advocacy, as well as mutually respectful, beneficial and non-paternalistic community partnership based on trust and dialogue[1]. Assessing community needs, engaging the community by listening to and addressing the clients' concerns about accessing services, and including community members in coalitions, decision-making and program planning are some examples of this principle.

Watch this video (https://www.youtube.com/watch?v=SaSHLbS1V4w) to understand the Cultural Humility concept better.

In addition to these principles, lactation support providers may use the **ASSESS**[8] method when aiming to provide culturally-appropriate education and support to pregnant and postpartum mothers.

Ask questions in a humble, safe manner,
Seek self-awareness,
Suspend judgment,
Express kindness and compassion,
Support a safe and welcoming environment and
Start where the patient is.

"We must become action-oriented in moving marginalized mothers to the center of the breastfeeding movement. Cultural humility comes into play here, as these mothers are often in very different situations than the "ideal" mother and often do not have the privilege to define themselves primarily as a mother. Thus, breastfeeding may not be at the forefront of her child-rearing decisions." (Quinn Gentry, MPH)

BREASTFEEDING CARE AND CULTURE HUMILITY

It is important to look at each mother-baby dyad as unique. Asking mothers questions about the specific structural barriers and personal challenges that need to be addressed in order to make the decision to breastfeed can help providers better understand each mother's worldview[7]. These challenges can be lack of resources and power, poor access to support, lack of maternity or sick leave, lack of social and workplace support and much more[9]. A provider simply stating the recommended breastfeeding duration and breastfeeding benefits will not resonate with these mothers until the provider actively listens and brainstorms solutions to the mother's specific hurdles[5]. The purpose of the visit should not be limited to the provider's agenda and point of view of what breastfeeding should look like for that mother. It should focus on understanding what the mother can and is willing to do, and actively supporting her personal goals.

Utilizing the CH principles and suspending prior judgement and stereotypes about a mother's likelihood of breastfeeding supports a safe, welcoming environment for mothers[5]. It is better to look at personal culture of the clients, or what they decide to share with the providers about themselves, rather than using stereotyped ideas of racial or ethnic cultures as a resource for predicting breastfeeding behavior and providing the appropriate, personalized care[4]. Race is only the tip of the iceberg; culture is the values, norms, and beliefs that you cannot see which determine decision, length of time, self-efficacy, and effort put into breastfeeding.

Low socioeconomic status (SES) alone generates its own set of cultural, beliefs, and practices, especially those related to barriers to breastfeeding[10]. Within this population, there is an inability to overcome those barriers due to lack of resources and power. Underserved new mothers usually struggle with transportation, safety, food security, childcare, healthcare, housing and lack of available and accessible support services in the community[9]. There are differences in the perceptions and reactions to breastfeeding barriers between different socioeconomic statuses, regardless of race. It is more likely that a low-income black and a low-income white new mother will have more in common and share more cultural similarities and struggles to breastfeeding than two black mothers from different socioeconomic statuses.

Mothers truly need to know that they are truly being heard by their providers and that providers are not solely feeding them information and answers based upon what providers believe to be the best practices.[4] Instead, they need solutions to their personal barriers that hinder them from reaching their breastfeeding goals.

CONCLUSION

One of the most serious barriers to providing culturally appropriate care is not a lack of knowledge of the details of any given cultural orientation, but the providers' failure to develop self-awareness and a respectful attitude toward diverse points of view.

Lactation support providers should not assume that they understand the client's cultural background or experience based on prior trainings or stereotypes. Rather, providers should *partner* with clients and the community to understand individual patients' cultural background, experience and personal challenges, and specific goals, and help facilitate the achievement of these goals.

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