2021

Black Mothers' Birthing Center Experiences and Exclusive Breastfeeding Practices

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Abstract

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by

Natashia LeNee Conner

MS, University of Cincinnati, 2017

BS, Union Institute & University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Education and Promotion

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Abstract

The persistence of racial disparities in breastfeeding is associated with a range of interconnected factors, such as historical, cultural, social, social, and psychological. The current gap in the prevalence of exclusive breastfeeding among Black mothers and White mothers has led to rising concerns in the United States. A basic qualitative approach was used to conceptualize the multidimensional constructs of the social–ecological model to investigate the individual, interpersonal, institutional, and community-level structures and existing policies in birthing centers that inadvertently harbor biases that impede care for Black mothers. Data were gathered through purposeful sampling and semistructured interviews with 10 Black mothers to acquire a contextual understanding of the experiences, attitudes, and beliefs among this population to reveal how perceptions of racism and discrimination in birthing centers can create negative implications for health-seeking behavior. The data show that many of the participants were less likely to obtain proper breastfeeding care and expressed underutilization of health services to meet their breastfeeding goals. The results of this study provide insight into the perceptions of implicit bias, racism, and discrimination in the institutional structure and existing policies of birthing centers, which can influence exclusive breastfeeding practices among Black mothers. The results of this study could lead to potential positive social change by providing insight into how to reduce exclusive breastfeeding disparities and assist with developing best practices for management and support of exclusive breastfeeding, which subsequently can lead to higher breastfeeding rates that could positively influence health outcomes among Black women and their children.

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Dedication

This dissertation is dedicated to all Black and Brown mothers and their families who have experienced racism or discrimination. May your voices be heard and counted, and may we move toward a more equitable and culturally appropriate society justly devoted to the attainment of these unalienable rights: life, liberty, and the pursuit of happiness and that all people are created equal. I would also like to dedicate this publication to my children, Israel, Immanuel, Gabrielle, Yasiel, and Azrael. May this life and the next be the place of our ancestors' wildest dreams. Never let anyone stop you on your pursuit of life, liberty, and happiness. To my husband Samuel, you always believed in me and supported my educational journey, and for that, I am earnestly grateful and appreciative. To my best friend, Vanessa, you have been my rock in moments of despair and a guiding light when all hope was gone. Thank you for helping through this remarkable journey. To my mother and father, I hope that I have made you proud. I love you all.

Acknowledgments

I want to thank Dr. Cheri N. Langley, Dr. Yitza Arcelay Rojas, and Dr. Deneen N. Long White for being my dissertation committee. Dr. Langley, you have been an absolute rock star and a phenomenal mentor. I could not have imagined this journey without you. Your expertise, guidance, and support were the most influential tools in completing this dissertation and reaching my goal of completing my doctorate. I would also like to thank Dr. Kim Kato for matching me with a fantastic committee. Dr. Rojas, thank you for pushing me and equipping me with the tools necessary to obtain my goals. Last, but certainly not least, I would like to thank Dr. Laurie Nommsen-Rivers: Without knowing, you became a maternal role model and spiritual guide throughout my adulthood. You're caring and gentle nature helped me pursue everything I set my mind to. Your dedication and passion for equity and equality strengthens my resolve in pursuit of racial and social justice. Dr. Francoise Knox-Kazimierczuk, thank you for showing me that I do not have to limit my ambitions. Thank you for being a friend and mentor.

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Chapter 1: Introduction to the Study

Introduction

Throughout the critical immediate postpartum period an extensive range of maternal, infant, and child health professionals to include physicians, midwives, nurses, lactation consultants, and other health care staff members play a crucial role in attaining the Healthy People goals (Louis-Jacques et al., 2017a). Specifically, for increasing the proportion of infants exclusively breastfed for three months, they encourage exclusive breastfeeding, providing access to accurate and unblemished culturally appropriate information and support (Louis-Jacques et al., 2017a). Exclusive breastfeeding rates in the United States are suboptimal (Bartick et al., 2016a; Centers for Disease Control and Prevention [CDC], 2019; World Health Organization [WHO], 2019). Suboptimal breastfeeding steams from a mother's inability to accomplish medical recommendations. Which is that all infants should receive no other substance than mothers' milk unless medically contraindicated for 6 months and continued breastfeeding with complementary foods until age one or longer (Bartick et al., 2017; CDC, 2019, WHO, 2019).

The persistence of racial disparities in breastfeeding amongst Black women is associated with a range of interconnected factors such as historical, cultural, societal, and psychological. According to Bartick et al. (2017) and Bartick et al. (2016b), suboptimal breastfeeding is attributed to poor health outcomes accounting for more than 2,619 premature maternal deaths and linked to more than 721 infant deaths. Lack of self-efficacy, social support, education, and support from hospital staff in the immediate postpartum period has been identified as individual and environmental factors linked to lower prevalence of breastfeeding among Black mothers' (Dunn et al., 2015, Louis-Jacques et al., 2017b).

In this study, I examined Black mothers' perceptions of subliminal racial, discriminatory, or biases beliefs, procedures, and maternity care practices within birthing centers that may be perceived as biased treatment concerning breastfeeding initiation and duration. Experiences during the birthing process and the immediate postpartum period within birthing centers affect breastfeeding outcomes, which include labor and delivery care, breastfeeding assistance, as well as structural and organizational aspects of care (Barrera et al., 2019). This study was designed to identify the intrapersonal, interpersonal, community, and institutional barriers within birthing centers that impede exclusive breastfeeding among Black mothers. With the intent to provide awareness of how Black mothers' feel concerning the individual, interpersonal and community-level factors that may affect Black mothers' decisions to initiate and sustain exclusive breastfeeding of their newborn infant.

Additionally, in this study I sought to bring awareness to Black mothers' perceptions of bias and racism within the institutional fabric and existing policies within and surrounding birthing centers. As a result, my overarching goal of this study was to promote changes in birthing center policy, practices, and procedures that disproportionately and negatively affect Black mothers'. Ultimately, this awareness may promote healthy discussions within birthing centers on how to serve this population of mothers better.

Chapter 1 will include an introduction to the problem under study, the background of the phenomenon, the purpose statement, a detailed review of the research questions, and the theoretical and conceptual framework used in this study. Chapter 1 contains the nature of the study, definitions, assumptions, scope and delimitations, limitations, and the significance of this study. The chapter concludes with a summary.

Background of the Problem

With the current perception of exclusive breastfeeding in the United States. being an expression of motherhood centered around meeting the infant's physical and emotional needs, maternal motivation, attitudes, beliefs, and experiences must be taken into consideration (Kestler-Peleg et al., 2015). A critical analysis of Black mothers exclusive breastfeeding attitudes was found to be favorable concerning exclusive breastfeeding initiation and duration (Reno et al., 2018). Black mothers were found to be knowledgeable about both the economic and health advantages of exclusive breastfeeding with 93.8% of Black mothers' endorsing that exclusive breastfeeding promotes bonding, 87.5% of Black mothers agree that breast milk alone gives babies all they need to eat, and 81.3% of Black mothers agree that exclusive breastfeeding protects infants from disease (Reno et al., 2018).

Despite Black mothers' favorable attitudes towards exclusive breastfeeding, their knowledge about the benefits of exclusive breastfeeding, and Black mothers' intent to initiate exclusive breastfeeding, Black mothers continue to fall short of meeting their exclusive breastfeeding goals (Reno et al., 2018). Race-based inequities against patients during care and their link to implicit bias are documented components of exclusive breastfeeding disparities (Thomas, 2018a). Black mothers continue to have the lowest rates of exclusive breastfeeding initiation, 69.5% compared to 85.9% among whites, as well as continuation at three months, 36.0% compared to their White counterparts 53.0%, and six months, 17.2% compared to 29.5%, compared to all other racial and ethnic groups in the United States (Beauregard et al., 2019). Receiving more information and support within birthing centers and receiving information from

the doctor are classified as factors that could help Black mothers to meet their breastfeeding goals (Reno et al., 2018).

Using the social-ecological model (SEM) framework, Chopel et al. (2019) identified these themes as significant influences at each social-ecological level that create barriers to exclusive breastfeeding among Black mothers', (a) roles, (b) place, (c) stigmas, and (d) support. Social barriers that inhibit exclusive breastfeeding are considered *roles* that influence exclusive breastfeeding (Chopel et al., 2019). Environmental barriers for exclusive breastfeeding or *place* are represented by structural facilitators correlated with exclusive breastfeeding comfort and safety (Chopel et al., 2019). Additionally, *stigma* constitutes structural barriers suggesting that although mothers do not let judgments bother them, mothers did, however, change their infant feeding practice (Chopel et al., 2019). Lastly, *support* is noted as a social facilitator that temper the influence of stigmas as a barrier to exclusive breastfeeding (Chopel et al., 2019). Negative racial stereotypes and microaggressions within these social structures lead to barriers that significantly lowers the odds of exclusive breastfeeding (Griswold et al., 2018). Other factors such as social exclusion from breastfeeding resources, neighborhood segregation, and the lack of racial diversity among lactation professionals result in non-culturally congruent care thus lowering exclusive breastfeeding rates (Gonzalez et al., 2018; Griswold et al., 2018).

Health care stigmas related to stereotyping, prejudices, discrimination, behavior, and attitudes influence population health outcomes, therefore worsening, undermining, or impeding several processes, including social relationships, resource availability, stress, and psychological and behavioral responses, exacerbating the issues that lead to poor health (Stangl et al., 2019). Experiences of invisibility, exclusion, and hostility in Black mothers' course of health care foster

very tangible consequences to include behavioral, psychological, and physiological responses such as higher incidence of obesity, cardiovascular disease, anxiety, and mortality. Other consequences include decreased educational attainment, more inadequate decision making, and failure to obtain necessary health care (Priest & Williams, 2018).

One third of Black adults disproportionately report chronic stress associated with experiences of perceived racial discrimination with an additional 22% report avoiding healthcare due to anticipated racial discrimination (Bleich et al., 2019; Braveman et al., 2017; Gavin et al., 2018). Chronic stress due to experiences of perceived racial discrimination across the life course has been linked to Black-White maternal-infant health disparities and adverse birth outcomes (Abramson et al., 2015; Attanasio & Kozhimannil, 2015; Braveman et al., 2017; Gavin et al., 2018). The prevalence of racism and discriminatory behaviors is experienced by individuals who identify as Black at a higher rate than other ethnicities and racial groups (Bleich et al., 2019; Braveman et al., 2017; Leung, 2015).

There is an active link between adverse and suboptimal health outcomes for Black mothers' and racism in the United States (Bailey et al., 2017). Paradies et al. (2013) provided different views of intrapersonal racism in healthcare and its' link to patient-provider interaction. Direct measures of healthcare provider racism assess the patient's abilities, personal characteristics, and stereotypes rated by the providers, while indirect are vignettes that infer physician bias through physician diagnosis, treatment, or behaviors (Paradies et al., 2013). Perception and attitudes regarding provider bias contribute to lower exclusive breastfeeding rates among Black mothers' (Jones et al., 2015).

Healthcare stigmas and discrimination related to race and ethnicity have been well documented to create barriers to health-seeking behavior and engagement (Stangl et al., 2019). Stigmas in healthcare include stereotypes, prejudices, and discriminatory attitudes based on perceived differences in race, class, gender, or sexual orientation. Stangl et al. (2019) argued that these health care stigmas interfere with the affected population by influencing access to justice, healthcare services, and advocacy. Ob-gyns and physicians have a unique opportunity to influence exclusive breastfeeding through clinical practice and policy that support exclusive breastfeeding behavior (Jones et al., 2015). Because exclusive breastfeeding initiation and duration are highly swayed by predelivery intention having physician involvement is paramount. The continued inequalities in social institutions hinder organizations from properly addressing discrimination experienced by people of color (Thomas, 2018a).

The findings of this study help fill the literature gap and demonstrates positive social change by providing insight into Black mothers' experiences individually, interpersonally, and within their community regarding exclusive breastfeeding. The results of this study provide a better understanding and create social change within the policies, practices, and procedures within birthing centers that may be perceived as racially biased and discriminatory treatment of Black mothers' that may ultimately impede or hinder initiation and duration of exclusive breastfeeding practices. Such interventions can impact the individual, the interpersonal, community-level factors, and the institutional and political norms surrounding exclusive breastfeeding practices among Black mothers. There is an active link between adverse and suboptimal health outcomes for Black mothers' and racism in the United States (Bailey et al.,

2017). Perception and attitudes regarding provider bias contribute to lower exclusive breastfeeding rates among Black mothers' (Jones et al., 2015).

Problem Statement

Racism includes unfair attitudes and violent hostility against another ethnic group (United Nations Educational Scientific and Cultural Organization, 2019). While many Americans who are unaware of social inequities may argue that racism no longer exists in the United States, equality without equity is meaningless in a system founded on racism and discrimination (Kwate, 2014). *Institutional racism* refers to how institutions operate systematically, both overtly and inherently, via the reinforcement and adoption of racist policies, procedures, operations, and culture that exclude racial minorities or create barriers to access quality health and resources (American Academy of Family Physicians, 2019; American Psychological Association, 2019). Race-based inequities against patients during care and the link to implicit bias are documented components of exclusive breastfeeding disparities (Thomas, 2018a). Black mothers continue to have the lowest rates of exclusive breastfeeding initiation (Beauregard et al., 2019).

Stangl et al. (2019) asserted that health care stigmas related to stereotyping, prejudices, discrimination, behavior, and attitudes influence population health outcomes, worsening, undermining, or impeding several processes, including social relationships, resource availability, stress, and psychological and behavioral responses, exacerbating the issues that lead to poor health. Priest and Williams (2018) illustrated the tangible consequences of the lived experiences of invisibility, exclusion, and hostility in health care as experienced by Black mothers. Other consequences include decreased educational attainment, more inadequate decision making, and

failure to obtain necessary health care (Priest & Williams, 2018). Little information in the literature has adequately identified remedies for the racism or discriminatory practices against patients during the birthing process and the immediate postpartum such as health care provider bias, which influences exclusive breastfeeding initiation and duration (Griswold et al., 2018; Thomas, 2018a). This study fills a gap in research by focusing on Black mothers' experiences of perceived racial discrimination after giving birth in birthing centers, the influence these experiences have on exclusive breastfeeding initiation and duration, and how these experiences may have led to suboptimal health outcomes for these Black mothers and their infants.

Purpose Statement

In this basic qualitative study, I explored how Black mothers' experiences of perceived racial discrimination after giving birth in birthing centers were a factor in the initiation and duration of exclusive breastfeeding practices. The purpose of this basic qualitative study was to examine and describe how the individual, interpersonal, and community factors, as well as the organizational structures and existing policies in birthing centers are perceived by Black mothers. Data collected from participants provide a means to better understand the individual, interpersonal, and community factors affecting the initiation and duration of exclusive breastfeeding practices among Black mothers after giving birth in birthing centers. Additionally, understanding the participants' perceptions of institutional biases, racism, and discrimination in the institutional structures and existing policies of these birthing centers can lead to change to better serve Black mothers in relation to exclusive breastfeeding initiation and duration. Additionally, awareness of Black mothers' perceptions of bias and racism in birthing centers could promote changes in birthing center policies, practices, and procedures that

disproportionately and negatively affect this population. Ultimately, this awareness may promote healthy discussions on how to serve Black mothers better.

Research Questions

RQ: How do Black mothers' experiences in birthing centers and their perceptions of racism and discrimination affect their initiation and duration of exclusive breastfeeding with their newborn infant?

Subquestions

SRQ1: How do Black mothers describe individual and interpersonal barriers in birthing centers that affect their attitudes and beliefs regarding exclusive breastfeeding of their infant?

SRQ2: How do Black mothers describe the interpersonal relationship with health care professionals in birthing centers regarding behavior that could be perceived as racist or discriminatory and its contribution to their experiences with exclusive breastfeeding?

SRQ3: How do Black mothers perceive the community-level factors of racism and discrimination surrounding birthing centers wherein social relationships become a factor in exclusive breastfeeding practices?

SRQ4: How do Black mothers perceive health care policies, practices, and procedures in birthing centers that could be perceived as biased affect a Black mothers' decisions to breastfeed exclusively?

Theoretical and Conceptual Framework

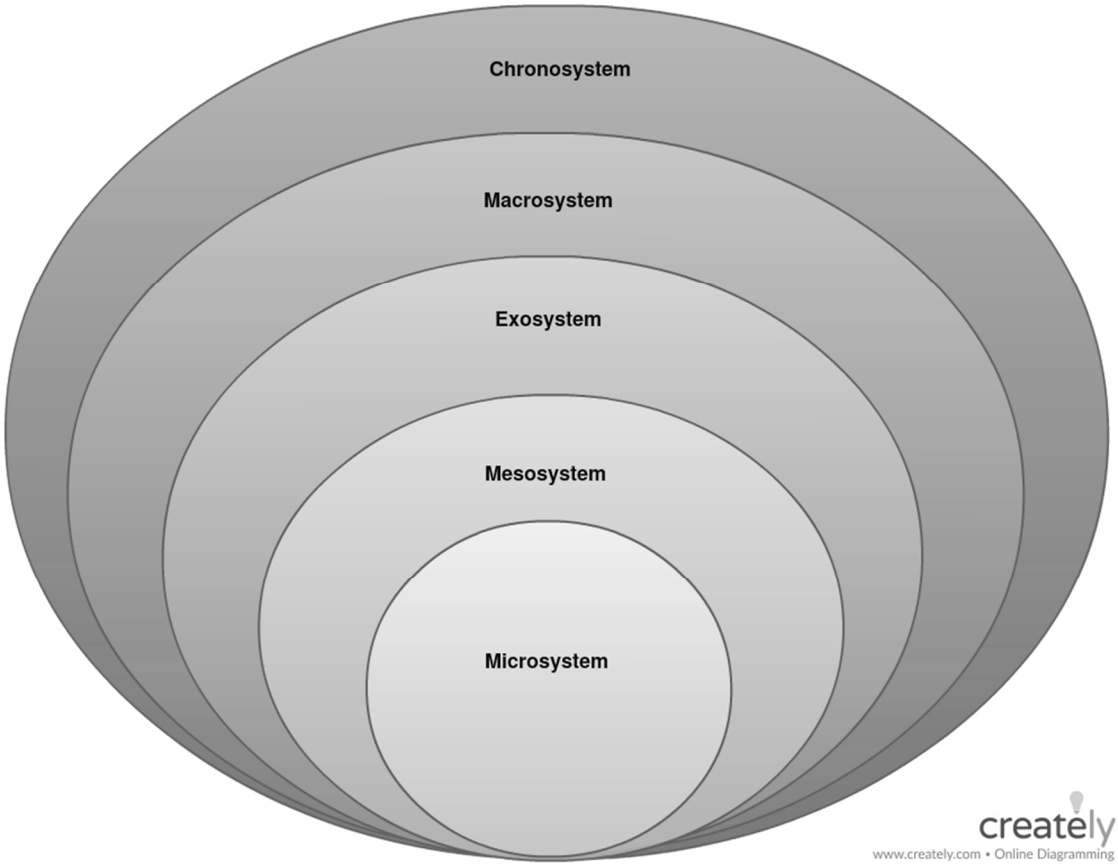
The conceptual framework selected for this study was based on SEM. The SEM was used to understand individual, interpersonal, and community-levels factors as well as institutional and policy influences that impede exclusive breastfeeding among Black mothers. The SEM was first

introduced in the 1970s by Urie Bronfenbrenner as a broad conceptual model for understanding human behavior. The model has since been adopted by many users, including the WHO and CDC (Kilanowski, 2017; Lee et al.; 2017). This multidimensional model illustrates the complexities that exist between human interactions and behavioral influences.

According to Bronfenbrenner's SEM, microsystems have the most potent influences and encompass the face-to-face interactions and relationships of the immediate surroundings (Kilanowski, 2017; McLeroy et al., 1988). The second innermost circle, the mesosystem, includes these relationships and the interactions between individuals and those they may have direct contact with (Kilanowski, 2017; Lee et al., 2017). The exosystem illustrates interactive influences on the individual, such as community and social networks (Kilanowski, 2017; Lee et al., 2017). The next circle, the macrosystem, includes societal, religious, and cultural values and influences (Kilanowski, 2017; Lee et al., 2017). Lastly, the chronosystem level includes the influence of policy guided by internal and external elements of time and historical content (Kilanowski, 2017; Lee et al., 2017; McCormack et al., 2017). Figure 1 is an illustration of Bronfenbrenner's social–ecological conceptual model showing nesting circles of various systems from chronosystem down to microsystem.

Figure 1

Social–Ecological Model Approach



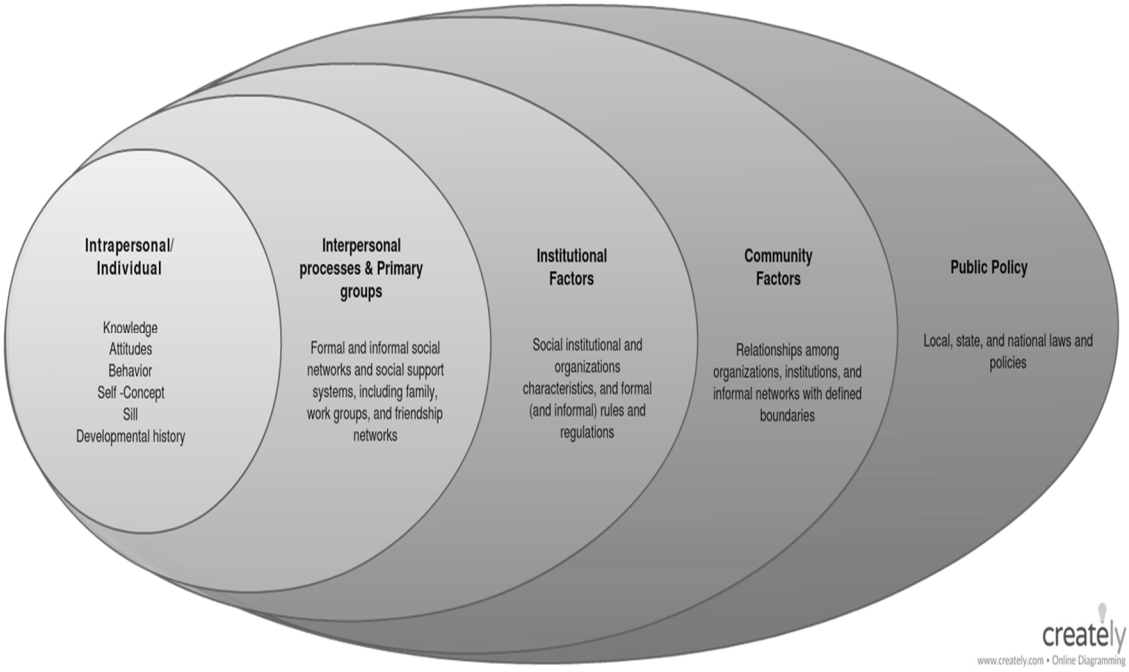
The SEM is a multifaceted framework that can be applied to understand health behavior. The model assumes that no single factor influences people's behavior; instead, it is a complex interaction among individuals and their environment (Perrin, 2016; United Nations International Children's Emergency Fund [UNICEF], 2016). The construct of SEM conceptualized that health is affected by the interaction between the characteristics of the individual, the community, and the environment, including the physical, social, and political components (Kilanowski, 2017; Lee et al., 2017). The inclusion of social and physical environment factors is an essential part of the SEM that shapes or constrains individual and interpersonal determinants of health behavior

(Glanz et al., 2008). The SEM is used to examine a full scale of elements that influence and contribute to the prevalence, prevention, and evaluation of programs and health behaviors (Glanz et al., 2008; Kilanowski, 2017).

Characteristics of the intrapersonal/individual level are factors that influence knowledge, attitudes, behavior, self-concept, skills, personality, and developmental history (Glanz et al., 2008). Formal and informal social networks and social support systems make up interpersonal-level influences involving family members, work relationships, and friendship networks that provide social support or create barriers to interpersonal growth that promotes healthy behavior (Glanz et al., 2008; Kilanowski, 2017; McLeroy et al., 1988). Institution-level characteristics include organizational formal (and informal) rules and regulations for operations that constrain or promote healthy behaviors (Glanz et al., 2008; Kilanowski, 2017; McLeroy et al., 1988). Relationships that exist among individuals, groups, organizations, institutions, and informational networks within defined boundaries can limit or enhance health behaviors (Glanz et al., 2008; Kilanowski, 2017; McLeroy et al., 1988). Lastly, the SEM policy level involves local, state, national, and global laws and policies that regulate or support health actions and practices (Glanz et al., 2008; Kilanowski, 2017; McLeroy et al., 1988). Figure 2 depicts McLeroy et al.'s (1988) social ecology approach to health promotion interventions.

Figure 2

Adapted Social–Ecological Model Approach



In this study, I explored SEM's hierarchical levels to include individual, interpersonal, organizational, and community/environment factors that influence Black mothers' decision to breastfeed. Specifically, I explored Black mothers' views of their experiences with perceived racism or discriminatory practices in birthing centers and the influence of those experiences on breastfeeding initiation and duration. I also explored whether Black mothers' views of exclusive breastfeeding were supported by those around them, and Black mothers' views on the policies and practices in birthing centers that may have affected their decisions to breastfeed. Figure 3 is a conceptual model applying the SEM to factors in birthing centers that affect Black mothers in relation to breastfeeding behaviors. The SEM is most useful for this research study because it helps to understand individual and group behaviors within the context of their environment; these are the social and physical situations in which behaviors occur (Hayden, 2017). The model

in Figure 4 shows a conceptual framework of factors in birthing centers that impede exclusive breastfeeding among Black mothers.

Figure 3

Application of the Social–Ecological Model

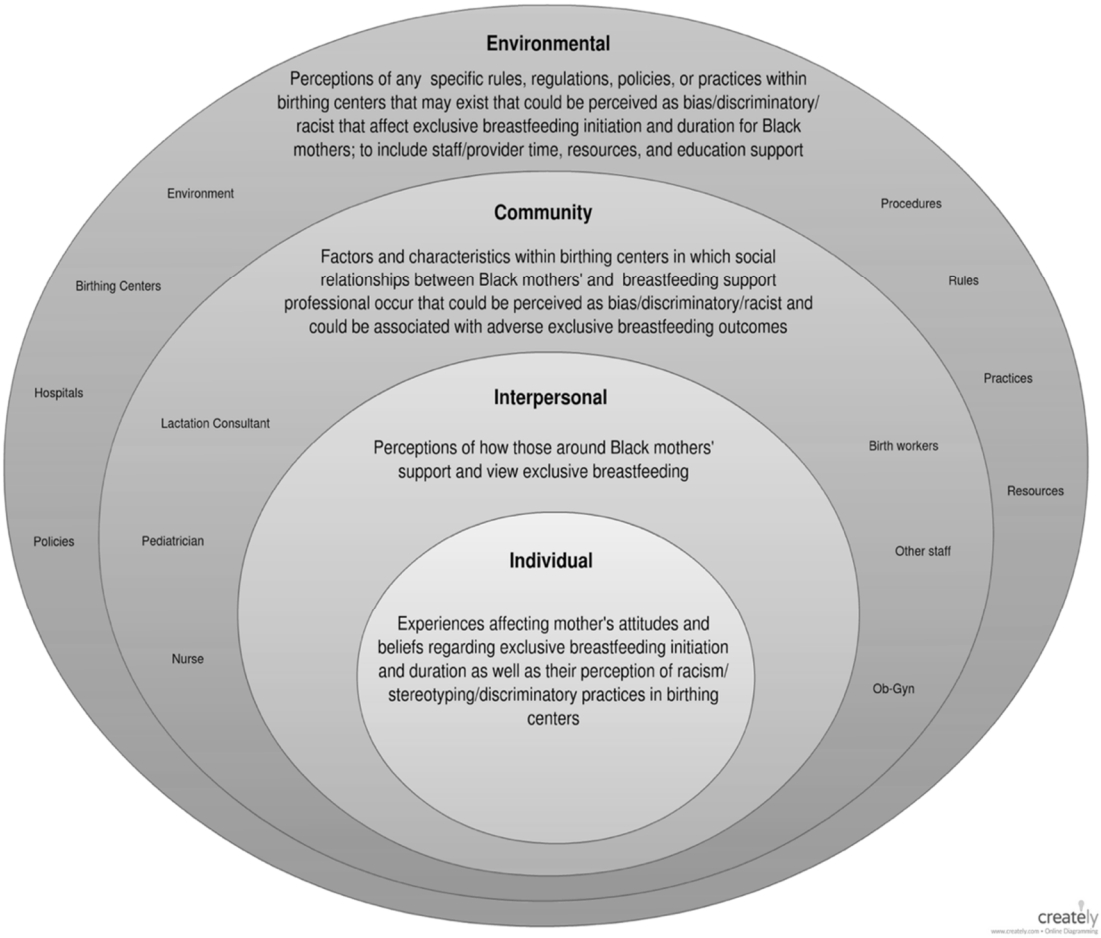
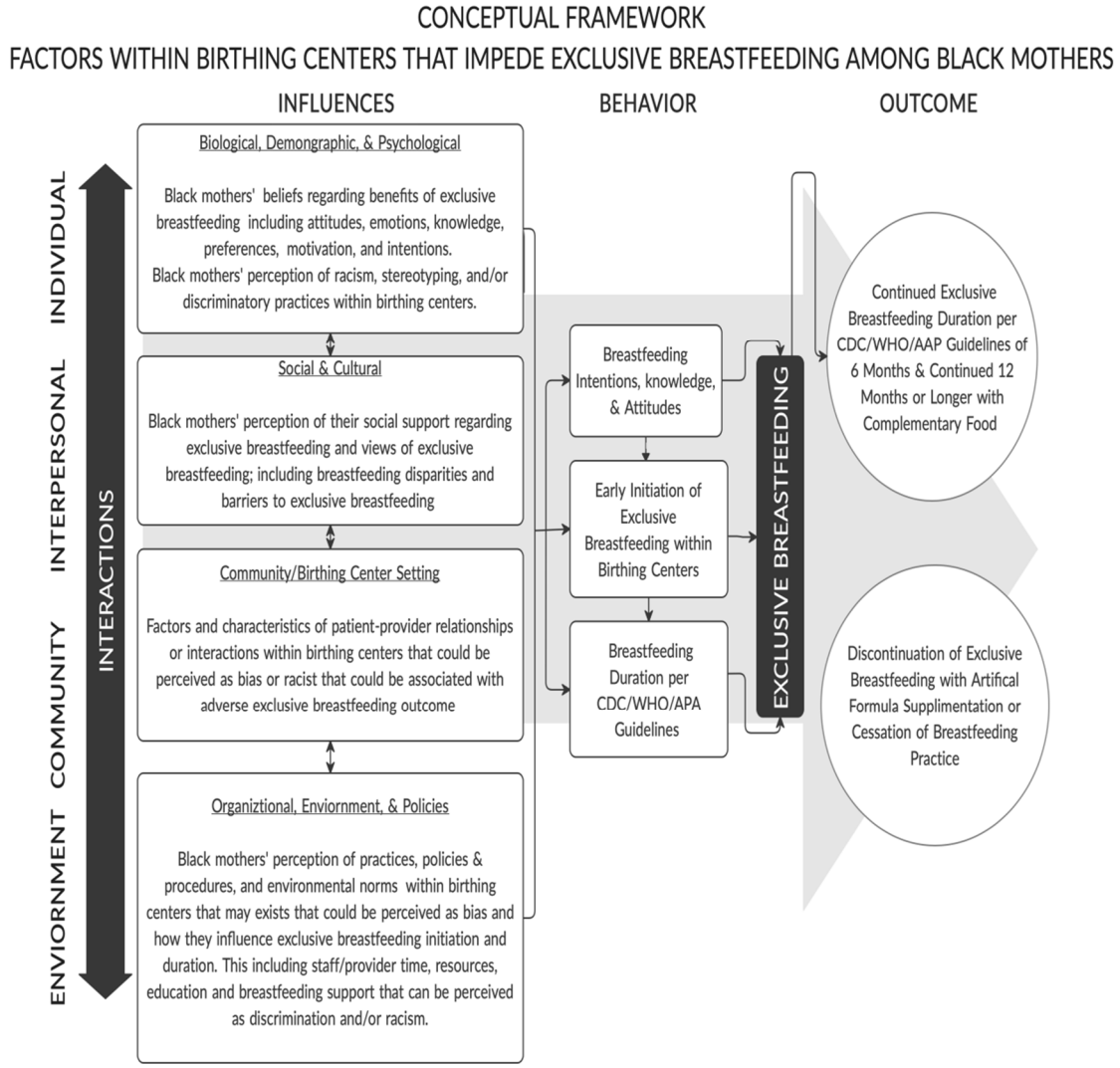


Figure 4

Conceptual Framework



Nature of the Study

This study was a basic qualitative design. To collect data, I used in-depth one-on-one semistructured video interviews through teleconference platforms with Black mothers who have given birth in birthing centers. Data were collected to explore how racism and discrimination in birthing centers affects the initiation and duration of exclusive breastfeeding practice among

Black mothers. In this basic qualitative study, I examined and described how the individual, interpersonal, and community factors as well as the organizational structures and existing policies in birthing centers are perceived by Black mothers. I also explored how Black mothers identified perceived racial discrimination after giving birth in a birthing center. According to Patton (2015), a basic qualitative inquiry aims for an in-depth, individualized, and contextual understanding of experiences, attitudes, and beliefs; in this study, I was focused on provider–patient care interaction and perception of racism, bias, or race-based discrimination (Thomas, 2018a).

The basic qualitative research design was chosen for this study because such a design is used to discover and understand (a) how people interpret their experiences, (b) how they construct their worldview, and (c) what meaning they attribute to their experiences. A basic qualitative research design is intended to obtain in-depth understanding, interpretation, and meaning of the lived experiences of participants (Merriam & Tisdell, 2015; Sale & Thielke, 2018). The inclusion criteria for this study were Black mothers who have delivered an infant within the last year who stated they experienced racism or discrimination in a birthing center.

Through basic qualitative inquiry, a researcher seeks to investigate participants' attitudes, opinions, ideas, or beliefs about a lived experience or issue (Percy et al., 2015). This project aligned with the basic qualitative methodology because little information was found in the literature that adequately identifies, addresses, and remedies how racism or discriminatory practices against patients during the birthing process and during the immediate postpartum stay influence exclusive breastfeeding initiation and duration (Griswold et al., 2018; Thomas, 2018a).

Definition of Terms

Birthing center: For the purpose of this study, this includes any and all birthing facilities, freestanding birthing centers, delivering hospitals, and health care facilities in the United States staffed by nurse midwives, midwives, and/or obstetricians, where mothers are assisted while in labor and delivery (Merriam-Webster, n.d.a).

Black: People who identify as African American who are descendants of slaves brought to the United States involuntarily, and the offspring born in the United States from families that originally came from Africa, regardless of additional ethnicity or race. These individuals may have varying ethnicities but have cultures that are historically rooted in the U.S. slave trade that brought people mostly from West and South Africa (Baugh, 2018; Merriam-Webster, n.d.a).

Discrimination: The act, practice, or instance of less than favorable treatment, prejudice, and refusal of rights against individuals based on skin color; usually against a group classified as a minority group compared to members of a majority group in similar circumstances (Bertrand & Duflo, 2017; Cambridge Dictionary Online, 2020; Merriam-Webster. (n.d.a).

Exclusive breastfeeding: Infant receives no other liquid or solid, excluding oral rehydration solution, vitamins, minerals or medicines, only human breast milk either directly from breasts or expressed from human breasts (Hunegnaw et al., 2017; UNICEF, 2016; WHO, 2019)

Health care professionals: Individuals who maintain health in humans through the application of the principles and procedures of evidence-based medicine and care, study, diagnose, treat, and prevent human illness, injury, and other physical and mental impairments; they professionals advise on or apply preventive and curative measures and promote health with

the ultimate goal of meeting the health needs and expectations of individuals and populations and improving population health outcomes (WHO, 2013).

Health care staff: two or more health professionals and other lay or professionals who work together to apply their complementary professional skills to accomplish an agreed-upon goal of coordinated, comprehensive patient care (Chamberlain-Salaun & Usher, 2013).

Institutional racism (organizational racism): How institutions operate systematically, both overtly and inherently, via the reinforcement and adoption of racist policies, procedures, operations, and culture that exclude Black people or create barriers preventing Black people from accessing quality health and resources (American Academy of Pediatrics [AAP], 2019; APA, 2019).

Perceived racism: The recognition of racism based on everyday unfair treatment and discrimination associated with behaviors for racial and nonracial attributes, negative attitudes and beliefs toward racial outgroups (prejudice), and differential treatment of members of these groups by both individuals and social institutions (discrimination); triggered by elevated exposure to traditional and racism-related stressors, especially those linked to social and economic deprivation (Glover et al., 2017; Hill et al., 2017).

Racial discrimination: A particular type of discrimination or unfavorable treatment specifically targeting members of racial and ethnic minorities due to characteristics associated with race such as hair texture, skin color, or certain facial features as well as particular policy or work procedures that put people of certain racial groups at a disadvantage (Assari et al., 2017; Tajeu et al., 2015).

Uncomplicated delivery: An uncomplicated spontaneous vaginal delivery is the most common type of birth. When vaginal labor and delivery is straightforward, it is considered an uncomplicated process. When assistance is needed in delivery, this is considered a *complicated delivery*. This need for assistance can vary from Cesarean section, blood loss, fetal injury, small baby, diabetes, high blood pressure disorders, substance abuse history, and status as positive for human immunodeficiency virus (American Academy of Family Physicians, 2019).

Assumptions

For this study, the single ethnicity being reflected by the participants are those who meet the definition of *Black*, which was used instead of *African American*. As defined in this study, participating mothers identify as African American or Black and are descendants of slaves brought to the United States involuntarily. The offspring born in the United States from families that originally came from Africa and lived under institutionalized slavery in the United States. These individuals may have varying ethnicities but have cultures that are historically rooted in the U.S. slave trade (Baugh, 2018; Slaves, n.d.). These assumptions were made because of the varying degree of individuals who identify as African American/Black from different ethnic and cultural backgrounds. An assumption was made that the participants answered the interview questions honestly and candidly. Regarding the nature of this study, an assumption was made that the participants have all experienced the same or similar phenomenon of race-based discrimination, health care bias, and racism. Lastly, it was assumed that participants had a sincere interest in participating in this research study and did not have any other motives for their participation.

Scope and Delimitations

The scope of this study was Black mothers who could speak to their experiences of racism and discrimination in birthing centers, including background comments and actions of health care providers and staff members, as well as policies and procedures perceived as discriminatory or racist. All participants were required to have had an uncomplicated vaginal delivery of full-term infants who required only well-newborn care. The two types of sampling used were purposeful sampling and snowball sampling. Initially, I used purposeful sampling to select participants who met the preselected criteria based on the research question. I used snowball sampling to obtain additional referrals to other people who may fit the criteria. In-depth one-on-one semistructured video interviews were conducted using online teleconference platforms or audio-only telephone interviews as the primary source of data for this study.

Black mothers who had recently delivered an infant within the last 24 months were the primary data source. I recruited potential participants for this study via social media through Facebook and through local birthing and maternal child health facilities and exclusive breastfeeding support groups. Mothers who had complications associated with labor and delivery, including delivery by cesarean section, and were unable to initiate exclusive breastfeeding due to medical contraindication were excluded from this study. Mothers who delivered preterm or infants who required a stay in the neonatal intensive care unit, mothers who delivered less than 37 weeks' gestation, and if mother or baby had any medical condition requiring formula supplementation were not eligible to participate in the study.

The main delimitation for this study was to explore how the experiences of Black mothers in birthing centers and their perceptions of racism and discrimination affect the initiation

and duration of exclusive breastfeeding practice. Transferability was established by providing in-depth contextual details that allow readers to understand the factors, participants, and experiences regarding how racism and discrimination in health care settings become a factor in the initiation and duration of exclusive breastfeeding practices of Black mothers, not to generalize findings but to provide sufficient thick description to illustrate that the findings of this study could apply to contexts and circumstances similar to this study (Bloomberg & Volpe, 2019). Lastly, due to the lack of available relevant and reliable data surrounding exclusive breastfeeding and race-based discrimination and racism during prenatal and postnatal care, the scope of the analysis was limited to exploring the awareness of how Black mothers feel concerning their caregivers in health care environments.

Limitations

Given the scope of the study, acquiring an adequate sample size of participants willing to discuss their experiences was a challenge. Additionally, participants' reliability and their honesty when discussing such a sensitive topic could be an issue if participants were not entirely truthful due to the nature of the study. Furthermore, an additional limitation to this study was the sampling methodology. Participants in this study were selected via purposeful and snowball sampling, which limited to participants linked with the aims of the investigation (Palinkas et al., 2015), which are Black mothers who can speak to their experiences of racism and discrimination in birthing centers including background comments and actions of health care providers and staff members as well as policies and procedures perceived as discriminatory or racist. Another potential limitation was that women who do not have access to the internet, a mobile device, or a

wireless connection may have been left out of the study as the study was completed using these technologies.

Potential researcher bias as a result of my role as a lactation consultant and my knowledge of breastfeeding support strategies as well as policies and procedures in birthing centers was addressed by self-reflection and bracketing (Bloomberg & Volpe, 2019) to avoid influencing the data collection and analysis process; I also used audio recordings to ensure accuracy of responses. During the data analysis phase, information collected from participates via auto and video recording were transcribed by a third-party transcription service in addition to the use of a research assistant, myself, and Atlas.Ti 9 MacOS qualitative software for coding data and identifying themes.

Significance of the Study

This research fills a gap in understanding how individual, interpersonal, and community-level factors may affect Black mothers' decision-making regarding exclusive breastfeeding initiation and duration. Additionally, this research can create a better understanding of how Black mothers' perceptions of racial biases in the institutional and existing policies in birthing centers may affect the initiation and duration of exclusive breastfeeding practices.

The results of this study contribute to the advancement of knowledge by informing the health education discipline and emboldening populations to engage in more healthy behavior and health-seeking behavior by satisfying significant knowledge gaps regarding the initiation and duration of exclusive breastfeeding practices of Black mothers and Black mothers' perceptions of racial biases in the institutional and existing policies in birthing centers (National Commission for Health Education Credentialing [NCHEC], 2015). This study provides insight into addressing

problems, such as (a) how to reduce disparities in exclusive breastfeeding rates associated with race/ethnicity and income (McGuire, 2011; Office of the Surgeon General U.S. Department of Health & Human Services [HHS], 2011); (b) how to develop best practices for management and support of exclusive breastfeeding for this population through evidence-based findings, subsequently leading to improved strategies that could result in higher breastfeeding rates and have a major impact on public health (McGuire, 2011; NCHEC, 2015; Trent et al., 2019). This research connection with the health education and promotion discipline includes the collection of primary data to determine the needs of this population and to analyze the relationships among behavioral, environmental, and other factors that influence behaviors that impact their health in addition to assessing the social, environmental, political, and other factors that may impact health education/promotion regarding exclusive breastfeeding (NCHEC, 2015).

The institutional factors and existing policies experienced in birthing centers may become a factor in initiating and sustaining exclusive breastfeeding during and after Black mothers' hospital stays. Racial health disparities due to structural racism are woven into the social and institutional structure of the United States and continue to show negative impacts for Black people compared to their White counterparts (Assari, 2018; Bailey et al., 2017; Bleich et al., 2019; Trent et al., 2019). These negative impacts also include racial disparities regarding exclusive breastfeeding initiation and duration (Jones et al., 2015; Thomas, 2018b). Disproportionately, Black mothers and their infants are affected by adverse health outcomes, which could be improved through the initiation and duration of exclusive breastfeeding (Jones et al., 2015). Unsurprisingly, the CDC (2018c) rates the current health status of Black people as fair or poor (Assari, 2018; CDC, 2018a; Prather et al., 2018; HHS Office of Minority Health, 2018).

Black Americans historically carry a higher burden of disease and the public health burden of higher rates of infant death (Assari, 2018; CDC, 2018a; HHS Office of Minority Health, 2018; Prather et al., 2018).

With a 17 percentage-point gap in the prevalence of initiation and duration of exclusive breastfeeding between Black and White mothers (Reis-Reilly et al., 2018) and the rising concerns of reducing exclusive breastfeeding disparities in the United States (CDC, 2018b), it is critical to investigate the individual, interpersonal, and community-level factors and the institutional structures and existing policies in birthing centers that may inadvertently harbor biases that may impede care (Thomas, 2018a). Supporting evidence links racially based biases and practices of health care providers to racial and ethnic health disparities (Crossley, 2016; Paradies et al., 2013). However, little is known about the phenomenon in terms of exclusive breastfeeding initiation and duration among Black mothers (Thomas, 2018b). Exclusive breastfeeding rates have been on the rise with the help of health communication campaigns triggered by the surgeon general's call to action to support exclusive breastfeeding and the Healthy People 2020 Maternal, Infant, and Child Health goals. Nonetheless, the health gap between Black mothers and White mothers has not decreased in relation to exclusive breastfeeding rates (CDC, 2018c; Thomas, 2018a).

The results of this study could lead to positive social change by providing an insight into Black mothers' experiences individually, interpersonally, and within their community regarding exclusive breastfeeding. Furthermore, in this study I examined how perceived implicit (unconscious) bias, racism, and discrimination in the institutional structure and existing policies of birthing centers may influence the initiation and duration of exclusive breastfeeding among

Black mothers. The insight gained from this study provides awareness surrounding cultural sensitivity in the birthing care system regarding exclusive breastfeeding initiation and duration, including workplace diversity and cultural competency. Lastly, the result of this study provide a better understanding and could lead to positive social change in the policies, practices, and procedures in birthing centers that may be perceived as racially biased and discriminatory treatment of Black mothers who may impede or hinder initiation and duration of exclusive breastfeeding practices. Such interventions can impact the individual, the interpersonal, and community-level factors and the institutional and political norms surrounding exclusive breastfeeding practices among Black mothers.

Summary

Race-based inequities against patients during care and its link to implicit bias are documented components of disparities in exclusive breastfeeding rates (Thomas, 2018a). Black mothers continue to have the lowest exclusive breastfeeding initiation rates compared to all other racial and ethnic groups in the United States (Beauregard et al., 2019). In this chapter, I provided an overview of the study and the use of SEM to help in understanding how Black mothers experiences of perceived racial discrimination after giving birth in birthing centers become a factor in initiation and duration of exclusive breastfeeding practices. In Chapter 2, I present a review of the literature on attitudes and beliefs regarding exclusive breastfeeding practices among Black mothers, breastfeeding perceptions and intentions of Black mothers, experiences of perceived racism and discrimination in health care settings, and how SEM has been used to address this research area.

Chapter 2: Literature Review

Introduction

In this basic qualitative study, I explored Black mothers' experiences of perceived racial discrimination after giving birth in birthing centers and how those experiences factor into their initiation and duration of exclusive breastfeeding practices for their newborns. I further explored how individual, interpersonal, and community factors, as well as the organizational structures and existing policies in birthing centers are perceived by Black mothers. The feedback provided from the participants may lead to a better understanding of the individual, interpersonal, and community-level factors affecting the initiation and duration of exclusive breastfeeding among Black mothers' giving birth in birthing centers. In addition, understanding the perceptions of institutional biases, racism, and discrimination within institutional structures and existing policies of these birthing centers may assist in better serving Black mothers related to exclusive breastfeeding initiation and duration.

In Chapter 1, I introduced the phenomenon under study, the problem, purpose, background, research questions, and nature of the study. I also discussed the study's significance, definitions of terms, and limitations. In Chapter 2, I explore peer-reviewed literature on Black mothers' experiences of perceived racial discrimination after giving birth in birthing centers. These experiences factor into the initiation and duration of exclusive breastfeeding practices of Black mothers with their newborn infants.

Literature Search Strategy

In this section, I describe peer-reviewed articles and dissertations I selected related to exclusive breastfeeding disparities and health care discrimination. The keywords and phrases I

searched included *benefits of exclusive breastfeeding, breastfeeding attitudes of Black women, exclusive breastfeeding motivation and intention, exclusive breastfeeding disparities and barriers, racism & health outcomes of Black women, perceived prejudice in health care, organizational discrimination in health care, institutional racism,* and *patient–provider relationship and racism*. I searched in the following databases: SAGE Journals, BioMedCentral, MEDLINE, ProQuest, U.S. Department of Human Services, UNICEF, and Google Scholar.

Theoretical and Conceptual Framework

The Social–Ecological Model

The SEM of health behavior includes visual depictions of dynamic relationships among individuals, groups, and their environments with an emphasis on environmental and policy in the context of behavior, while incorporating social and psychological influences (Golden et al., 2015; McCormack et al., 2017; Sallis et al., 2015). The fundamental constructs of SEM originated from the notion that individuals are influenced by multiple types of factors, including intrapersonal (biological, psychological), interpersonal (social, cultural), organizational/community, physical environmental, and policy (Golden et al., 2015; McCormack et al., 2017; Sallis et al., 2015). The SEM provides a comprehensive insight of the multilevel interaction and the relationship that exists between individuals and their environment as underlying determinants of health behaviors (Golden et al., 2015; McCormack et al., 2017; Sallis et al., 2015).

The theoretical framework selected for this study helps to understand individual, interpersonal, and community-level factors, as well as institutional and policy levels that impede exclusive breastfeeding among Black mothers. The SEM is a multifaceted framework that helps

researchers understand health behavior and assumes that no single factor influences individuals' behavior; instead, it is a complex interaction between individuals and their environments (Perrin, 2016; UNICEF, 2016). Specifically, in this study, I explored the hierarchical levels of SEM that influence Black mothers' decisions to initiate and sustain exclusive breastfeeding. I explored how Black mothers view their experiences with initiating exclusive breastfeeding and their perceptions of racism or discriminatory practices in the birthing centers during their postnatal care. In addition, I explored how exclusive breastfeeding is supported and viewed by those within Black mothers' interpersonal circles and birthing center policies and practices that may have affected Black mothers' decisions to exclusively breastfeed.

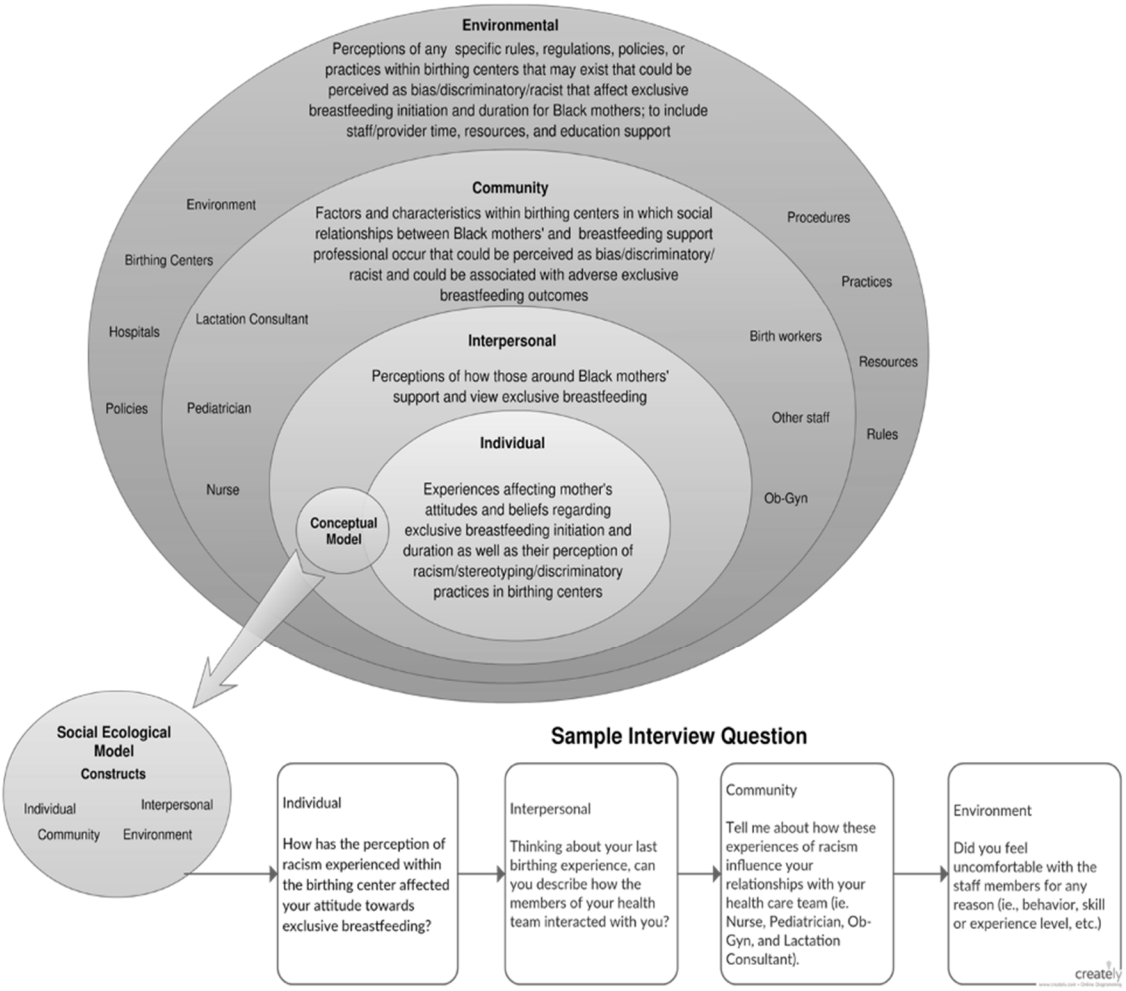
The SEM was an appropriate theoretical framework for this study because the SEM allows researchers to examine how the interaction of multiple factors within the social environment influence health behavior (Hayden, 2017; Munn et al., 2016). Thus, the SEM provides a deeper understanding of the phenomenon and offers insight into the interactions and influence of perceived racial discrimination of Black mothers in the context of birthing centers. These are the social and physical situations in which early initiation of exclusive breastfeeding take place (Hayden, 2017; Munn et al., 2016).

For this basic qualitative study, the SEM provided a framework for understanding Black mothers' experiences of perceived racial discrimination after giving birth in birthing centers and how those experiences factor into initiation and duration of exclusive breastfeeding practices. In this study, I used the SEM to examine how each level's interaction affects exclusive breastfeeding initiation and duration in the context of birthing centers. As illustrated in Figure 5, the SEM can be used to explain how exclusive breastfeeding outcomes are influenced by factors

associated with perception of racism or discrimination toward Black mothers (mother–infant dyad), health care professionals, community, and environmental levels.

Figure 5

Application of the Social–Ecological Model



The individual and interpersonal levels of the SEM are used to explore how the experiences of perceived racism by Black mothers affects their attitudes, beliefs, and perceptions regarding exclusive breastfeeding initiation and duration, as well as their perceptions of others' views and support of exclusive breastfeeding initiation and duration. Black mothers'

breastfeeding self-efficacy and motivation are directly influenced by these factors, which impact exclusive breastfeeding initiation and duration of Black mothers (Dunn et al., 2015; Golden et al., 2015; Hayden, 2017; Munn et al., 2016). At the community level, I investigated the social relationships in birthing centers between Black mothers and health providers who nurture Black mothers' attitudes and motivations regarding exclusive breastfeeding initiation and duration. I also explored how these interactions could be perceived as biased, discriminatory, or racist and the association with adverse exclusive breastfeeding outcomes (Dunn et al., 2015; Golden et al., 2015; Hayden, 2017; Munn et al., 2016). Last, I used the environmental level of the SEM to examine Black mothers' perceptions of the quality of care and discrimination in birthing centers, including staff education, training, and knowledge availability and time spent with Black mothers and access to resources (Dunn et al., 2015; Golden et al., 2015; Hayden, 2017; Munn et al., 2016).

Dunn et al. (2015) conducted a qualitative assessment using a community breastfeeding promotion coalition and field-based focus groups. The researchers found that the SEM provided a means for an in-depth examination of personal attributes and environmental circumstances that aid in the understanding of determinants that influence Black mothers' decisions for exclusive breastfeeding initiation and duration practices (Dunn et al., 2015). At the individual level, both barriers and positive contributors were identified with breastfeeding, support, and general knowledge on the importance of breastfeeding (Dunn et al., 2015; Munn et al., 2016). The influence of social relationships between parents, partners, and relatives was identified as a barrier and positive contributors to breastfeeding at the interpersonal level (Dunn et al., 2015; Munn et al., 2016). At the community level, breastfeeding in public as a social norm was

identified, as there are limited positive portrayals of breastfeeding compared to formula displays. At the organizational level, misinformation and lack of health care professional support contributed to breastfeeding barriers, yet the authors' finding revealed that baby-friendly hospital practices supported breastfeeding (Dunn et al., 2015; Munn et al., 2016). Barriers and contributors to breastfeeding were identified and spanned across each level of the SEM, revealing how the levels are intertwined and contribute to personal attributes and environmental circumstances that aid in understanding determinants that influence Black mothers' decisions for initiation and duration of exclusive breastfeeding practices (Dunn et al., 2015; Munn et al., 2016).

Literature Review Related to Key Variables

Benefits of Exclusive Breastfeeding

The first 1,000 days of an infant's life, beginning with maternal conception, is the most critical time for proper nutrition, health, and development because during this period, the infant is provided all the vitamins, minerals, and antibodies needed to grow and thrive (Binns et al., 2016; UNICEF, 2018). Exclusive breastfeeding is a source of essential nutrition and optimal health for most infants (AAP, 2019; National Institute of Child Health and Human Development, 2019). Six months of exclusive breastfeeding and continuing breastfeeding while introducing complementary foods until age 24 months or older is ideal for optimal nutrition and support for the growth and development of children, according to the AAP (2019) and WHO (2019).

Binns et al. (2016) conducted a systematic review of the association between exclusive breastfeeding and early development and long-term health benefits, and findings aligned with those from WHO (2019) and UNICEF (2018) regarding reduced incidences of health conditions

for both infants and mothers. The infant gut microbiome is significantly shaped by the mode of delivery transmitting beneficial microbiota from mother to infant and infant diet, which provide maturation of the gut, acquired immune system, and metabolism (O'Sullivan et al., 2015). The effects of breast milk on the human microbiome are significant in reducing childhood illnesses (Binns et al., 2016; O'Sullivan et al., 2015). These illnesses include diarrhea, necrotizing enterocolitis, otitis media, late-onset sepsis in preterm infants, Type 1 and Type 2 diabetes, lymphoma, leukemia, and childhood obesity (AAP, 2019; Binns et al., 2016; CDC, 2018a, National Institute of Child Health and Human Development, 2019; Wallace, et al., 2017).

UNICEF (2018) explained that an estimated 800,000 deaths of children younger than 5 years and 20,000 deaths of women would be prevented each year by meeting breastfeeding recommendations (CDC, 2018a; WHO, 2019). Long-sustained duration of breastfeeding is associated with maternal health benefits (Binns et al., 2016). Further, breastfeeding has been associated with decreased menstrual blood loss and postpartum bleeding due to rapid uterine involution, as well as lactational amenorrhea (increased child spacing), swifter return to prepregnancy weight as a result of burning additional calories, and reduced risk of breast and ovarian cancers (AAP, 2019; CDC, 2018b; Louis-Jacques et al., 2017a).

Breastfeeding Attitudes Among Black Women

Intentions of exclusive breastfeeding initiation and duration, attitudes toward exclusive breastfeeding initiation and duration, and perceptions of exclusive breastfeeding initiation and duration are influenced by interactions between Black mothers and their environments. In a qualitative study, Barbosa et al. (2017) conducted mini focus groups, according to the SEM, discussing attitudes toward infant feeding practices and intentions. The researchers found that

Black mothers demonstrate determination, persistence, assertiveness, self-reliance, confidence, and resourcefulness (Barbosa et al., 2017; Kamoun & Spatz, 2017).

Despite being aware of adverse social norms, attitudes toward breastfeeding in public, or breastfeeding barriers, Black mothers were consistent in their decision to initiate breastfeeding (Reno et al., 2018). Similarly, Reno et al. (2018) found that Black mothers held favorable attitudes toward exclusive breastfeeding initiation and duration and demonstrated a sound understanding of both the economic and health advantages of breastfeeding. Kim et al. (2017) attributed knowledge about the benefits of breastfeeding to Black mothers' positive attitudes toward exclusive breastfeeding initiation and duration as a preferred infant feeding choice. Jefferson (2015) found that positive attitudes toward exclusive breastfeeding initiation and duration to be the strongest predictor for intentions to breastfeed compared to overall knowledge.

Exclusive Breastfeeding Motivation and Intention

The decision to breastfeed, also known as *breastfeeding intentions*, is often made before conception. Unlike breastfeeding attitudes, breastfeeding intentions are more often associated with exposure to breastfeeding and individual values surrounding the benefits of exclusive breastfeeding initiation and duration (Barbosa et al., 2017; Kamoun & Spatz, 2017; Lok et al., 2017; Reyes et al., 2019). Nnebe-Agumadu et al. (2016) found that among mothers who participated in the U.S. Infant Feeding Practices Study II (IFPS II), of those who had the intention to breastfeed, nearly one third of mothers strongly valued exclusive breastfeeding. Despite the strong association between maternal breastfeeding attitudes and behavioral intent of the mothers who established intention and initiated exclusive breastfeeding, many of them still

did not accomplish the recommended duration of breastfeeding (Jefferson, 2016; Nnebe-Agumadu et al., 2016).

Exclusive Breastfeeding Disparities and Barriers

Historically, Blacks have suffered physical, mental, and social brutalization, extending beyond slavery, resulting in systematic discrimination for more than 150 years post slavery. More specifically, Blacks have continued to endure health disparities compared with those who identify as White in the United States and have remained below the target Healthy People Goals established by the U.S. Department of Health and Human Services (Assari, 2018, Louis-Jacques et al., 2017b, U.S. Department of Health and Human Services [HHS], 2011). Black mothers' continue to have the lowest rates of exclusive breastfeeding initiation, at 69.5% compared with 85.9% among white mothers, as well as continuation at 3 months, at 36.0% compared with their white counterparts at 53.0%. At 6 months, these percentages are 17.2% among Black mothers compared with 29.5% among White mothers, when compared with all other racial and ethnic groups in the United States (Beauregard et al., 2019). These disparities disproportionally affect Black mothers' and have been associated with a more significant burden of disease and mortality, including health conditions that are more prevalent among Black mothers' such as sudden infant death syndrome (Bartick, Jegier, et al., 2017; Bartick, Schwartz, et al., 2017; Jones et al., 2015).

In a large, multiethnic clinical retrospective cohort study conducted by Xiang et al. (2019) regarding breastfeeding trends within an integrated health care system from 2008 to 2015, findings demonstrated a significant increase in breastfeeding rates, however, there was no substantial improvement in closing the gaps in disparities associated with race and ethnicity, age,

obesity status, and education. This is consistent with Reis-Reilly et al.'s (2018) findings, which revealed a 17 percentage-point gap in the prevalence of initiation and duration of exclusive breastfeeding between Black and White mothers. Breastfeeding education and support from health care settings were less likely to be implemented in birth facilities in ZIP code areas with a more significant percentage of Black residents (Louis-Jacques et al., 2017a).

Perceived Prejudice and Discrimination in Health care

Bleich et al. (2019) found that 92% of Blacks report that racial discrimination exists compared to 55% of whites. The perception of discrimination and implicit provider bias in health care settings towards Black mothers' negatively affects Black mothers' and their infants' health and health care. Of those who participated in a nationally administered survey and reported experiencing discrimination, 22% of Blacks report avoiding going to the doctor, or seeking health care due to fear of inadequate treatment, 52% of Blacks reported hearing microaggressions, and 51% of Blacks reported hearing racial slurs (Bleich et al., 2019). Another study conducted by Beauregard et al. (2019) had similar findings, with 43% of participants reported experiencing discrimination compared to 3% of whites.

Factors contributing to the perceptions of discrimination in health care include low-quality care, involvement in decision making, time spent with the provider, and communication (Attanasio & Kozhimannil, 2017, Benjamins & Middleton, 2019). Abramson et al. (2015) suggest that the perception and source of discrimination are multifaceted and include conscious and unconscious prejudice, stereotyping by providers, and potential differences in racism sensitivity, as well as verbal (non-verbal) cues. Tajeu et al. (2015) conducted focus-groups finding that Black mothers' report that non-physician health care workers also contribute to

perceived racism. The participant has also reported feeling that they were subjected to less than favorable treatment due to their race/ethnicity and socioeconomic status related to their health insurance.

Patient–Provider Relationship and Racism

Stangl et al. (2019) addressed how discrimination and stigmas in health care which includes stereotypes, prejudices, and discriminatory attitudes based on perceived differences in race, class, gender, or sexual orientation and discrimination related to race and ethnicity have been well documented to create barriers to health-seeking behavior and engagement. Perceived discrimination has been identified as a barrier to quality patient-provider relationships in health care settings for Black mothers', which has been attributed to provider mistrust and ineffective or biased communication that become apparent during patient-provider interactions (Cuevas et al., 2016). Semistructured interviews conducted during focus groups (Gonzalez et al., 2018) found that explicit racism and subtle slights in health care settings were prevalent among all participants. These perceptions of provider bias or discrimination were often from experiencing subtle forms of bias and discrimination in their day to day lives, thus, they were well-informed to notice non- verbal behaviors and identify them as biased behaviors (Gonzalez et al., 2018).

In addition to non-verbal behaviors that led to perceptions of provider bias, participants also identified treatment by support staff as a prime to perceived bias (Cuevas et al., 2016, Gonzalez et al., 2018). In addition, providers overlooking their ethnic background in regard to patient-provider communication as well as the less active exchange of information and limited involvement in decision making, as factors that negatively affect the quality of care thus

increasing the perception of discrimination among Black mothers' (Cuevas et al., 2016, Gonzalez et al., 2018).

Organizational Discrimination and Structural Racism in Health care

The continued inequalities in social institutions hinder organizations from properly addressing discrimination experienced by people of color (Thomas, 2018a). Thomas (2018a), drawing from the critical race theory, asserts that historically based and institutional ideology of white supremacy and privilege is sustained by racism ingrained in our society (Obasogie et al., 2017, Volpe et al., 2019). Hicken et al. (2018) affirms that organization racism over time functions as a "cloak of invisibility" rendering racialized and racially hierarchical structures racially neutral and rational. It is through societal, cultural processes that health care institutions are created to be racialized, demonstrating racism through policies and practices (Bailey et al., 2017, Hicken et al., 2018). A report of 43,020 U.S. adults that compared perceptions of health care discrimination among various ethnic groups found that Blacks were more likely to perceive discrimination in health care than their white counterparts (Abramson et al., 2015).

Benjamins and Middleton (2019) and Stepanikova and Oates (2017) found that individuals reporting perceived discrimination in the health care setting have negative implications for health-seeking behavior and are less likely than others to obtain preventative care, various health screenings, postpone treatment, and underutilization of health services. The perception of discrimination within the health care system by Black mothers was also found to be linked to the insurance they had, which played a role in the health care service they received (Cuevas et al., 2016, 2017).

Summary

Race-based inequities against patients during care, namely lactation care and its link to implicit bias are documented components to breastfeeding disparities (Thomas, 2018a). The incidence of overt racial discrimination against Black mothers' manifests as a clinician's interpretation of people of color as noncompliant (Geiger & Borchelt, 2003). There is little information regarding how the perception of racism or discrimination against patients during the birthing process and the immediate postpartum found within the literature that adequately addresses, identifies, and remedies racism and discriminatory practices within birthing centers including health care provider biases and exclusive breastfeeding initiation and duration (Griswold et al., 2018; Thomas, 2018a). This study fills a gap in research by focusing on Black mothers' experiences of perceived racial discrimination after giving birth within birthing centers, the influence these experiences have on exclusive breastfeeding initiation and duration, as well as how these experiences may have led to suboptimal health outcomes for these Black mothers and their infant children. Chapter 3 contains the methodology research design and procedures that was used for this study, as well as the researcher's role and ethical considerations.

Chapter 3: Research Method

Introduction

In this basic qualitative study, I explored how Black mothers' experiences of perceived racial discrimination after giving birth in birthing centers becomes a factor in their initiation and duration of exclusive breastfeeding practices. The purpose of this study was to examine how the individual, interpersonal, and community factors, as well as the organizational structures and existing policies in birthing centers are perceived by Black mothers who have identified experiencing racial discrimination after giving birth in a birthing center. The theoretical framework selected for this study was the SEM, which was used to understand influences that impede exclusive breastfeeding among Black mothers. The SEM is a multifaceted framework used to understand health behavior. The SEM is based on the assumption that no single factor influences people's behavior; instead, it is a complex interaction between individuals and their environment (Perrin, 2016; UNICEF, 2016).

Using the SEM as the framework allowed for a deeper understanding of the hierarchical levels of SEM, including individual, interpersonal, organizational, and community/environment factors that influence Black mothers' decisions to breastfeed exclusively. In this chapter, I discuss the study design, sample, data collection, my role as the researcher, ethical considerations, research questions, study population, data collection instrument, data analysis, and human subject protection.

Research Design and Rationale

This basic qualitative inquiry was conducted to capture an in-depth understanding of maternal experiences, attitudes, and beliefs (Patton, 2015) focused on provider–patient care

interactions and perceptions of racism, bias, or race-based discrimination (Thomas, 2018a). I conducted one-on-one semistructured video interviews using online teleconference platforms or audio-only telephone interviews to gather data to explore how racism and discrimination in birthing centers become a factor in the initiation and duration of exclusive breastfeeding practice among Black mothers. The main research question for this study was: How do the experiences of Black mothers in birthing centers with and perceptions of racism and discrimination affect their initiation and duration of exclusive breastfeeding practices with their newborn infants? Subquestions guiding the study were:

SRQ1: How do Black mothers describe individual and interpersonal barriers in birthing centers that affect their attitudes and beliefs regarding exclusive breastfeeding of their infant?

SRQ2: How do Black mothers describe the interpersonal relationship with health care professionals in birthing centers regarding behavior that could be perceived as racist or discriminatory and its contribution to their experiences with exclusive breastfeeding?

SRQ3: How do Black mothers perceive the community-level factors of racism and discrimination surrounding birthing centers wherein social relationships become a factor in exclusive breastfeeding practices?

SRQ4: How do Black mothers perceive health care policies, practices, and procedures in birthing centers that could be perceived as biased affect a Black mothers' decisions to breastfeed exclusively?

A quantitative approach was not selected for this study because such an approach is used to quantify opinions, attitudes, behaviors, and other defined variables to either support or contradict hypotheses concerning a specific phenomenon (McLeod, 2019). Furthermore,

quantitative inquiry limits the possible ways participants react to and express appropriate social behavior, resulting in a fixed and measurable reality (McLeod, 2019). Similarly, a phenomenological approach would not be suited for this study because such an approach is used to seek to uncover and interpret the inner essence of the participants' cognitive processing regarding a shared social phenomenon in which the participants' experiences are bracketed, analyzed, and compared to the identity of the essences of the phenomenon (Worthington, 2013).

Merriam and Tisdell (2015) assert that qualitative research is based on the concept that knowledge is constructed by people engaging in and making meaning of activities, experiences, or a phenomenon. A basic qualitative inquiry approach was selected for this study because the basic qualitative approach seeks to discover and understand (a) how people interpret their experiences, (b) how they construct their worldview, and (c) what meaning they attribute to their experiences (Bloomingberg & Volpe, 2019; Worthington, 2013). The basic qualitative research design is intended to obtain in-depth understanding, interpretation, and meaning of participants' experiences (Merriam & Tisdell, 2015; Sale & Thielke, 2018). Through basic qualitative inquiry, a researcher seeks to investigate participants' attitudes, opinions, ideas, or beliefs about a lived experience or issue (Percy et al., 2015).

According to Patton (2015), case study design in qualitative research can be either empirical units (individuals, families, organizations) or theoretical constructs (resilience, excellence) that explores the bounds or systems over time holistically through data collection. Bounded systems of a case study are within the context of both time and place (person, organization, behavioral condition, event, or social phenomenon) using an assortment of data sources. According to Baxter and Jack (2008), a case study design should be implemented when

(a) the researcher is focused on answering *how* and *why* questions, (b) the behavior of participants cannot be manipulated, (c) the study covers contextual conditions relevant to the phenomenon under study, or (d) the boundaries are not clear between the phenomenon and context. The case study approach was not chosen for this study because this methodology limitation may not cover all issues raised by the phenomenon, as it is used to explore a particular case in detail and may not offer sufficient evidence regarding the phenomenon as interviews were conducted within 24 months of giving birth (Astalin, 2013; Baxter & Jack, 2008; Patton, 2015; Suryani, 2013).

The data were collected through basic qualitative inquiry provide information regarding real-world events, experiences, and processes represented by the sample of participants (Bloomberg & Volpe, 2019; Percy et al., 2015). Data collection in this approach typically uses semistructured or fully structured (closed-ended) interviews, questionnaires, or surveys conducted face to face, over the phone, or via focus group discussions (Merriam & Tisdell, 2015; Sale & Thielke, 2018). The researcher is the primary instrument for data collection and analysis in qualitative inquiry (Bloomberg & Volpe, 2019). Qualitative research assumes that thick, rich data are nested in a real-world context that captures the interactive process between the researcher and the participants (Bloomberg & Volpe, 2019; Merriam & Tisdell, 2015).

A basic qualitative approach was selected for this study because of the social issue of perceived racial discrimination after giving birth in birthing centers and how these experiences become a factor in the initiation and duration of exclusive breastfeeding practices of Black mothers with their newborn infants, which is a multifaceted problem. This approach brings perspective to what the experiences of perceived racism and discrimination mean to Black

mothers by interpreting these experiences in the context of birthing centers and how Black mothers attribute these experiences to the initiation and duration of exclusive breastfeeding (Merriam & Tisdell, 2015; Noonan et al., 2016; Sale & Thielke, 2018; Worthington, 2013). By uncovering and interpreting how Black mothers feel concerning the individual, interpersonal, and community-level factors with their caregivers were experienced in the context of birthing centers, this study allows for a deeper understanding of the phenomenon (Brinkman, 2013; Collingridge & Gantt, 2019).

Role of the Researcher

In qualitative inquiry, the researcher's role is to attempt to access the thoughts and feelings of study participants (Bloomberg & Volpe, 2019; Kar, 2019). This involves asking people to talk about things that are often personal, some of which may be fresh in their minds and other incidences could cause them to relive the past (Bloomberg & Volpe, 2019; Kar, 2019). The data collected through qualitative inquiry are the researcher's primary responsibility; a researcher is charged with safeguarding participants and their data (Bloomberg & Volpe, 2019; Sutton & Austin, 2015). For this study, as the interviewer, I also was the recorder and used an audio recording device during the in-depth one-on-one semistructured video interviews or audio-only telephone interviews. The data were collected and transcribed using a third-party transcription service for efficiency and accuracy.

Rev (n.d.) automated speech to text transcription is an advanced voice and speech recognition technology. Audio files are transcribed by a machine; no humans are involved. The accuracy of Rev automated speech recognition algorithms is directly related to the quality of the audio file input, which correlates to the transcript quality (Rev., n.d.). Thus, to ensure accuracy

of the automated transcript, Rev's transcript editor function enables quick and easy revision by joining the audio/video files to the text for synchronized audio and text (Rev., n.d.). Audio files are securely stored and transmitted using TLS 1.2 encryption, the highest level of security available (Rev., n.d.).

Ethical challenges in this qualitative study were setting up partnerships with sites, recruiting participants, obtaining and documenting consent, maintaining data privacy, and sharing the results of this study with stakeholders. Due to the COVID-19 pandemic, I worked with each organization partner via email and telephone. The study invitation was sent via email and mail to the contact person at each partner organization. The partner organization agreed to provide contact information to me for individuals believed to meet inclusion criteria and to forward, distribute, and post the attached invitation on my behalf. I facilitated individual recruitment at the partner organization and via social media.

To overcome ethical challenges regarding recruitment of participants online, transparency was established with the selected sites' gatekeepers including information regarding the goals and recruitment selection criteria for this study. Once permission was obtained, individual recruitment was facilitated by the gatekeeper at each site, thus building participants' trust and ensuring the protection and representation of the site (Rattani & Johns, 2017).

Informed consent was obtained and documented through electronic informed consent via email (Wilbanks, 2020). Upon entering the questionnaire, potential participants read the informed consent form and provided their consent by selecting "I consent" before continuing to the qualifying questionnaire. The informed consent was written at a reading level appropriate for the participants and included information pertaining to the expertise of the researcher, the

purpose of the study, possible benefits and risks, assurance of confidentiality, right to participate and withdraw from the study, as well as contact information and an explanation of what would happen with the data collected.

Ethical issues that could arise in qualitative inquiry include relationship and intimacy established between the researchers and participants. A range of different ethical concerns can arise, including dilemmas such as respect for privacy, the establishment of honest and open interactions, and avoiding misrepresentations (Bloomberg & Volpe, 2019, Collingridge & Gantt, 2019, Kar, 2019). Other ethical concerns of qualitative research include anonymity, confidentiality, and informed consent (Bloomberg & Volpe, 2019; Collingridge & Gantt, 2019; Kar, 2019). Confidentiality was achieved by ensuring interviewees would not be identified. Interviewee were given full informed consent before the interview, and during the interview, I explained the participants' full autonomy and ability to discontinue at any time.

Additionally, as a Black international board-certified lactation consultant who has worked among a diverse group of health care members who have expressed discriminatory and differential care, I recognized that my insight and motivation drew from these experiences. Furthermore, having experienced racism and discrimination in the field of lactation and other life experiences, I recognized that these experiences may inform my interpretations of others' experiences. These challenges were mitigated by establishing my role as the researcher through the use of analyst triangulation. Analyst triangulation uses multiple analysts to review the findings to highlight any selective perceptions or blind spots that may exist (Bloomberg & Volpe, 2019; Carter et al., 2014). Analyst triangulation yields both confirmation of findings and

different perspectives, adding extensiveness to the phenomenon of interest (Bloomberg & Volpe, 2019; Carter et al., 2014).

In this study, I used rigorous selection criteria to avoid sampling bias. I included only Black mothers who could speak to their experiences of racism and discrimination in birthing centers, thereby also establishing generalizability. Reflexive bracketing was used to shape the data collection effort and maintain transparent processes and unbiased input throughout the scientific decision-making process (Pannucci & Wilkins, 2010; Tufford, & Newman, 2012).

Methodology

Participant Selection Logic

Participants were recruited for this study through social media—specifically, via Facebook—and from local birthing and maternal child health facilities and exclusive breastfeeding support groups. No contact was made with participants before obtaining Walden University Institutional Review Board (IRB) approval (#12-09-20-0963796). The two types of sampling used were purposeful sampling and snowball sampling. Initially, I used purposeful sampling to select participants who met the preselected criteria based on the research question. In addition to purposeful sampling, I used social media and snowball sampling to obtain potential participant referrals of individuals who fit the criteria.

The recruitment criteria for this study were Black mothers 18 years of age or older, who had an uncomplicated delivery of a full-term well newborn (37 weeks gestational age or older) within the last 24 months. Mothers who delivered preterm or had infants in the neonatal intensive care unit (less than 37 weeks' gestation) and mothers or babies who had any medical condition requiring formula supplementation were not eligible to participate in the study. Mothers who had

complications associated with labor and delivery and were unable to initiate exclusive breastfeeding due to medical contraindication were excluded from the study population as well.

Sampling Strategy

Purposeful sampling use in qualitative studies to find participants who provide thorough information about the phenomenon in the study. Purposeful and snowball sampling of participants selection linked to the aims of the investigation (Palinkas et al., 2015), including Black mothers that can speak to their experience of racism and discrimination in birthing centers, including background comments and actions of health care providers and staff members, as well as policies and procedures that are perceived as discriminatory or racist. These individuals meet specific criteria designed to accomplish the study purpose, research question and inform the literature gap.

Using purposive sample inclusion, participates had to meet the qualifying criteria questions. These qualifying questions are: (a) Do you identify as Black per the study guideline, a persons who identify as African Americans who are descendants of slaves brought to the United States involuntarily, and the offspring or descendant born in the United States from families that originally came from Africa, regardless of the ethnicity or race of the other parent that lived under institutionalized slavery in the United States, (b) are you at least 18 years of age or older, (c) have you recently had an uncomplicated delivery of a full-term well-newborn (37 weeks gestational age or older) within the last 24 months, (d) experience of perceived racism, discrimination, or bias in a birthing center, (e) is a resident or delivered , and (f) prenatal intent to breastfeed (Appendix A) exclusively.

Sample Size

In qualitative research, sample size selection is purposefully leading to information-rich interviews with the objective to yield insight and understanding of the study phenomenon (Bloomberg & Volpe, 2019; Malterud et al., 2016). Purposeful sampling is used to access appropriate data that fits the purpose of this study (Bloomberg & Volpe, 2019). Therefore, 10 Black mothers were recruited to speak to their experience of racism and discrimination in birthing centers, including background comments and actions of health care providers and staff members, as well as policies and procedures that were perceived as discriminatory or racist. Appropriate selection of participants in this basic qualitative study is specific to the study aim and provides sufficient information power through robust interview dialogue that explores the experience of racism and discrimination in birthing centers of Black mothers (Malterud et al., 2016).

Information power, as opposed to saturation, indicates that the more information the sample holds pertinent to the study, the lower number of participants is needed (Malterud et al., 2016). According to Malterud et al. (2016) information power depends on (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialogue, and (e) analysis strategy. When successfully acquired, information power influences empirical data to provide new knowledge through interpretation and analysis (Malterud et al., 2016). In contrast, saturation occurs when the researcher no longer receives information that adds to the theory that has been developed. According to Saunders et al. (2017), data saturation is evident at six in-depth interviews and is evident at 12 in-depth interviews.

Participant Recruitment

Participants were recruited through social media, specifically Facebook, and recruitment from local birthing and maternal child health facilities (to include WIC- Women Infant Child Nutrition Program) and breastfeeding support groups. A culturally appropriate flyer was developed (Appendix B) to explain the study's aim, the study process, the potential benefit of the study, participant qualifying questions, and contact information needed for potential participants. The flyer will invite Black mothers' who have recently delivered within the last 24 months to participate in one-on-one dialogue about their experiences of perceived racial discrimination after giving birth within birthing centers and the role it may have played in the initiation and duration of exclusive breastfeeding practices.

Instrumentation

A basic qualitative approach was adopted for this study to explore the social issue of perceived racial discrimination after giving birth within birthing centers and how these experiences become a factor in initiation and duration of exclusive breastfeeding practices of Black mothers' with their newborn infant(s) by conducting in-depth one-on-one semistructured video interviews utilizing teleconference platforms such as Zoom, Apple Facetime, Facebook messenger video, Microsoft's Teams, or audio-only telephone interviews guide. This approach was selected for two reasons, (a) it is an effective means of conducting the qualitative inquiry, and (b) it allowed for the most flexibility for scheduling interview times and locations, crucial for interviewing Black mothers of newborn infants (Russell et al., 2016).

In-depth one-on-one semistructured video interviews were conducted and recorded, collecting audio data using teleconference platforms such as Zoom, Apple Facetime, Facebook

messenger video, Microsoft's Teams, or audio-only telephone interviews. The interview protocol (Appendix C) consists of a series of open-ended questions that I have developed to capture Black mothers' perceptions of racism, bias, and discrimination after giving birth within birthing centers, and the role it may have played in the initiation and duration of exclusive breastfeeding practices (Bloomberg & Volpe, 2019). Table 1 illustrates the interview question aligned with research questions for this study.

Table 1

Interview Question Aligned with Research Questions

SEM constructs	Research question	Interview question
Environmental level	1. How do Black mothers perceive health care policies, practices, and procedures within birthing centers that could be perceived as biased affect a Black mothers' decision to breastfeed exclusively?	1. Did you feel uncomfortable with staff member for any reason? 2. Do you think you received timely attention to your needs, including taking your needs seriously? 3. Can you tell me about your environment (i.e., labor & delivery room, postpartum room)? 4.Thinking about your last birthing experience, can you describe any specific rules, regulations, policies, or practices within the birthing center that you perceived as racist/ discriminatory?
Interpersonal level	2. How do Black mothers describe the interpersonal relationship with health care professionals within birthing centers regarding their behavior that could be perceived as racist or discriminatory and its contribution to their exclusive breastfeeding experience?	5.Thinking about your last birthing experience, can you describe how your health care staff interacted with you? 6.What about their behavior gave you the perception that they were being racist or discriminatory? 7.Thinking about your health care staff's behavior, do you feel that you were heard? 8.Thinking about the health care staff's behavior, did you feel comfortable with them? 9. Describe your health care staff's positions about exclusive breastfeeding? 10.Thinking about your health care staff, do you feel that they were supportive of exclusive breastfeeding?
Community	3.How do Black mothers perceive the community-level factors of racism and discrimination surrounding the birthing centers in which social relationships occur to become a factor in exclusive breastfeeding practices?	11.Tell me about how experiences of racism influence your relationships with your health care staff (i.e., Nurse, Pediatrician, Ob-Gyn, and Lactation Consultant) 12. How has these relationships influence your decision to breastfeed exclusively? 13. Describe things and features within the birthing center that you perceived as discriminatory/racist?
Individual level	4. How do Black mothers' describe individual and interpersonal barriers within birthing centers that affect a Black mother's attitudes and beliefs regarding exclusive breastfeeding of their infant?	14. Has racism experienced while you were in the birthing center affected your attitudes about exclusive breastfeeding? 15. Do any of these experiences seem discriminatory? 16. How has your experiences of stereotyping while in the birth center, affected your beliefs about exclusive breastfeeding?

Telephone conference and video conference interviews conducted via video conference tools are an optimal source for data collection when face-to-face interviews with participants are

not possible (Bloomberg & Volpe, 2019; Merriam & Tisdell, 2015). Thus, this study uses video conference tools to conduct one-on-one semistructured interviews. Prospective participants received an e-invitation posted on social media (Appendix D) that encouraged interested candidates to complete the informed consent obtaining and documenting electronic informed consent (Wilbanks, 2020). Upon entering the questionnaire, potential participants read the informed consent form and provide their e-consent by selecting "I consent" before continuing to the qualifying questionnaire, before proceeding with the interviews, a detailed discussion reminding each participant of the signed consent form to make sure that each participant has read and understands the consent form as presented. Permission was given before continuing will recording the audiotape.

Instrument Development

Using the SEM conceptual framework, a series of open-ended interview questions to align with the research question were developed (Table 1). These open-ended questions enable the researcher to capture Black mothers' perceptions of racism, bias, and discrimination after giving birth within birthing centers. Additionally, the interview questions enable the researcher to explore the role this phenomenon may have played in the initiation and duration of exclusive breastfeeding practices (Bloomberg & Volpe, 2019).

Data Collection

An expert panel of healthcare professionals conducted an instrument validation to analyze individual interview questions for dependability and yield logistical and feasibility insights. Appropriateness and credibility only involved consulting stakeholders (or experts) in supplying feedback on my materials (Appendix D). The feedback obtained was used to make

appropriate revisions to the research instrument, ensuring alignment with the design of this study. Informed consent was obtained and documented through electronic informed consent via email (Wilbanks, 2020). Upon entering the questionnaire, potential participants will read the informed consent form and provide their e-consent by selecting "I consent" before continuing to the qualifying questionnaire. All participants were required to sign an informed consent form to grant permission to record the interviews.

Participants scheduled a convenient date and time to participate in the in-depth one-on-one semistructured video interviews. To ensure that each participant read and understood the consent form, the researcher held a detailed discussion to remind each participant of the signed consent form. The researcher obtained verbal permission before continuing as well as permission to audiotape. After consent and verification from each participant, the researcher initiated each interview as outlined in the interview protocol; this included an introduction, background information on the study, an explanation as to why their participation is essential, disclosed how the information provided will be used, and reassuring participant confidentially associated with their responses. After the introduction and the interview protocol were shared (Appendix E), individual interviews were conducted. Data were recorded and stored on a password-protected external hard drive and kept in a safe deposit box in a local bank for five years until being destroyed. Lastly, after each interview of the data collection process, the researcher held a brief debrief and thank the participants for their time and participation.

Data Analysis Plan

The researcher obtained automated transcription of audio responses from participant interviews responses via Rev transcription service. In addition, the researcher reviewed all

written responses several times to compare audio responses to ensure data validity for analysis and coding using Atlas.Ti 9 MacOS qualitative software. The use of qualitative software will help to reduce the manual task of coding and optimize the opportunity to discover, sorting, and organizing data into concepts and categories in order to interpret the meaning of the data collected into emerging themes and narrate the study findings derive to interpretations of the selected phenomena.

Issues of Trustworthiness

Credibility

Whether or not the participants' perceptions of the phenomenon match the researcher's portrayal or an accurate representation of the participants' thoughts, feelings, and experiences in qualitative research is known as credibility (Bloomberg & Volpe, 2019). The researcher established credibility by using member checks, prolonged engagement, thick description, and reflexivity (Bloomberg & Volpe, 2019). Member checks entail sending a copy of the transcribed interview or summaries and notes from audio recordings to the participants, thus enabling them to review detailed interview responses, verify the interpretive accuracy, and make corrections and provide feedback concerning the accuracy (Bloomberg & Volpe, 2019, Simon & Goes, 2016). One-on-one interview engagement encouraged an in-depth understanding of the phenomenon, encourage participants to support their statements with examples, and allow the researcher to ask follow-up questions (Bloomberg & Volpe, 2019, Korstjens & Moser, 2017). Finally, ensuring memos, notes, and journals that contain all necessary details through reflexivity provides a thick description (Bloomberg & Volpe, 2019).

Transferability

The extent to which the study's results can be related or transferred to the broader population while maintaining content-specific richness is transferability (Bloomberg & Volpe, 2019). This basic qualitative study aims to provide in-depth contextual details regarding the perception and description of the phenomenon, participants, and experiences included in this study (Bloomberg & Volpe, 2019). Purposeful sampling and the depth and richness (thick description) of detail give the element of a shared experience, allowing readers to form their own opinions about the quality of the research and the meaning of the findings (Bloomberg & Volpe, 2019).

Dependability

Ensuring documentation of the research process and data are logical, stable, and consistent over time is known in qualitative research as dependability (Bloomberg & Volpe, 2019). Dependability was achieved by adequately tracking all processes and procedures used throughout the data collection and interpretive process, maintaining clear records of field notes and memos known in qualitative research as audit trails, and utilizing member checks for comparative data analysis (Bloomberg & Volpe, 2019). Thus, analyst triangulation uses multiple analysts to review the findings to highlight any selective perceptions or blind spots that may exist (Bloomberg & Volpe, 2019; Carter et al., 2014). In addition, analyst triangulation yield both confirmation of the study findings and different perspectives of the data analyst, adding extensiveness to the phenomenon of interest (Bloomberg & Volpe, 2019; Carter et al., 2014). The dependability strategy of consistency appropriately documented the entire interview process, including notes, data gathering, analysis, and interpretation. The research design, implementation

of the design, data collecting details, and reflective evaluation of the process's effectiveness are in Chapter 5.

Confirmability

Confirmability in qualitative research establishes the values of the data and how the interpretations are reached (Bloomberg & Volpe, 2019). Continuous reflexivity and reflective disclosure allow the researcher to critically reflex through in-depth journaling, memos, and reports from the use of member checks that include participants' views supported interpretive accuracy, thus assessing the trustworthiness of the findings. Reflexivity in qualitative research is the intentional, active, ongoing awareness to monitor the role of the researcher (Bloomberg & Volpe, 2019). Keeping a research journal provided an ongoing chronology of thoughts, assumptions, and ideas that will allow for a deeper connection, self-reflection, and perspective development (Bloomberg & Volpe, 2019). Also, audio recorded files that match participant responses, process notes with data reduction, and analysis with computer stamped dates of modifications from the systematic usage of Atlas.Ti 9 MacOS qualitative software.

Ethical Procedures

The Belmont Report outlines three guiding principles, respect for persons, beneficence, and justice in human subjects research (Master et al., 2018). Respect for persons refers to individual autonomy or allows individuals the right to decide whether they want to participate in research (Master et al., 2018). The researcher relayed all necessary information to make an informed decision regarding participation and the right to withdraw from the study to all participants via informed consent. Thus, the researcher honored and respected participants' decisions without undue influence. Beneficence refers to the principle of doing good, also known

as "do no harm," and increases potential benefits while decreasing possible adverse events or harm (Master et al., 2018). This study did not pose any risk beyond those of typical life.

Additionally, the researcher ensured a clear understanding of participants' right to refuse to answer any questions considered invasive or terminate their participation at any time if any form of stress, anxiety, or discomfort during participation in the study. Justice refers to equal treatment and fairness for all people without discrimination (Master et al., 2018). The principle of justice also promotes a sense of trust between the participant and the researcher. Finally, following the inclusion and exclusion criteria without exception prohibited some prospective participants' eligibility to partake in this study.

The following ethical procedures when arranging partnerships with sites (Appendix F, Appendix G), recruiting participants, obtain and document consent, maintaining data privacy, and sharing the results of this study with stakeholders. Informed consent was obtained and documented through electronic informed consent via email (Wilbanks, 2020). Upon entering the questionnaire, potential participants read the informed consent form and provide their e-consent by selecting "I consent" before continuing to the qualifying questionnaire. The informed consent was written at a reading level appropriate for the participants and includes information about the expertise of the researcher, the purpose of the study, possible benefits and risks, assurance of confidentiality, right to participate and withdraw from the study, as well as contact person information and what will happen with the data that is collected.

This study used rigorous selection criteria to avoid sampling bias to include only Black mothers' who could speak to their experience of racism and discrimination within birthing centers, thereby also establishing generalizability. Transparency was established with the

selected sites' gatekeepers to include information regarding the study's goals and recruitment selection criteria. With permission, the researcher facilitated individual recruitment at each site. Thus, building participants' trust and ensuring the protection and representation of the site's interests (Rattani & Johns, 2017). During the data collection effort, reflexive bracketing maintains transparent processes and unbiased input throughout the scientific decision-making process (Pannucci & Wilkins, 2010; Tufford, & Newman, 2012).

To protect the identity and ensured confidentiality for participants, data was secure using password protection, data encryption, use of codes in place of participant names, storing names separately from the data, and stored on a password-protected external hard drive and were kept in a safe deposit box for five years until being destroyed. Lastly, the researcher gave briefs debrief and thanks to the participants for their time at the end of the data collection process. Participants choose a space that provided privacy, comfort, and the ability to record without interruption with a door for privacy. During this study, the researcher conducted individual interviews from a self-contained room to ensure confidentiality and privacy. The researcher did not use any personal information of the participants for purposes outside of this research project. Additionally, the researcher notified participants that in the event of a breach of confidentiality or unauthorized use of information.

Summary

The purpose of this basic qualitative study is to examine how Black mothers who have identified racial discrimination after giving birth within a birthing center perceive the individual, interpersonal, and community factors and the organizational structures and existing policies within birthing centers. The SEM theoretical framework selected for this study is to understand

individual, interpersonal, and community levels factors and institutional and policy level influences that impede exclusive breastfeeding among Black mothers. Moreover, the SEM is a multifaceted framework that allows for a deeper understanding of the hierarchical levels of SEM to include individual, interpersonal, organizational, and community/environment factors that influence Black mothers' decision to breastfeed exclusively.

Chapter 3 examined the methodology, research design, and procedures used for this study and the researcher's role and ethical considerations. This chapter discusses all necessary components of the research method, design, and approach used for this basic qualitative research study to explore how to do a Black mothers' experience in birthing centers and the perception of racism and discrimination affect the initiation and duration of exclusive breastfeeding practice of Black mothers with their newborn infant. In addition, this chapter covers the researcher's role, participant selection, data collection and analysis, instrumentation, protection of human participants, and ethical considerations. Finally, Chapter 4 will discuss data collection, analysis, implementation, and analysis.

Chapter 4: Results

Introduction

This basic qualitative study explores how Black mothers' experiences of perceived racial discrimination after birth in birthing centers factor into their initiation and duration of exclusive breastfeeding practices. Additionally, this basic qualitative study examines how Black mothers perceive the individual, interpersonal, and community factors and the organizational structures and existing policies in birthing centers. Participants identified factors they perceived as racial discrimination after giving birth in a birthing center. The data collected from the participants could lead to a better understanding of the individual, interpersonal, and community-level factors affecting the initiation and duration of breastfeeding among Black mothers giving birth in birthing centers. The main research question for this study was: How do the experiences of Black mothers in birthing centers with and the perception of racism and discrimination affect the initiation and duration of exclusive breastfeeding practices of Black mothers with their newborn infants? The subquestions for this study were:

SRQ1: How do Black mothers describe individual and interpersonal barriers in birthing centers that affect their attitudes and beliefs regarding exclusive breastfeeding of their infant?

SRQ2: How do Black mothers describe the interpersonal relationship with health care professionals in birthing centers regarding behavior that could be perceived as racist or discriminatory and its contribution to their experiences with exclusive breastfeeding?

SRQ3: How do Black mothers perceive the community-level factors of racism and discrimination surrounding birthing centers wherein social relationships become a factor in exclusive breastfeeding practices?

SRQ4: How do Black mothers perceive health care policies, practices, and procedures in birthing centers that could be perceived as biased effect a Black mothers' decisions to breastfeed exclusively?

Chapter 3 provides insight into the study design, sample, data collection, the role of the researcher, ethical considerations, research questions, study population, data collection instrument, data analysis, and human subject protection. Furthermore, Chapter 4 reiterates the research question and associated subquestions and defines the correlation to the findings. Additionally, Chapter 4 expounds on the study setting, demographics of the participants, the data collection process, the data analysis, and evidence of trustworthiness.

Setting

The setting for this study consisted of in-depth one-on-one semistructured video interviews using online teleconference platforms or audio-only telephone interviews. Telephone conference and video conference interviews conducted via video conference tools are an optimal source for data collection when face-to-face interviews with participants are not possible (Bloomberg & Volpe, 2019; Merriam & Tisdell, 2015). Additionally, participants provided a convenient date and time to participate in the interviews. Participants choose a space that provided privacy, comfort, and the ability to record without interruption with a door for privacy. One-on-one interviews were conducted from a private room to ensure confidentiality and privacy. Finally, participant identifiable information remained private outside the purpose of this research project.

Demographic

Participant recruitment and conduction of 10 in-depth one-on-one virtual semistructured video interviews using teleconference platforms or telephone. Purposive sampling and snowball sampling to obtain potential participant referrals of individuals who fit the criteria; digital flyers were posted on Facebook and LinkedIn social media platforms to recruit participants who met the qualifying criteria questions. This study's recruitment of potential participants occurred through breastfeeding support groups and professional groups dedicated to lactation professionals.

Establishing transparency with sites' gatekeepers to include information regarding the study's goals and recruitment selection criteria helps overcome ethical challenges regarding online participant recruitment. In addition, with permission, the researcher facilitated individual recruitment at each site. Thus, building participants' trust and ensuring the protection and representation of the site's interests (Rattani & Johns, 2017). Of the 20 participants who expressed interest in the study, ten did not meet qualifications per the study's exclusion criteria. Exclusion of potential participants (a) the participant experienced complications associated with labor and delivery and (b) were unable to initiate exclusive breastfeeding due to medical contraindication, (c) the participant delivered preterm, (d) the infant required admission to the neonatal intensive care unit that required formula supplementation, (d) the participant delivered less than 37 weeks' gestation weeks mothers, or (e) babies who had medical conditions requiring formula supplementation.

Adequate representation of diversity among research participants is vital. Participants in this study reflect diversity among Black culture, resources, and circumstances, including varying

education, age, income, marital status, support systems, WIC recipient status, and insurance status. Sharing similar ethnic, racial, or cultural backgrounds as potential participants for this study and similar life experiences, like racism and discrimination, the researcher overcame limitations regarding diversity among Black mothers willing to discuss their experiences of racism and discrimination. This shared history or experiences could have helped better understand participants' concerns and build rapport when interacting with them (Sierra-Mercado & Lázaro-Muñoz, 2018).

Black mothers who participated in this study were from different states across the United States. Figure 6 and Figure 7 show the geographical variation of the participants in this study. Participants consisted of 10 Black mothers with infants ranging from newborn to age 24 months. Participants' ages ranged from 21 to 40; 70% of the participants were between 21–30 years of age. Figure 8 shows a graphical representation of the participants' ages. Fifty percent of participants identified as single, never married, 40% were married, and 10% identified as married but separated. Figure 9 displays the marital status of the participants. Seventy percent of participants held a high school diploma, and 30% held an associate degree or higher. Figure 10 shows the education level of the participants. The number of participants insured with either Medicaid or Medicare was 70%, while 40% held private insurance, as shown in Figure 11.

Figure 6

Geographic Location of Participants

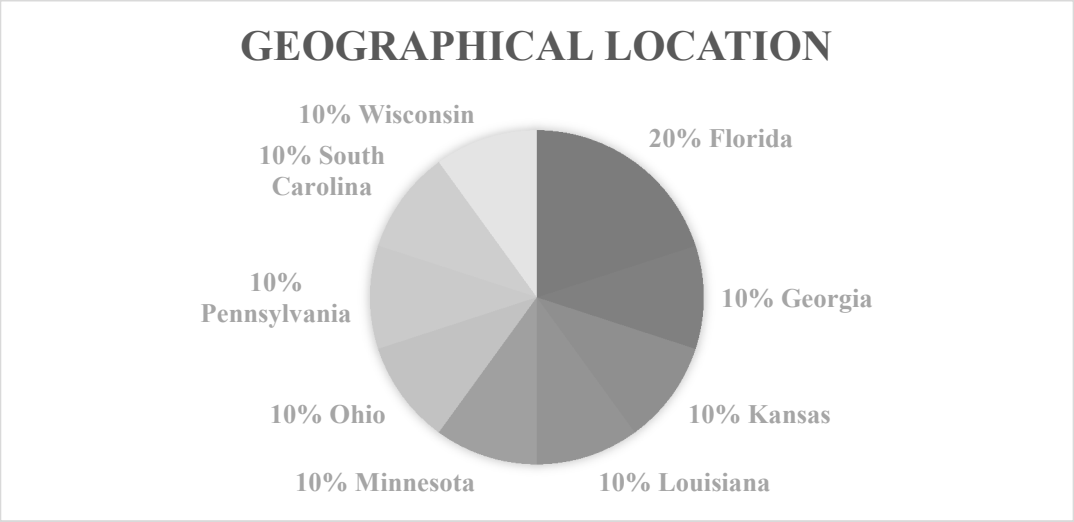


Figure 7

Geographic Distribution Across the United States

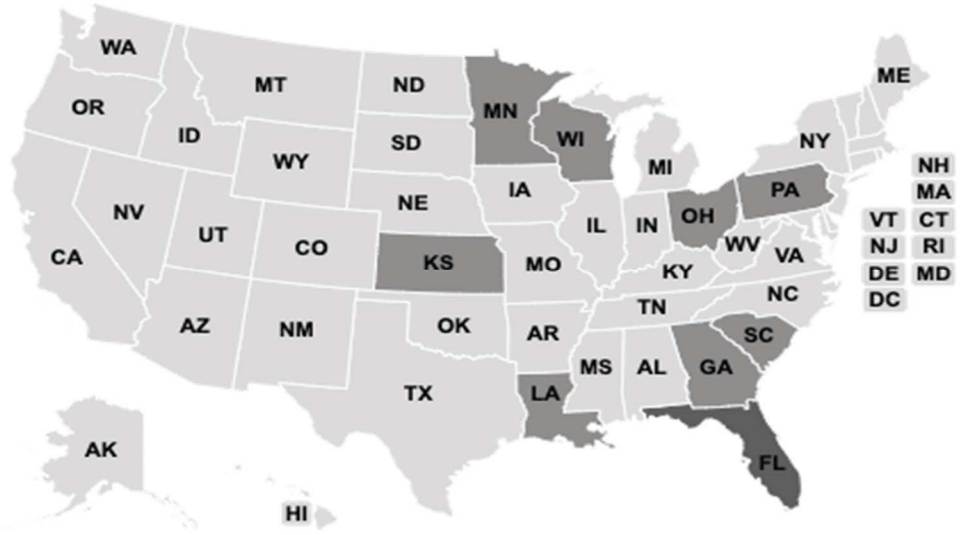


Table 2

Participant Demographics

Participant code	Age	Marital status	Education level	Employment status	WIC participant	Insurance type	Household income
WUB80E	36–40	Separated	Associate degree	Y	N	Private	$40,000–$59,999
WU81BI	26–30	Single	HS/GED	N	N	Medicaid	$40,000–$59,999
WU3F58	21–25	Single	HS/GED	N	Y	Medicaid	$40,000–$59,999
WUF751	21–25	Single	HS/GED	N	N	Medicaid	$20,000–$39,999
WUDBR6	26–30	Married	HS/GED	N	N	Private	$60,000–$79,999
WUUN9F	26–30	Married	Master's degree	Y	Y	Private	$20,000–$39,999
WUFEI7	21–25	Married	HS/GED	N	Y	Medicaid	$20,000–$39,999
WU1CFH	31–35	Married	Doctorate	Y	N	Private	<$100,000
WUMACQ	21–25	Single	HS/GED	N	Y	Medicaid	$40,000–$59,999
WUIXWG	26–30	Single	HS/GED	Y	Y	Private	$20,000–$39,999

Figure 8

Participant Age Distribution

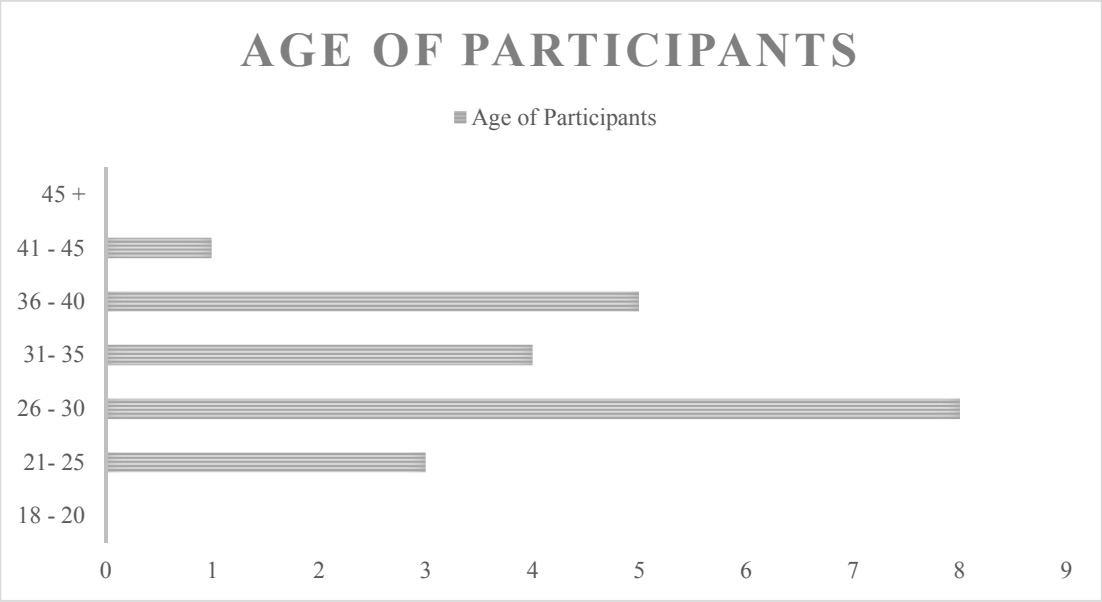


Figure 9

Participant Marital Status

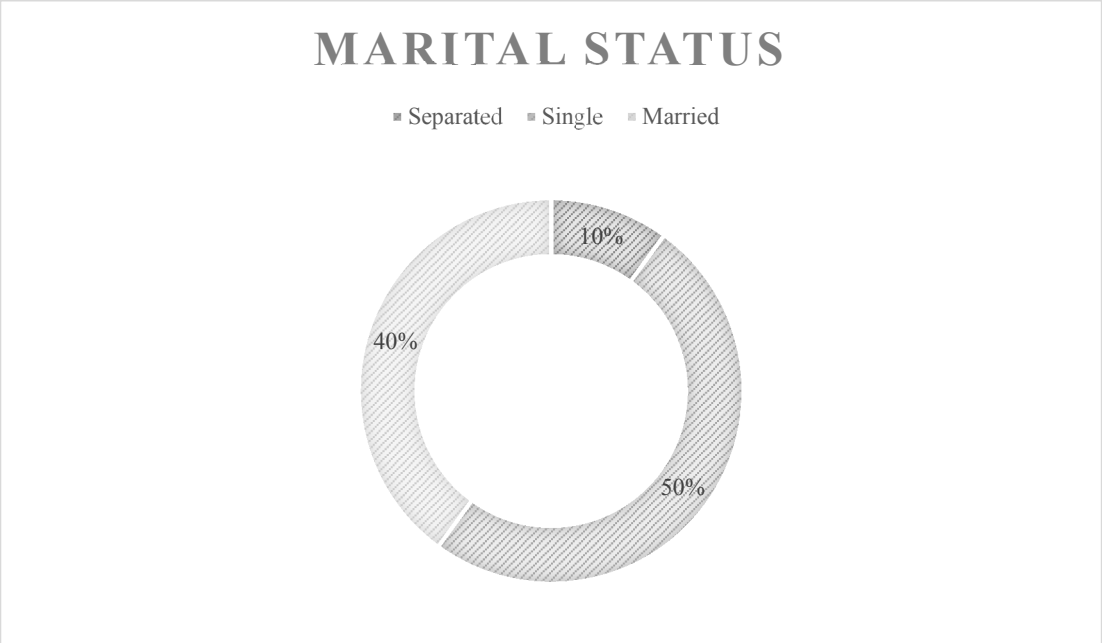


Figure 10

Education Level Distribution

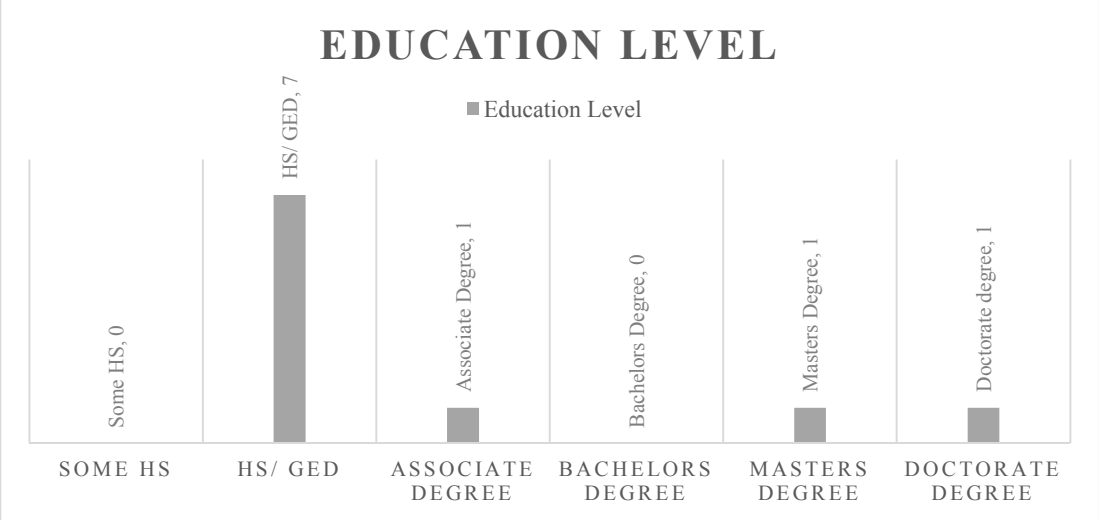
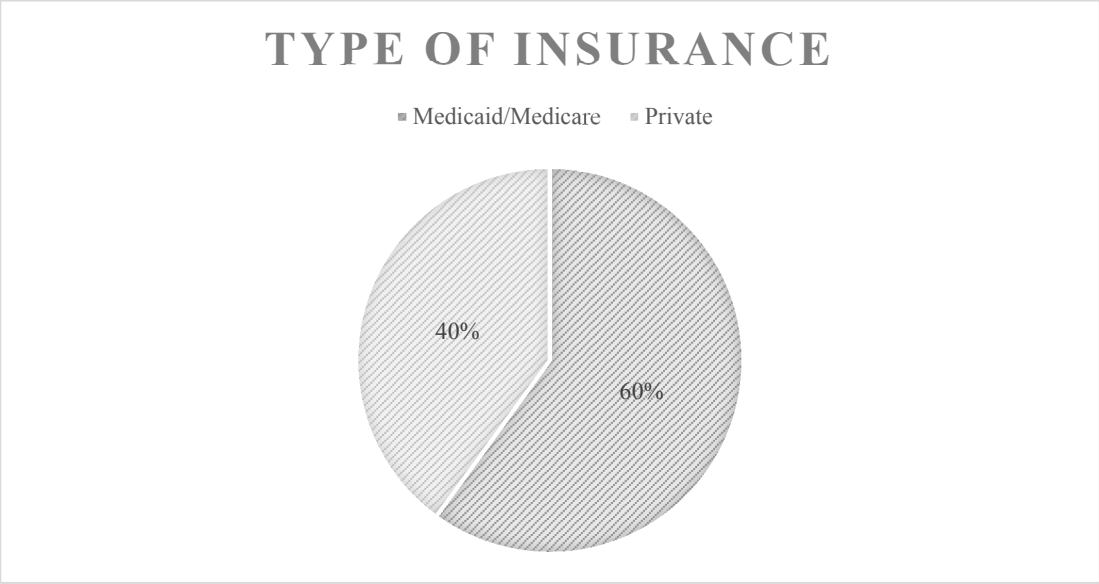


Figure 11

Participant Insurance Coverage



Data Collection

Instrument validation proceeded with the conduction of interviews with participants. First, an expert panel of health care professionals analyzed the survey items for trustworthiness and credibility and yielded logistical and feasibility insights. Next, the panel of subject matter experts reviewed the data collection instrument for trustworthiness and credibility. Validation involved consulting stakeholders (or experts) in supplying feedback on my materials. The expert panel consisted of a labor doula, an assistant professor and graduate director, and an associate professor of nutrition and registered dietitian. All three experts were international board-certified lactation consultants. These individuals have extensive experience in maternal-child health and a commitment to promoting, protecting, and supporting culturally appropriate exclusive breastfeeding. The preliminary review of the data collection instrument helped determine if the interview questions were clear and concise. The feedback from this panel of experts informed

make revisions to the research instrument aligned with the study's design. After this initial review of the data collection instrument, the researcher made all appropriate changes e conducting the final study (Appendix D).

The data collection phase, according to the plan outlined in Chapter 3, was implemented as follows. First, informed consent was obtained and documented through electronic informed consent via email (Wilbanks, 2020). Then, upon entering the questionnaire, potential participants read the informed consent form and provided their e-consent by selecting "I consent" before continuing to the qualifying questionnaire. Next, the researcher segregated data collected by the qualifying questionnaire to identify participants who met the inclusion criteria for the study.

Afterward, the researcher contacted participants who met the qualifying criteria to schedule a convenient date and time to participate in the in-depth one-on-one semistructured video interviews utilizing one of the following teleconference platforms that were accessible to the participant; these included Zoom, Apple Facetime, Facebook messenger video, Microsoft's Teams, or audio-only telephone interviews. A detailed discussion to remind each participant of the signed consent form took place before each interview to ensure that each participant has read and understands the consent form as presented. Participants the researcher to continue with the interview as well as permission to audiotape. Once verified, the researcher provided an introduction, background information on the study, why participation is essential, and the disclosure of how the information provided will be used and ensured confidentially associated with their responses.

Individual semistructured one-on-one interviews were structure per the interview protocol (Appendix C) and recorded and then stored on a password-protected external hard drive.

As needed or when appropriate, the researcher asked follow-up probing questions to gain clarification. Lastly, after each interview, participants were thanked for their time and a brief debriefs at the end of the data collection process. Finally, the researcher sent all audio file data to a third-party transcription service, REV automated transcription, for efficiency and accuracy. In order to ensure validity, each transcript was checked for accuracy while listening to the associated audio recording to verify participants' responses.

Data Analysis

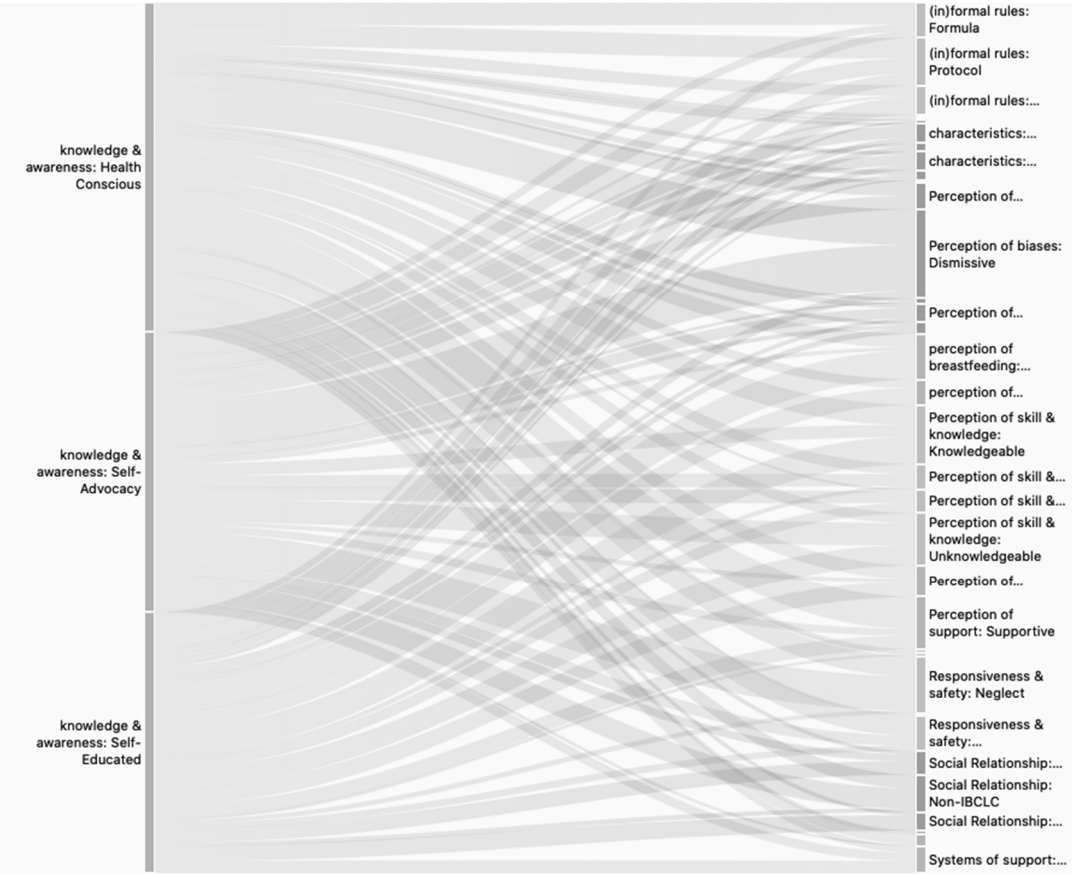
REV automated transcription services provided efficient and accurate transcripts of recorded interview responses. The researcher reviewed all written responses several times to compare audio responses for data validity for analysis and coding using Atlas.Ti 9 MacOS qualitative software. The use of Atlas.Ti 9 MacOS qualitative software helped to reduce the manual task of coding and optimize the opportunity to discover, sorting, and organizing data into concepts and categories in order to interpret the meaning of the data collected into emerging themes and narrate the study findings derive to interpretations of the selected phenomena (Friese, 2019, Merriam & Tisdell, 2015). There were10 participants in the study. The initial coding process began with the first three interviews conducted and transcribed. After that, analyst triangulation uses two coders during the coding phase to review the findings t highlight any selective perceptions or blind spots that may exist (Bloomberg & Volpe, 2019, Carter et al., 2014).

Analyst triangulation yields both confirmations of finding and different perspectives, adding extensiveness to the phenomenon of interest (Bloomberg & Volpe, 2019, Carter et al., 2014). Figure 12 is a data visualization that illustrates the complexity of understanding

relationships among emerging themes on the individual level and all other themes within the SEM.

Figure 12

Visualization of Code Co-Occurrence: Sankey Diagram



Microsoft Word was used to complete the first round of coding, which entailed selecting three de-identified transcripts. Next, three transcripts with personal identifiable information redacted were randomly selected and coded inductively by the researcher and coder 1. Thus, establishing the initial codebook that identified the initial 200 codes. Next, the researcher and coder I coded each document using the comment option in Microsoft Word to extract a macro of the comments (McAlister et al., 2017). The Microsoft Word macro document contained all codes

from each coder. The process of developing the finalized codebook involved numerous conversations among the coders and the researcher. The conclusion was creating a codebook containing 60 codes, thus beginning the initial step establishing Inter Coder Reliability (ICR)(Table 4).

ICR measures the agreement between different coders regarding how to code the same data and is a helpful exercise in promoting researcher reflexivity (Campbell et al., 2013). This process allowed the researcher and each coder to compare their work to the established definitions, inclusion criteria, and exclusion criteria. In addition, this process aimed to develop a codebook that could be used reliably by all research team members to consistently analyze the remaining interview transcripts and eliminate inconsistencies during coding (McAlister et al., 2017). Table 4 illustrates an example of codes used in this study and the associated emerging themes and accompanying analytic categories using the SEM characteristics.

Table 3

Emergent Themes and Categories

Example of codes	Emerging themes	Analytic categories
AMA Teen mother	Pregnancy, birth outcomes, and motherhood	Individual
Multip Traumatized	Experiences and attitudes	
Unsupported Health conscious Self-advocacy Determination	Knowledge and beliefs	
Personal support team Family	Systems of support	Interpersonal
Exposure to breastfeeding Normalized breastfeeding	Perceptions of breastfeeding	
Motivation Supportive	Perceptions of support	
Stereotyping Aggressive	Perception of biases	Community factors
IBCLC Social media	Social relationships	
Build rapport Mistrust Predominantly White	Characteristics	
Protocol Violation privacy Insurance	(In)Formal policies and protocol	Environment factors
Typical birthing room Neglect Errors	Safety and responsiveness	
Knowledgeable Prejudice Racial representation	Perceptions of skills and knowledge	

The second phase of coding required Atlas.Ti 9 MacOS qualitative analysis software to import all of the transcripts for coding. After coding individually, the coders' findings were merged with the master project bundle to calculate ICR. Krippendorff's Family Alpha was the select method of ICR to test the reliability of coding and increase consistency and transparency throughout the coding process. In addition, according to O'Connor & Joffe (2020), ICR helps provide confidence that the researcher made specific efforts to ensure the final analytic

framework represents a credible account of the data (Friese, n.d.a; O'Connor & Joffe, 2020; Shabankhani et al., 2020).

Cu-alpha is the global coefficient for all cu-alphas. It considers that codes from multiple semantic domains apply to the same or overlapping quotations (Friese, n.d.a; O'Connor & Joffe, 2020; Shabankhani et al., 2020). The basic formula for all Krippendorff's alpha coefficients is as follows: alpha = 1 - observed disagreement (Do)) / expected disagreement (De). $\alpha = 1$ indicates perfect reliability. $\alpha = 0$ indicates the absence of reliability.

The units and the values assigned to them are statistically unrelated. $\alpha < 0$ when disagreements are systematic and exceed what is probable by chance (Friese, n.d., O'Connor & Joffe, 2020, Shabankhani et al., 2020). Table 5 illustrates Inter Coder Agreement calculated using the Krippendorff's Family Alpha by the participant, including a semantic domain containing all codes over three phases.

Table 4

Krippendorff's Alpha Intercoder Agreement

Participant transcript	Coder	Krippendorff's α	Round
WUB80E	PI/ Coder I	0.925	3
WU81BI	PI/ Coder II	0.765	1
WUF751	PI/ Coder II	0.793	1
WUDBR6	PI/ Coder II	0.816	2
WUUN9F	PI/ Coder I	0.843	2
WUFEI7	PI/ Coder I	0.903	3
WU1CFH	PI/ Coder II	0.784	1
WUMACQ	PI/ Coder I	0.912	3
WUIXWG	Coder I/ Coder II	0.907	3
WU3F58	PI/ Coder I	0.853	2

The second coding round consisted of the initial brainstorming phase for testing the inter-coder agreement (Table 5). This process revealed potential inconsistencies in the coding system in which the coders were simply given the codebook and instructed to code the first set of transcripts independently (81BI α =0.765, F751 α = 0.793, 1CFI α = 0.784), resulting in a Krippendorff's alpha reliability coefficient larger than 0.6 (Friese, n.d.a; O'Connor & Joffe, 2020; Shabankhani et al., 2020). Although statistically acceptable, the researcher made additional changes to define a more rigorous coding system (Table 5). The following outlines the new coding system:

1. The coders independently grouped the codes from the codebook into subcategories within the categories reflecting the four constructs of the SEM (Individual, Interpersonal, Community, Environment).
2. Once merged, both coders and the researcher aggregated in the same manner. Thus, through inductive reasoning, semantic domains can be developed using the emerging themes.
3. Dialogue between the researcher and coders inform the refinement of the coding system to improve precision. After evaluation, 13 codes were updated to the codebook for clarity of interpretation to expand the meaning and provide examples.
4. The researcher created semantic domains in Atlas.Ti 9 MacOS grouping codes that share a mutual meaning.
5. Coding with codes from multiple semantic domains encouraged interpretation of how the various semantic domains relate for analyses other than inter-coder agreement.

6. Coders were not allowed to alter the code definition, change the code name, or the code color.
7. Coders created memos and comments to justify the code selections and comments they may have had about coding.
8. Each text character within the transcript is a unit of analysis for ICA (Friese, n.d.). Therefore, to avoid inconsistencies in ICA due to textual segments, pre-defined quotation limits containing 1-3 complete sentences that capture the whole idea of the content were provided.

ICA conducted at the end of the second round of coding, although higher (DBR6 α =0.816, UN9F α = 0.843, 3F58 α = 0.853) still displayed a few inconsistencies with selecting all codes necessary to illustrate complete understanding of the textual segment (Table 5). The analytical experience of the researcher comparative to the new coders explains the disproportionate coding selection (Campbell et al., 2013; O'Connor & Joffe, 2020). When the coding team discussed disagreements in coding sizeable textual data sets, a negotiated agreement among coders and the researcher came to a joint decision (Campbell et al., 2013; O'Connor & Joffe, 2020). As the most experienced coder, the researcher finalized the definitive coded data set (Campbell et al., 2013; O'Connor & Joffe, 2020).

Evidence of Trustworthiness

Credibility

Whether or not the participants' perceptions of the phenomenon match the researcher's portrayal or an accurate representation of the participants' thoughts, feelings, and experiences in qualitative research is known as credibility (Bloomberg & Volpe, 2019). The researcher

established credibility by using member checks, prolonged engagement, thick description, and reflexivity (Bloomberg & Volpe, 2019). Member checks entail sending a copy of the transcribed interview or summaries and notes from audio recordings to the participants, thus enabling them to review detailed interview responses, verify the interpretive accuracy, and make corrections and provide feedback concerning the accuracy (Bloomberg & Volpe, 2019; Simon & Goes, 2016). One-on-one interview engagement encouraged an in-depth understanding of the phenomenon, encourage participants to support their statements with examples, and allow the researcher to ask follow-up questions (Bloomberg & Volpe, 2019; Korstjens & Moser, 2017). Finally, ensuring memos, notes, and journals that contain all necessary details through reflexivity provides a thick description (Bloomberg & Volpe, 2019).

Transferability

The extent to which the study's results can be related or transferred to the broader population while maintaining content-specific richness is transferability (Bloomberg & Volpe, 2019). This basic qualitative study aims to provide in-depth contextual details regarding the perception and description of the phenomenon, participants, and experiences included in this study (Bloomberg & Volpe, 2019). Purposeful sampling and the depth and richness (thick description) of detail give the element of a shared experience, allowing readers to form their own opinions about the quality of the research and the meaning of the findings (Bloomberg & Volpe, 2019).

Dependability

Ensuring documentation of the research process and data are logical, stable, and consistent over time is known in qualitative research as dependability (Bloomberg & Volpe,

2019). Dependability was achieved by adequately tracking all processes and procedures used throughout the data collection and interpretive process, maintaining clear records of field notes and memos known in qualitative research as audit trails, and utilizing member checks for comparative data analysis (Bloomberg & Volpe, 2019). Thus, analyst triangulation uses multiple analysts to review the findings to highlight any selective perceptions or blind spots that may exist (Bloomberg & Volpe, 2019; Carter et al., 2014). In addition, analyst triangulation yield both confirmation of the study findings and different perspectives of the data analyst, adding extensiveness to the phenomenon of interest (Bloomberg & Volpe, 2019; Carter et al., 2014). The dependability strategy of consistency appropriately documented the entire interview process, including notes, data gathering, analysis, and interpretation. The research design, implementation of the design, data collecting details, and reflective evaluation of the process's effectiveness are in Chapter 5.

Confirmability

Confirmability in qualitative research establishes the values of the data and how the interpretations are reached (Bloomberg & Volpe, 2019). Continuous reflexivity and reflective disclosure allow the researcher to critically reflex through in-depth journaling, memos, and reports from the use of member checks that include participants' views supported interpretive accuracy, thus assessing the trustworthiness of the findings. Reflexivity in qualitative research is the intentional, active, ongoing awareness to monitor the role of the researcher (Bloomberg & Volpe, 2019). Keeping a research journal provided an ongoing chronology of thoughts, assumptions, and ideas that will allow for a deeper connection, self-reflection, and perspective development (Bloomberg & Volpe, 2019). Also, audio recorded files that match participant

responses, process notes with data reduction, and analysis with computer stamped dates of modifications from the systematic usage of Atlas.Ti 9 MacOS qualitative software.

Results

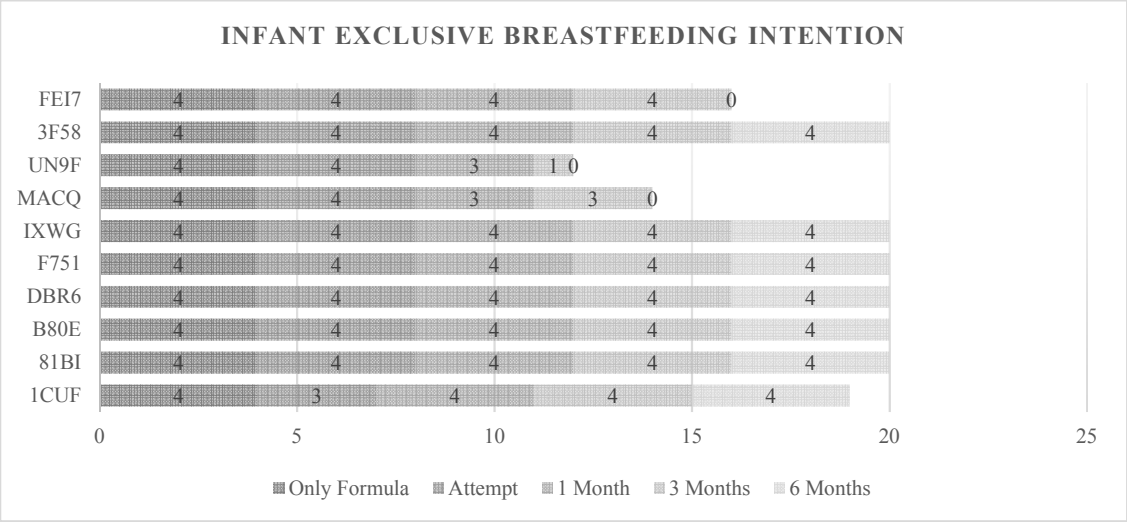
The main research question for this study is, how do the experiences of Black mothers in birthing centers with and the perception of racism and discrimination affect the initiation and duration of exclusive breastfeeding practices of Black mothers with their newborn infants. The results of the interviews, along with Black mothers' descriptions of their birthing experiences for this study, are arranged by SRQ and the aligned interview questions. The data analysis obtained from this study resulted in 12 themes (3 for each level of the SEM based on the SRQ).

To fully explore the scope of this question 4 secondary questions were asked that aligned with the SEM, which allowed exploration of how the experience of racism and discrimination of Black mothers interact on multiple levels within the birthing centers social environment, thus influences their health behavior, initiation, and duration of exclusive breastfeeding (Figure 13).

The decision to breastfeed, also known as breastfeeding intentions, is often made before conception. The Infant Feeding Intentions, as illustrated in Figure 13, measure strength of intentions to breastfeed exclusively at 1, 3, or 6 months, score ranges from 0 (no intention to breastfeed) to 20 (intentions to fully breastfeed for 6 months) (Nommsen□Rivers et al., 2010).

Figure 13

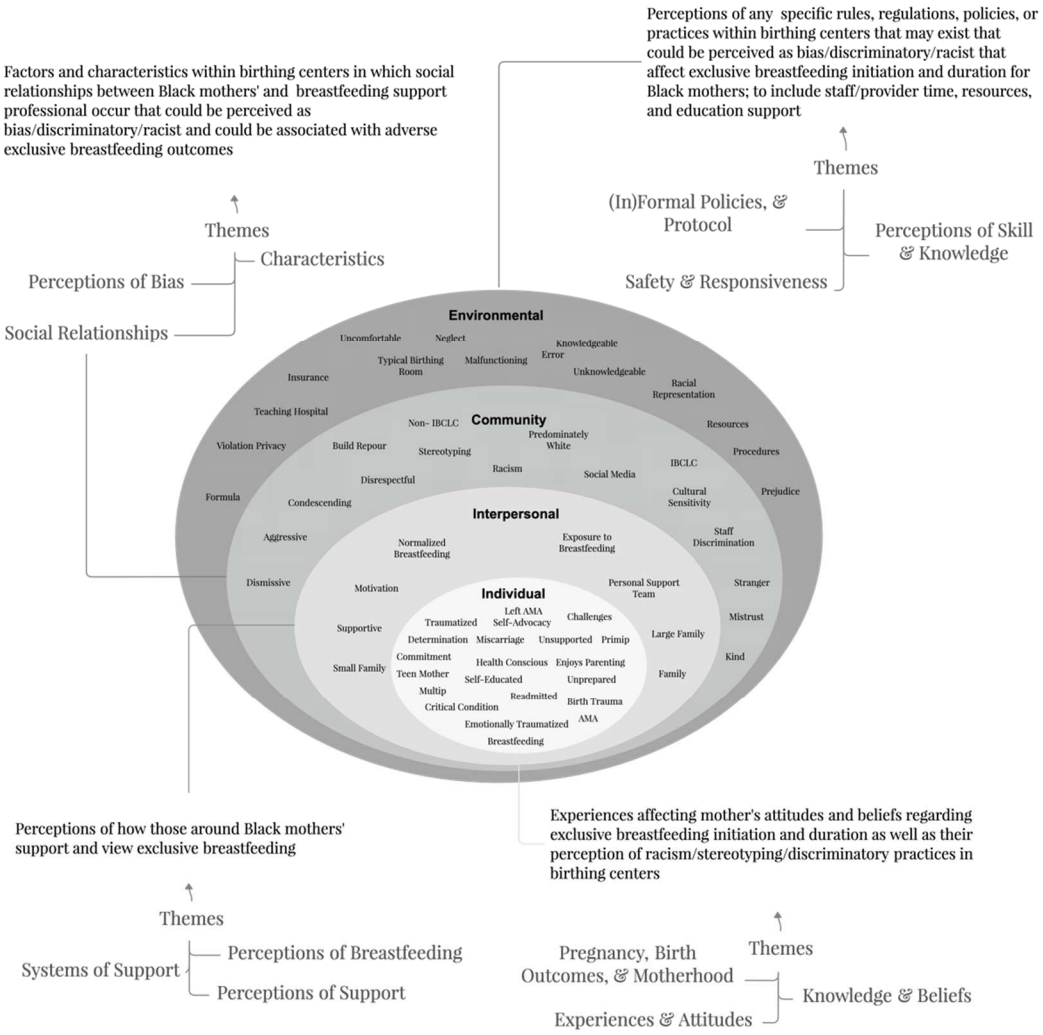
Infant Exclusive Breastfeeding Intention Scale



The majority of Black mothers who participated in this study had firm intention to initiate exclusively breastfeed, while all initiated exclusivity. Very few could not accomplish the recommended duration of breastfeeding; however, most of the participants' commitment to exclusive breastfeeding was not swayed. Figure 14 is an illustration that depicts the emerging themes of this study associated with the SRQ's and the appropriate SEM level containing the finalized codes from the codebook (Appendix I).

Figure 14

SEM Illustration and Emerging Themes



The overarching research question for this study examines how Black mothers' experiences in birthing centers with and the perception of racism and discrimination affect the initiation and duration of exclusive breastfeeding practices of Black mothers with their newborn infants. To further examine this phenomenon, this study includes four additional sub-research questions to examine and describe how the individual, interpersonal, and community factors, as well as the organizational structures and existing policies within birthing centers, are perceived

by Black mothers' as well as how Black mothers identified perceived racial discrimination after giving birth within a birthing center. This section discusses the emerging themes associated with SRQ1. Table 5 illustrates the emerging themes listed by sub research question and grouping of codes.

Table 5

Emerging Themes Related to SRQ 1

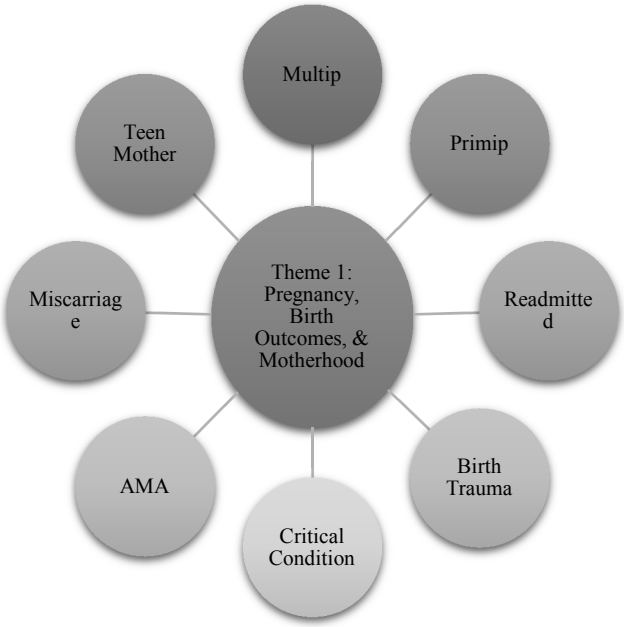
Research question	Codes	Emerging themes
SRQ1: How do Black mothers describe individual and interpersonal barriers within birthing centers that affect a Black mother's attitudes and beliefs regarding exclusive breastfeeding of their infant?	AMA	Pregnancy, birth outcomes, and motherhood
	Birth trauma	
	Critical condition	
	Miscarriage	
	Teen mother	
	Readmitted	
	Primip	
	Multip	
	Traumatized	Experiences and attitudes
	Emotionally traumatized	
	Unsupported	
	Left AMA	
	Unsupported	
	Challenges	
	Commitment	Knowledge and beliefs
	Determination	
	Health conscious	
	Enjoy parenting	
	Self-educated	
	Self-advocacy	
	Breastfeeding	

SRQ1: Black Mothers' Descriptions of Individual and Intrapersonal Barriers

The first subquestion asked: How do Black mothers describe individual and intrapersonal barriers within birthing centers that affect a Black mother's attitudes and beliefs regarding exclusive breastfeeding of their infant? The emerging themes of the first subquestion at the individual level are pregnancy, birth outcomes, & motherhood, experiences & attitudes, knowledge & beliefs. Figure 15 illustrates the SRQ 1 Theme 1 with associated codes.

Figure 15

SRQ1, Theme 1: Pregnancy, Birth Outcomes, and Motherhood



Theme 1: Pregnancy, Birth Outcomes, and Motherhood

Pregnancy, birth outcomes, and motherhood is consequential from a multitude of experiences and complex dynamics that exist within, regarding, and resulting from Black mothers' perception and attitude toward exclusive breastfeeding initiation and duration, plus are greatly influenced by the combination of interactions between Black mothers' and their environments. In this theme, factors ranging from biological influences such as the mothers' age, racial, ethnic, and cultural identity to psychological influences such as expectations regarding birth outcomes shape their attitudes, behavior, and self-concept.

Many participants spoke similarly about the role of being an experienced mother as compared to the challenges of being a first-time mother not knowing what to expect:

> I'm very experienced, so I didn't feel that I would not be able to, but I can't imagine what a new mother would feel like not having that support and an education to be able to confidently say they're going to breastfeed. (Participant B80E)

Among these factors, the most significant influences occurring 62% of the time within this theme were birth trauma and critical condition. Despite intention and positive attitudes towards breastfeeding, barriers that arise because of the birthing processes such as biases regarding pain management and unexpectant delivery methods, inhibited Black mothers from achieving their goals:

> I just couldn't focus on anything other than my pain. I just, I felt like every time I moved, somebody was stabbing me with the hot knife…So yeah, I just felt like, even though I was explaining my pains and stuff, I wasn't taken seriously, which kind of led me not to be able to focus on my son, I don't even really remember his first month of life. (Participant UN9F)

Participant 1CFU mentioned how an unplanned emergent cesarean section contributed to a traumatic birthing experience and contributed to the impression of bias resulting from limited communication, "I went straight from the triage to the surgery table, it was more so my anxiety had me freaking out and I've never went through any major surgery. So that for me that was automatically a scary experience."

Additionally, Black mothers describe changes in attitudes regarding breastfeeding due to the experiences of racism and discrimination in birthing centers. The most significant barrier was their ability to transcend obstacles resulting from the birthing process, such as cesarean section or discomfort with health care staff to remain committed to exclusive breastfeeding, "I wasn't

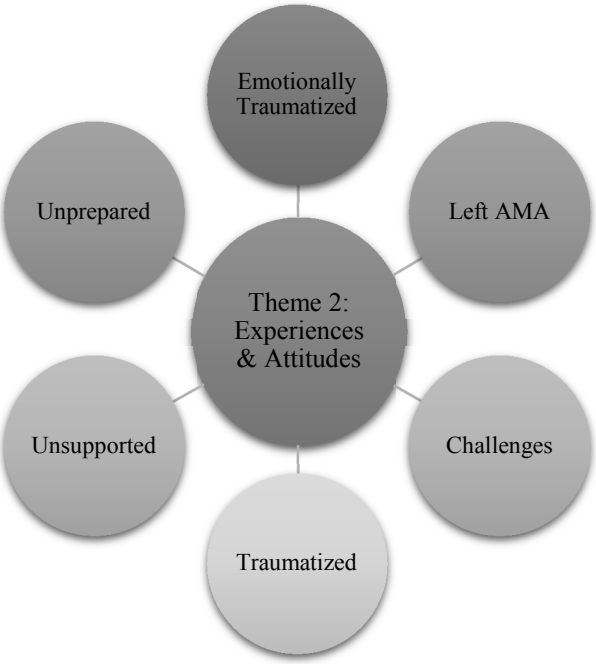
really getting the help that I wanted or needed" (Participant UN9F). The perception of lack of breastfeeding support based on provider actions was a critical factor in Black mothers decision to supplement with infant formula "because I'm having trouble with feeding him, so, it kind of pushed me into the direction of breastfeeding and supplementing." (Participant UN9F)

Access to positive social supports aid in the restored beliefs regarding exclusive breastfeeding of their infant. When possible Black mothers' family, friends, social media, and other groups focused on breastfeeding support helped to restore mothers' attitudes, behavior, and self-concept:

> It actually kind of turned me off to it, honestly, because I was so frustrated and I was so sick, that I was not able to breastfeed it wasn't until afterwards that a friend of a friend of a friend was a part of a lactation group, the people who tagged me in your interview actually, that I helped me through the whole re-lactation process. And honestly, thank the Lord, because there was one day where I was excited. I was so tired. I was connected to a wound vac for three months and my baby just latched. It was not a good latch. (Participant F751)

Figure 16

SRQ1, Theme 2: Experiences and Attitudes



Theme 2: Experiences and Attitudes

The theme Experiences and attitudes emerged from features associated with Black mothers' ideals of their self-concept, their coping skills, resiliency, and their perception of stigmas related to accessing and acquiring adequate care. Figure 16 illustrates SRQ1 Theme 2 experiences and attitudes with associated codes.

The participants spoke of experiences and challenges surrounding the birthing process and breastfeeding within birthing centers that left them feeling unprepared, unsupported, as well as physically and emotionally traumatized:

> I just felt like when you're a black woman, you're dismissed more. So, whether it's intentional or not, those actions show bias, you know, racism and discrimination. So, it wasn't like they were intentionally trying to be racist or bias, but probably like the way

> that they were raised or something kinda made them dismissive, which then as like, your kind of discriminating against me because you have your own racial biases that are affecting your treatment of me because you're dismissing because I'm telling you what's going on. And it's like, you really don't care because you may or may not believe in what I'm saying. (Participant UN9F).

Actions and behaviors of health care staff that Black mothers perceived as being invalidating, discouraging, obstructive, or deterring was a commonality explained among participants and described as factors that impede Black mothers' ideals of their self-concept, their coping skills, and resiliency. Black mother describes these behaviors as discriminatory:

> The only time I felt like I couldn't tell if it was discriminatory or not was after I gave birth, I guess there was some bleeding and the doctor physically had to put his hand back into my vagina right after birth. And it was very, very, very painful because I had just, literally, my son was like 30 minutes old, an hour old maybe. And I was not aware that they were having to go in my vagina, and I was not aware that like, of what exactly was happening and why it had to happen right then. And I kept expressing it's very painful and he's like, I know, but we really need to stop the bleeding. (Participant MACQ)

Perceptions of being treated less fairly or less well than other people or group based solely on race contributed to negative birthing experience and viewed as discriminatory. All of the participants spoke of how their racial identity played a part in the treatment they received from the health care staff, "I should not have been made to feel so uncomfortable where I would have discharged myself so soon." (Participant B80E) These encounters of discrimination and

racism with member of the health care staff left mothers feeling, “ mentally” and “emotionally traumatized”. (Participant B80E)

The perception of neglect and mismanagement of proper health care experienced by another participant was described as being associated with not only her racial identity but her method of insurance:

> My wound was not cleaned. My O2 was too low for them to send me home. When I, by the time that I got home, I had a low-grade fever, and my wound was infected. So, I don’t think that they did everything that they were supposed to do. I think they looked at me as a black Medicaid patient and they were going to keep me there for as long as Medicaid was covering it. And they cover four days. And after that, they were, they didn’t care what state I was in. I was going home. (Participant F751)

Health consciousness about breastfeeding and their overall health equipped Black mothers to advocate for themselves when the health care staff was disrespectful, dismissive, and discriminatory towards them. Of the participant who were not first-time mother, exhibited resiliency and thus were most prepared for their birth experience. Making it possible for them to vocally advocate for themselves and what their expectation were from the health care staff:

> So, there was some people, you know, try to push that, that formula mindset. and just pretty much like if you can’t do it, it’s okay. And for me, you know, that’s not my mental (laughing), you know, I just feel like, when it comes to them and black women, they don’t really try to motivate you to do these things because they want to set your children on a certain path because that’s what they expect from us. (Participant 1CFH)

Even though many Black mothers reported feeling unsupported and emotionally traumatized by their staff, some were able to preserver through adversity and continue to exclusively breastfeed. However, the discernment of being unsupported during the birthing process and the subsequent hospital stay directly impacted some participants and their motivation to exclusively breastfeed:

> A woman may have to use formula. You know what I mean? But I'm not for it being used recklessly… It is so casually offered. Like fearmonger… when they tell you, oh, your baby's not going to gain weight, your baby's going to fail to thrive. I don't like the way that it is seen as the only way your baby will live… I felt like I was experiencing textbook medical bias. Like I had never I've never been in a situation where somebody believed that I was in pain after I had just had a surgery like it. (Participant 81BI)

Theme 3: Knowledge and Beliefs

Impacts of health literacy regardless of the methods by which it was attained by the mother to include formal breastfeeding education by qualified health professionals or social media via YouTube or Facebook is an enormous component of breastfeeding knowledge and are influential factors for breastfeeding commitment, self-advocacy, and determination. Figure 17 shows an illustration of SRQ 1 Theme 3 knowledge and beliefs with associated codes.

Figure 17

SRQ1, Theme 3: Knowledge and Beliefs

The attainment of basic information about their health and the ability for Black mother to make health decisions for herself and her baby were greatly influenced by her health literacy level and determination, " honestly when it came to me breastfeeding, that was a decision that I made myself personally that I don't think anybody could break my mind from" (Participant 1CFH). Breastfeeding attitudes and breastfeeding self-efficacy were also a direct indication of mother's knowledge about exclusive breastfeeding. Health literacy regarding exclusive breastfeeding initiation and duration invigorated participants to endure perceived challenges or potential barriers that may have resulted from breastfeeding or the birthing process.

Black mothers discussed how having a formal understanding of how breastfeeding works translated into perseverance when faces with inherent apprehension of producing enough breast milk for their infant to thrive, "It strengthened my resolve. It strengthens my Research, I understood that I could still exclusively breastfeed in the NICU. I can supplement with my own milk. My milk is enough" (Participant 81BI). Another participant spoke of how attending a

parenting class helped to normalize breastfeeding, “my parenting class, pushed me to want to breastfeed. And I know when they were supportive of it, it just kept me going” (Participant DB6P).

Another participant revealed how the inception of intrapersonal beliefs regarding exclusive breastfeeding practices factored into health seeking behavior including breastfeeding education with the intent to engage in exclusive breastfeeding practices:

I was taking courses just to understand breastfeeding because it was something I want to do. It didn’t make sense for me to buy formula… the reason why breast is made is to supply milk. If you look at all these other animals, that’s what they do. So, I was like, okay, these are what my breast are made for to supply milk. (Participant IXWG)

SRQ2: Black Mothers’ Interpersonal Relationships with Health Care Professionals and Perceptions of Racism and Discrimination

The second subquestion asked: How do Black mothers describe the interpersonal relationship with health care professionals within birthing centers regarding their behavior that could be perceived as racist or discriminatory and contribute to their exclusive breastfeeding experience? The emerging themes at this level are systems of support, perceptions of breastfeeding, and perceptions of support. Table 6 illustrates the emerging themes listed by SRQ2 and grouping of associated codes.

Table 6

Emerging Themes Related to SRQ2

Research questions	Codes	Emerging themes
SRQ2: How do Black mothers describe the interpersonal relationship with health care professionals within birthing	Family Small family Large family Personal support team	Systems of support

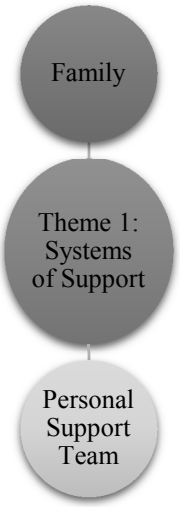
centers regarding their behavior that could be perceived as racist or discriminatory and contribute to their exclusive breastfeeding experience?	Exposure to breastfeeding Normalized breastfeeding Motivation Supportive	Perceptions of breastfeeding Perceptions of support

Theme 1: Systems of Support

Participants discuss social support systems as a key influence of breastfeeding success. Black mothers who feel supported and encouraged to breastfeed were more likely to initiate and sustain exclusive breastfeeding. Figure 18 is an Illustration of SRQ 2 Theme 1 with associated codes.

Figure 18

SRQ2, Theme 1: Systems of Support



Social support systems including biological family, work groups, friendships, and formal support systems such as laboring doulas and midwives play a significant role in the continued encouragement of Black mothers' decision to breastfeed. This theme emerged from coding systems that include family and personal support team. One participant spoke of the extent of support she received and the role it played in her decision to initiate exclusive breastfeeding, "

there was a black woman in the WIC program she was the one lady who really encouraged me. She gave me so many tips, even the co-sleeping" (Participant FE17). Having the support of a biological family equipped mothers with the resilience needed to overcome challenges to achieve long-term breastfeeding, "I expected that I might not be able to breastfeed for the whole six months. So, I did have some formula, but I never used them because I was producing more than enough breast milk for my daughter". (Participant FEI7)

Black mothers spoke about the significance of having a comfortable environment as well as companionship during their birthing experience and its impact on the perception of breastfeeding support. The experiences of Black mother's described varied based on their perception of who those around them viewed and supported breastfeeding, " So it was a pretty nice sized room... there was the bed they had the bathroom, for delivery space for my mom and my husband to be in there and my doula." (Participant MACQ)

Additionally, some mothers interpreted support based on the availability or lack of resources necessary to preserve exclusive breastfeeding such as equipment for pumping:

> My OB team was very supportive. I do know that my midwife, same as my doula as they were supportive. as far as the hospital, I did not feel that they weren't supportive because of how long it took for them to get me a breast pump. I thought that was absolutely horrible. (Participant B80E)

Equally important Black mothers described the importance of having the support of their families that rallied around them. These interpersonal connections provided support and were often times a source of information where the birthing center staff failed to provide:

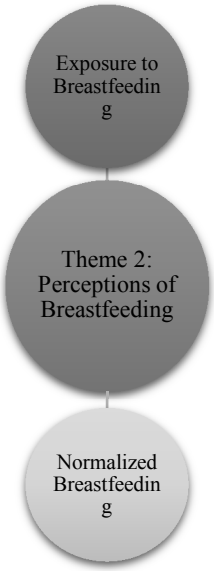
Definitely dad. he was very big on breastfeeding. He was making sure that I got my pump. He was like, I want everything all natural. You know, he wanted to see that experience and he really thought it was beautiful watching that progress… Well, of course for him being important because we created them together. So, you know, one thing I really took in was his opinion because they are boys and you know, a man's dream in this world is to have some sons and I got to bear those for him. (Participant 1CFH)

Theme 2: Perceptions of Breastfeeding

The theme perceptions of breastfeeding are comprised of Black mothers' exposure to breastfeeding and their discernment of normalization of breastfeeding within their environments. Figure 19 is an Illustration of SRQ 2 Theme 2 with associated codes.

Figure 19

SRQ2, Theme 2: Perceptions on Breastfeeding



Participants were asked to describe some of their general influences on their breastfeeding intentions prior to giving birth, in which Black mother describe how being exposed

to breastfeeding prior to having children instilled unwavering values regarding exclusive breastfeeding, " some are motivational. they really got me through it, honestly the people that work there, they really do love babies, and they want us to make sure that they get here healthy and there's no complications." (Participant 1CFH)

Other factors that played a role in Black mothers' perception of breastfeeding support was rather or not the facility was certified Baby-Friendly by the Baby-Friendly Hospital Initiative (BFHI) founded by the WHO and UNICEF. Equally important, Black mother explain how access to a professional in lactation counseling who has demonstrated the necessary skills, knowledge, and attitudes to provide clinical breastfeeding counseling and management support critical for breastfeeding:

> I think they were baby friendly. So, my baby stayed in the room the entire time in the Bassinet next to the bed. So, it was just kind of, I would say fairly standard. But they, they, I mean, I guess they seem to support it. Nobody tried to stop me. I don't think anybody was necessarily trained in lactation and I don't ever recall the CLC or IBCLC they had on staff ever coming in the room. (Participant 81BI)

Additionally, Black mothers described their perception whether or not individuals within birthing center demonstrate favorable attitudes for exclusive breastfeeding as receiving sufficient breastfeeding education, instructions, supplies, and management:

> I mean, with the breastfeeding was pretty good. They came, like I said, they came in, they explained it and they around the clock, they checked, and I had a problem with her latching, and they came in, they did the nipple shields and they, they tried to do what they

could to get her to breastfeed because they were saying breast is the best. So, they actually push breastfeeding more. (Participant DBR6)

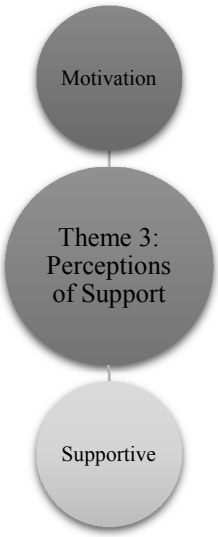
Other Black mothers equate having access to and utilization of lactation consultants within the birthing center demonstrate favorable support of exclusive breastfeeding, " there was multiple lactation consultants. One was black, one was white, they're a breastfeeding hospital, so they promote breastfeeding." (Participant MACQ)

Theme 3: Perceptions of Support

Perceptions of support develops from Black mothers' acuities of motivation and whether or not those around them are supportive of breastfeeding. Figure 20 is an Illustration of SRQ 2 Theme 3 with associated codes.

Figure 20

SRQ2, Theme 3: Perceptions of Support



First-time Black mothers who describe having little to no guidance with breastfeeding, lack emotional and physical support and dealing with racism and discrimination within birthing

centers describe the experience as overwhelming and stressful. However, Black mother associates their ability to withstand these barriers through supportive interpersonal relationships, " my mother and watching her breastfeed, my brother, and then she educated me on the importance of it. She showed me the pros more than I ever seen any cons." (Participant B80E)

Additional factors that contributed to Perception of interpersonal social support perceived by Black mothers as continuity of care, emotional, resources and informative support regarding their decision to exclusively breastfeed, " I had a maternity care coordinator so, I got a lot of information, classes, breastfeeding materials, a breast pump, pads, nipple cream, and breast milk bags from the VA really made me want to continue or try my best to breastfeed." (Participant UN9F)

When asked about their perception of how those around them support their decision to exclusively breastfeed, some Black mothers describe how having the support from family and friends help to made it a less stressful birth experience. Black mothers' perception of support from other people who were able to advocate for the health of the mother and the baby was a huge factor for Black mother's decision-making process in attempts to understand how those around her felt about breastfeeding. On the other hand, the lack of social support was described as extremely stressful on new Black mothers, having to navigate the health care system with little or no help:

> I watched a series on YouTube called extraordinary breastfeeding. So, I had an idea of what the social aspect of breastfeeding was and the scientific or the medicinal purposes of breastfeeding. I didn't have a lot of likes; my doctor really didn't talk about it. I, I never

seen a lactation consultant until postpartum. So, a lot of it was just my own research. (Participant F751)

Cultural practices, traditions, and cultural acceptance of exclusive breastfeeding was also a contributing factor for Black mothers' perception of social support, " I don't support formula. One of the main ingredients is corn, it's just my perspective, especially in Eritrean culture we don't have formula. So, it was the honor to go on that journey with my baby." (Participant IXWG)

SRQ3: Black Mothers' Perceptions of Community-Level Factors of Racism and Discrimination in Birthing Centers

The third sub research question asks: How do Black mothers perceive the community-level factors of racism and discrimination surrounding the birthing centers in which social relationships occur to become a factor in exclusive breastfeeding practices? This level focuses on relationships within the social networks between Black mothers and their health care staff within birthing centers. Table 7 illustrates the emerging themes listed by sub research question and grouping of codes.

Table 7

Emerging Themes Related to SRQ3

Research questions	Codes	Emerging themes
SRQ3: How do Black mothers perceive the community-level factors of racism and discrimination surrounding the birthing centers in which social relationships occur to become a factor in exclusive breastfeeding practices?	Aggressive Condescending Dismissive Disrespectful Stereotyping Racism	Perception of Biases
	IBCLC Non-IBCLC Social media Stranger	Social relationships
	Build rapport Mistrust	Characteristics

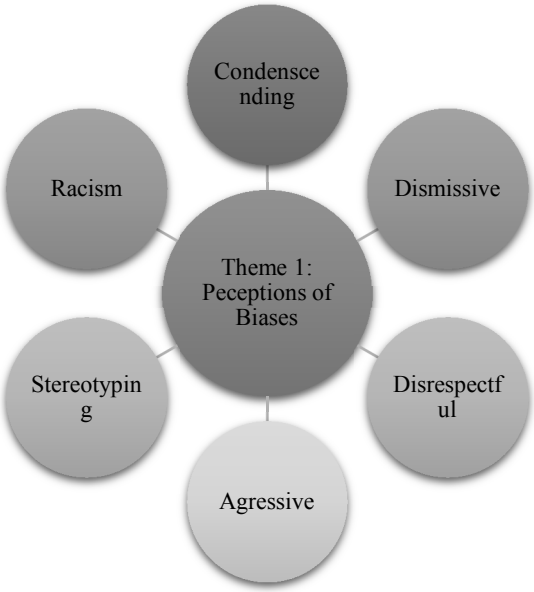
	Kind Predominately White Staff discrimination Cultural sensitivity

Theme 1: Perceptions of Biases

When asked to discuss their informal or formal relationships that existing among the health care organization, Black mothers who participated in this study identify behaviors such as aggression, being dismissive, and condescending as barriers for achieving their breastfeeding goals. Thus, the theme perceptions of biases surfaced as a description on behaviors as describe by participants show inclination towards them. Figure 21 is an Illustration of SRQ 3 Theme 1 with associated codes.

Figure 21

SRQ3, Theme 1: Perceptions of Biases



The perception of health care biases by Black mothers was the single greatest indication of support or lack of support from health care professionals. Black mothers all describe their

experience of health care bias as not having access to a certified IBCLC, lack of breastfeeding information, or imposing formula on the mother all factors into Black mothers' description of racism and discrimination within birthing centers. One participant described the experience saying, "they want to set your children on a certain path". Here is what she had to say:

> It's just the attitude, you know, and their attitude then bounced off of their actions. And I didn't let that make me have a negative experience because it was only one in maybe every four… So, there was some people, you know, try to push that, that formula mindset. and just pretty much like if you can't do it, it's okay. And for me, you know, that's not my mental (laughing), you know, I just feel like, when it comes to them and black women, they don't really try to motivate you to do these things because they want to set your children on a certain path because that's what they expect from us. (Participant 1CFH)

Participants spoke of experiences that often-left Black mothers feeling dismissed, disrespected, and stereotyped due to their race. In some instances, the IBCLC was very helpful, but some mothers did not feel this way about their interaction with the IBCLC. Furthermore, some Black mothers spoke of the lack of any interaction with a lactation professional at all. One participant described the staff as "nice-nasty, like I'm not going to be outright rude, I'm going to not answer your questions, and not give you things you need just because. So, her behavior was like she didn't believe that I was in pain." (Participant 81BI)

Black mothers explained how they struggled with staff discrimination and racism as well as the consequence on quality of care rendered by heath care professionals within birthing

centers. Participants spoke in great detail regarding symptoms being ignored, dismissed, and not taken seriously. One participant describes her experience:

> I wasn't being listened to my symptoms were being ignored. distancing, speaking down again as if I was not educated, not providing proper care, you know, most time when you have a baby, your nursing team is really hands on, and you know comforting to some degree. They talked around me versus talking to me. So I have to speak up and advocate for myself. (Participant B80E)

In a more diminishing nature, some participants equate the attitudes, body language, and behavior of heath care professionals to an ethnic slur used most often against black people. This slur has often been described as a trigger for psychological trauma that ensues when a person from a stigmatized group believes those negative stigmas. One mother described how her experience elicited feelings of internalized oppression revealed as a result of her care team's actions:

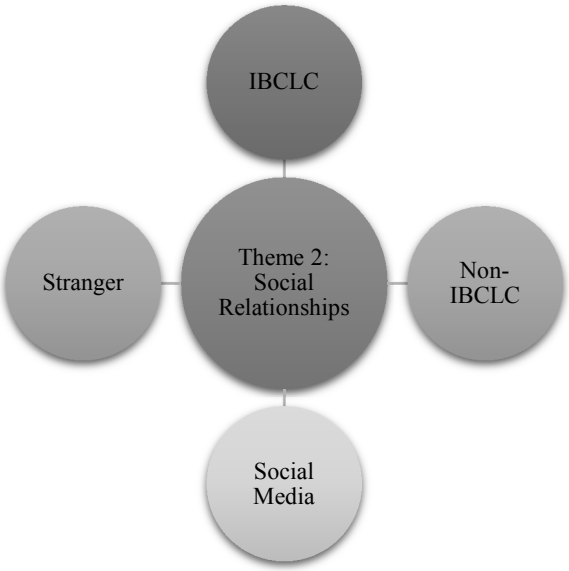
> They would dismiss it and, well, I would have a question about my baby… And it was like, they would just, I don't know. It was more feeling, no one like came out and called me a n****** or anything like that. I just kinda felt like they were dismissive… I was like, I'm a first-time mom, I'm exhausted. I want to know that my baby is breathing in his sleep. He swaddled, he's not on me. I just, I need to know for my own, you know, my own security and she didn't laugh, but you know how you have a smirk on your face. (Participant F751)

Theme 2: Social Relationships

The theme social relations encompass the varying type of relationships that exist within birthing centers and Black mother perception of these relationships. Figure 22 is an Illustration of SRQ3 Theme 2 with associated codes.

Figure 22

SRQ3, Theme 2: Social Relationships



Black mothers discuss the importance of having access to IBCLC for proper breastfeeding care as well as the invasiveness of other health care staff, " certain nurses came in with attitudes. Some really wouldn't talk, some were trying to just have like quick, you know, this is what, you know, this is who I am for the day, you know, see you later." (Participant 1CFH)

While other Black mothers described bring disregarded and going unnoticed by her health care staff as something other than unsupported, " I guess they seem to support it. I don't

think anybody was necessarily trained in lactation and I don't ever recall the CLC or IBCLC they had on staff ever coming in the room." (Participant 81BI)

Another participant describes her interaction with health care staff and having to advocate for proper breastfeeding care stating:

> I didn't know what that would look like, but I did not want her to be given formula. So, I had to argue with them because they wanted to fortify her milk. And I said, it's not necessary. She's going to get more than the calories. So, I demanded a lactation consultant to come in and I told her, let's do pre-weight and then we'll do a post weight, and then you can see how much she's taken in. (Participant B80E)

Nearly all of the participants gave examples of social relationships with their IBCLC and other staff members as being unsupportive or helpful when it come the breastfeeding, which in turn making self-advocacy and self-education even more valuable, " my lactation consultant wasn't really helpful. They were very busy at the hospital, I just took what I needed, but thankfully I did my own education, so I didn't really rely on the lactation consultants to assist me." (Participant IXWG)

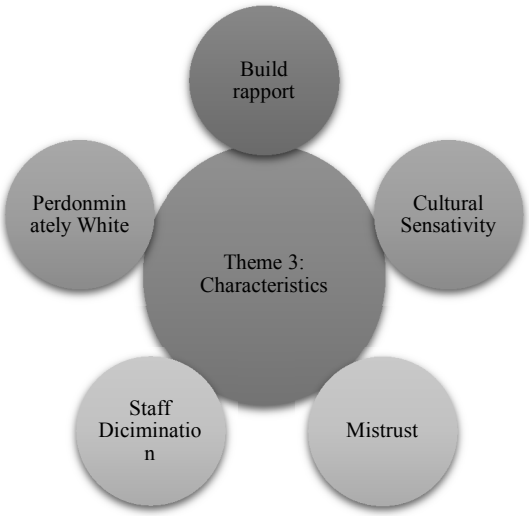
Contrarily, there were incidence when the mother described having breastfeeding support but described their health care staff as emotionally detachment. Resulting in the mother feeling that her health care staff was unable to fully engage with her feelings regarding birth or breastfeeding challenges, which interfered with the physical, psychological, emotional, and social dynamics of the relationship, " I had a lactation consultant she was really nice. She was like, here, this is what you do but not taking into consideration what I had been through physically and emotionally might affect me and my milk supply." (Participant UN9F)

Theme 3: Characteristics

The characteristics theme describes the various interactions between Black mothers and their ideals of how social relationships within birthing centers influence Black mothers' attitudes and motivation regarding exclusive breastfeeding initiation and duration. This includes building rapport, mistrust, cultural sensitivity, and staff discrimination. The participants describe how these interactions foster the perception of discrimination or racism as well as the association with adverse, exclusive breastfeeding outcomes. Figure 23 is an Illustration of SRQ 3 Theme 3 with associated codes.

Figure 23

SRQ3, Theme 3: Characteristics



Time spent face-to-face with patients was described as a key component of a successful patient-provider relationship as well as fostering patient trust. Quality time between physician and patient was considered a valuable resource during the birthing experience. Several Black mothers in this study perceived that their health care staff spent more time face-to-face with white mothers, resulting in Black mothers' experiences of discrimination:

> It was so swift within five minutes, I was out of the hospital, and I came home, and I told my husband, I just don't feel okay. That is because I'm black, because anything that happens to me, I'll always ask myself, would they treat white people this way? Or is it because I'm black? Because I see the kind of attention that they give to others. So, the time policy is one thing. And then another thing is like, the whole attitude around me when they're walking is like, there's this superiority... I remember when I was pregnant and then I went to the hospital and the nurse said again, you your here again? She said, I don't know. I'm always asking myself. Would you say that to a white person? (Participant FE17)

Other characteristics described by Black mothers as important was racial representation. The need for racial and ethnic representation among health care professionals not only provide a sense of comfort for the mothers but also its importance with creating and connect with every mother regardless of racial ethnicity. The participants spoke of the need for having a health care staff that "looks like them", not only for themselves but their children as well:

> We moved and I um was asking the pediatrician prior, who she recommended. And then I, with asking people on Facebook, where they recommended and, doctor, one of the doctors here, he's a highly recommended black physician. And I felt like that would be important for my sons just to have a male, talking to them, looking at them. And it, just, to me, it's a better relationship when you're dealing with what's going on with your body, because there's somebody that looks like them. That's been through some of the things they've been through. (Participant 3F58)

Being dismissed or ignored by their health care professional was one of the most common complaints made by participants. These mothers describe feelings of fear, anger, and potential harm that created a breach of trust when their symptoms were discounted, dismissed, or ignored. This resulted in both emotional and practical damage:

> I just felt like when you're a black woman, you're dismissed more. So, whether it's intentional or not, those actions show bias, you know, racism and discrimination. So, it wasn't like they were intentionally trying to be racist or bias, but probably like the way that they were raised or something kinda made them dismissive, which then as like, your kind of discriminating against me because you have your own racial biases that are affecting your treatment of me because you're dismissing because I'm telling you what's going on. And it's like, you really don't care because you may or may not believe in what I'm saying. (Participant UN9F)

Additionally, published images within birthing centers and printed literature with an underrepresentation of minorities compared to the general population, also contributed to Black mother perception of racial inequities in health care and tarnished patient-provider relationships, " I saw great representation as far as having like black nurses and, and so, and black doctor when I first checked in but the doctor that was on call, I don't feel like he did a good job of explaining things to me." (Participant MACQ)

When describing birthing center characteristics where Black mother who participated in this study gave birth, the lack of racial and cultural diversity among the staff contributed to the perception of discrimination. Black mothers described the underrepresentation of minorities within the birthing centers as predominately white and thus bring into question the staffs' ability

to provide care safely and efficiently for women who identify as Black, " A lot of distrust for them. And I should have known better when I had to drive to a predominantly white area. I'm not sure how much experience they even have working with women of color." (Participant B80E)

SRQ4: Black Mothers' Perceptions of Policies, Practices, and Procedures in Birthing Centers

The fourth sub research question asks: How do Black mothers perceive health care policies, practices, and procedures within birthing centers that could be perceived as biased affect a Black mothers' decision to breastfeed exclusively? This level of the SEM focuses on Black mothers' perceptions of the quality of care and discrimination w17ithin birthing centers. This included including staff education, training, and knowledge, availability and time, and access to resources. Table 8 illustrates the emerging themes listed by sub research question and grouping of codes.

Table 8

Emerging Themes Related to SRQ4

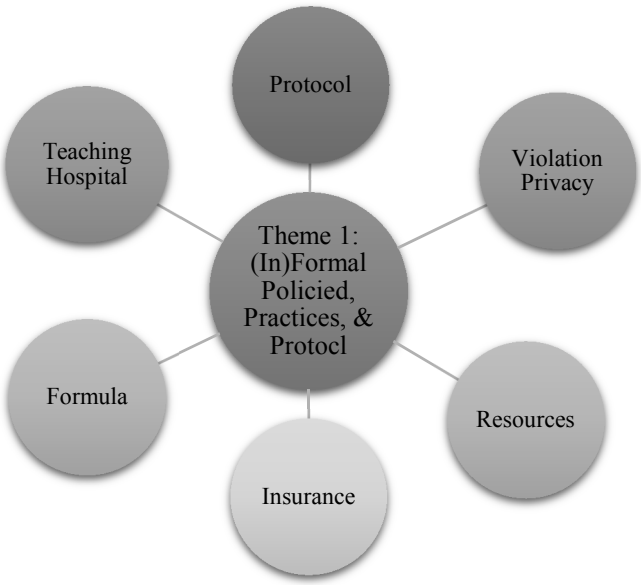
Research questions	Codes	Emerging themes
SRQ4: How do Black mothers perceive health care policies, practices, and procedures within birthing centers that could be perceived as biased affect a Black mothers' decision to breastfeed exclusively?	Protocol Violation privacy Resources Insurance Formula Teaching hospital	(In)Formal policies & protocol
	Uncomfortable Typical birthing room Malfunctioning Errors Neglect	Safety & responsiveness
	Knowledgeable Unknowledgeable	Perceptions of skills & knowledge
	Racial representation Prejudice	

Theme 1: (In)Formal policies and protocol

This theme derives from the participant's account and insight of allocated resources and the positive and negative nature of formal and informal policies and practices within birthing centers that impact Black mothers' exclusive breastfeeding initiation and duration. Participants described their perceptions of formal and informal unwritten rules or tacit within birthing centers that Black mothers perceived as acceptable roles and activities based on a combination of social norms, culture, and historical factors. Figure 24 is an Illustration of the SRQ3 Theme with associated codes.

Figure 24

SRQ4, Theme 1: (In)formal policies, practices, and protocols



Black mothers described violation or invasion of privacy and beneficence as prominent protocols or practices as traumatic and discriminatory. Black mothers' perception of discriminatory mandates, procedures, practices, and routines was shaped by staff's typically carried out functions. These practices include the strictness and adherence to health care practice

rather formal or informal, medical treatments and management of patients, and how daily practice and procedures were carried out. Among these practices were the process and procedures in which teaching hospitals go about pediatric training residence:

> They didn't ask my permission to touch my baby or to look at my wound or anything. They just kind of came in with students with three or four students, that I didn't know. And I just, I felt like a piece of meat. So, I kind of wished that when they came in, they said, hi, I was familiar with the doctor, but introduce your students. This is why we're here. We just want to take a look at this, this, this, okay. It wasn't like that. It was just, they in came just coming to check. And then like, my business is out and everybody's taking turns looking and I was just taken back, and I wish I was just saying this to my mom. (Participant F751)

Infant formula practices in birthing centers were very influential on Black mothers' perception of exclusive breastfeeding support from both their health care staff and birthing facility. The ease of access to infant formulas compared to accessing breastfeeding supplies and equipment was perceived ad marketing of infant formula feeding practice. These factors include led Black mothers to feel like the health care environment was, "setting mothers up to fail, just the prepackaged formula that was already in the fridge providing them a hospital grade pump hours after they've given birth, telling them that their milk hasn't come in yet" (Participant 81BI).

Cultural, religious competence of health care staff and birthing center policies also factored in Black mothers' perceptions of bias regarding racial discrimination. Black mothers described the lack of consideration of their religion and spirituality preferences when they had a

particular request regarding birth and breastfeeding, thus dealing with complex medical decisions for Black mothers and their families. One participant spoke of how the lack of respect for the patient's religious and spiritual needs made her feel uncomfortable:

> I will definitely say, certain policies. like it just didn't make sense to me. I had this on my birth plan. And unfortunately, like I told them for religious reasons. I don't know if this, this is not related to breastfeeding, but, for religious reasons, I really wanted to keep a placenta and they would just not let me keep it at all. So, it was just kind of my word against their policy… just one of the nurses, which just assuming things about my insurance, it's starting government assistance, that I may have been receiving. I didn't confirm anything from her, but she was discussed assuming things. (Participant IXWG)

Another practice perceived as discriminatory was the lack of respect for a person's autonomy. Black mothers describe not having their choices and decisions heard or simply being denied the opportunity to discuss actions regarding birth or breastfeeding without deliberate obstruction. One mother state that although her staff was courteous, the staff's failure to thoroughly explain processes or procedures, compromised her ability to decide what she thought would be best, "The resident was friendly, but I did not like his demeanor. He rushed a lot; things were not explained, and instead of laying out options to make a decision, they put forth what they thought was best. (Participant MACQ)

Relatedly, Black mothers spoke of receiving selective health intervention during the birthing process instead of making personal decisions by limiting birthing options available to her. For example, one mother described her perception of differential treatment:

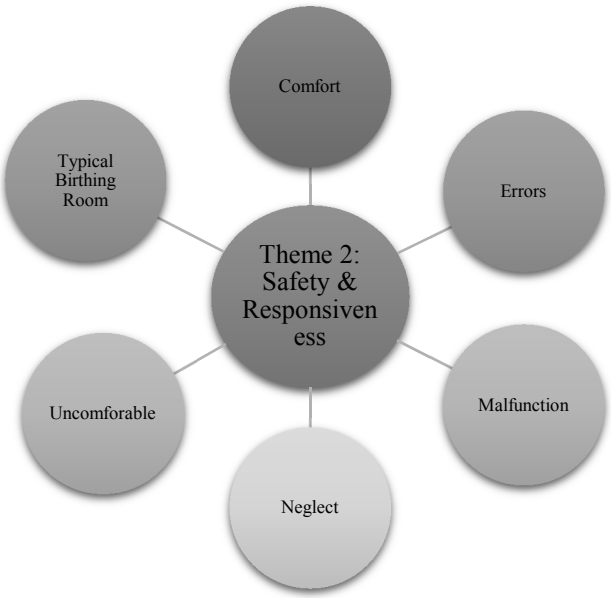
> I realized they were quick to induce labor and all they used was the Pitocin and didn't try other methods to progress my labor. and I wasn't really given any other options. about my care. I had a friend who gave birth at the same hospital, she was white and, they gave her so many different options, like Pitocin, the balloon catheter to dilate your cervix, and they allowed her a lot longer time to give birth than, than me. So, I felt like if I was white, I probably would have had the same options or more options compared to the options that I had. (Participant UN9F)

Theme 2: Safety and Responsiveness

The environment in which Black mothers gave birth played a significant role in their birthing and breastfeeding experience and their perception of discrimination or racism. Participants in this study described feeling uncomfortable while in the labor and delivery room when transferred to the mother and baby floor or simply interacting with health care staff because of their perception of negative attitudes. Figure 25 is an Illustration of the SRQ 4 Theme with associated codes.

Figure 25

SRQ4, Theme 2: Safety and Responsiveness



Participants spoke of elements that either encouraged or inhibited their exclusive breastfeeding in terms of their environment. Barriers to achieving this goal include comfort level within birthing centers, their safety regarding adequately working equipment, and attentiveness of the staff, " the lack of time because I see them with other non-black people and how they pay attention to them is so dismissive, and that is not the kind of attention that I needed" (Participant FE17).

Back mothers who participated in this study described factors such as being ignored, prolong wait times when requesting assistance, and staff members coming into their room and examining them without asking permission or giving a proper introduction and explanation as to why they were there, or simply, "doesn't care. I didn't feel comfortable with them just because they were dismissive. It's like, how can you feel comfortable with somebody who isn't listening

to you? How can you feel comfortable with somebody who doesn't care what you're saying?" (Participant UN9F)

Additional factors that went into the perception of safety were aspects within the birthing center that caused discomfort or annoyance. This included not only the the conditions of the environment but things around the mother within her environment that fosters or creates discomfort for her:

> The first room, it was like, we were in like a basement. It was so weird. It was dirty, there was spiders and I just felt like so uncomfortable. And like, this is the hospital, like what, compared to like my plan's going to her center. So, it was very strange, and it was just too much for me to handle. Like we were transferring every stage, there was a progress, there's just three different, departments we were going to while I was there. And it was a little like overwhelming, especially I was just so exhausted. (Participant IXWG)

An overwhelming concern was the number of participants that described perception of racial discrimination as the failure of health care staff to meet the mother's needs, or the perception of health care staff inflicting physical or emotional harm by way of passive omissions of proper care and gross carelessness that steam from a lack of compassion or neglect, "My wound was not cleaned and infected, my O2 was low, and I had a low-grade fever. They a black Medicaid patient and kept me as long as Medicaid covered it. They did not care what state I was in". (Participant F751)

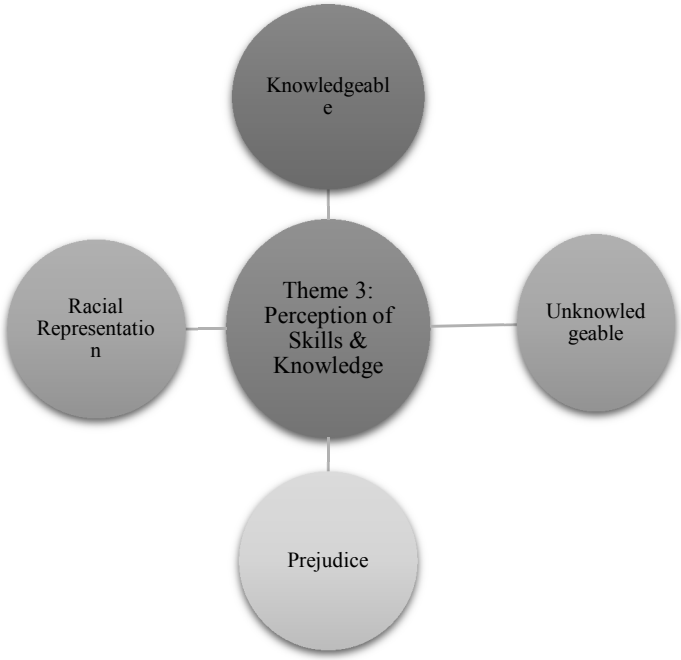
Theme 3: Perceptions of Skills & Knowledge

The theme of knowledge and skill was consequent of Black mothers' perceptions of the health care staff's acquired level of education, or the assumption based on shared knowledge that

the provider has a college degree. For example, the assumption that a physician is knowledgeable based solely upon career status as a doctor or nurse and no actual evidence of acquired skill or knowledge. Thus, the participants presume the health care staff to be well-informed about breastfeeding or have the essential skills necessary to perform their job duties. Figure 26 is an Illustration of the SRQ 4 Theme with associated codes.

Figure 26

SRQ4, Theme 3: Perception of Skills and Knowledge



On the other hand, some participants considered if their health care team demonstrated having or showing knowledge or intelligence regarding cultural and racial difference the range of one's information or understanding involved with rendering proper care, " my experience made me want an all-Black team. So, just that fear of. Having somebody who wouldn't believe me

again was enough for me to be like, no, I need black women in this room at all times." (Participant 81BI)

Black mothers described Non-conscious racial and ethnic biases as the lack of patient representation in health literature. Participants described implicit biases that may be unconsciously integrated into breastfeeding curricula or within birthing centers in general. One participant discussed how the birthing center failed to provide her with any information on breastfeeding, " I was only confident because I have experience, but I did not receive any type of support education. I never saw a picture of a black mother or babies or any sort of black family. they were all white." (Participant B80E)

Racially biased educational materials were among the many characteristics within birthing centers that Black mothers described as factors that may limit their health care teams' ability to identify and treat patients of color. Black mothers in this study also described processes or policies regarding the skill level and knowledge of their health care in terms of breastfeeding care. For example, one participant describes a lactation consultant as being more knowledgeable about breastfeeding as compared to having a nurse to which she was denied and therefore perceived discriminatory practice:

> I wanted to breastfeed my baby and have been offered a lactation consultant, but because I wasn't knowledgeable, what I got was that a nurse could help. Moreover, a nurse is not a lactation consultant, and the nurse, what they are going to do is they want the baby to fatten up. They don't want them to lose weight. It would be the attitude of the staff. Subliminal on the mom and baby floor. You have lots of pictures of moms and babies

> with blonde hair and blue eyes, giant murals of white women and their babies, some of those daddies, but it was like, there, no one looks like you on. (Participant F751)

Summary

This chapter introduced Black mothers' perception of racial discrimination after birth within birthing centers and how these experiences become a factor in the decision-making process of initiation and duration of exclusive breastfeeding practices of Black mothers with their newborn infant(s). Next, chapter 4 reviewed the demographic characteristics of the participants to include state of residence within the United States, education, employment status, income, age, marital status, and breastfeeding intentions. Additionally, Chapter 4 reexamined the data collection method, analysis, implementation, and analysis. Finally, the participants spoke of their birthing experiences and their interactions with healthcare staff and how these encounters impact exclusive breastfeeding health-seeking behavior. The research question for the study asked, "How do the experiences of Black mothers in birthing centers with, and the perception of racism and discrimination affect the initiation and duration of exclusive breastfeeding practices of Black mothers with their newborn infants?" To fully explore the scope of this question 4 secondary questions were asked that aligned with the SEM, which allowed exploration of how the experience of racism and discrimination of Black mothers interact on multiple levels within the birthing centers social environment, thus influences their health behavior, initiation, and duration of exclusive breastfeeding.

The first sub-research question asked How do Black mothers describe individual and intrapersonal barriers within birthing centers that affect a Black mother's attitudes and beliefs regarding exclusive breastfeeding of their infant? Three specific themes emerged from this

question: pregnancy, birth outcomes, & motherhood, experiences & attitudes, knowledge & beliefs. These themes surfaced from a multitude of experiences and complex dynamics within, regarding, and resulting from Black mothers' perception of pregnancy, birth outcomes, & motherhood.

The second sub-research question asked How do Black mothers describe the interpersonal relationship with health care professionals within birthing centers regarding their perceived behavior as racist or discriminatory and its contribution to their exclusive breastfeeding experience? The emerging themes at this level are support systems, perceptions of breastfeeding, and perceptions of support.

The third sub-research question asked How do Black mothers perceive the community-level factors of racism and discrimination surrounding the birthing centers in which social relationships occur to become a factor in exclusive breastfeeding practices? Three specific themes emerged from this question which was perceptions of biases, social relationships, and characteristics. This level focuses on relationships within the social networks between Black mothers and their health care staff within birthing centers. Finally, this level explored how exclusive breastfeeding is supported and viewed by those within Black mothers' interpersonal circles and birthing centers.

The fourth sub-research question asked How do Black mothers perceive health care policies, practices, and procedures within birthing centers perceived as biased that could affect Black mothers' decision to breastfeed exclusively? Three specific themes emerged from this question: informal and formal policies & protocol, safety & responsiveness, perceptions of skill and knowledge. In addition, this level examined Black mothers' perceptions of the quality of

care and discrimination within birthing centers, including staff education, training, knowledge, availability and time spent with Black mothers, and access to resources.

Chapter 5 covers a comprehensive synopsis of the study findings, identifying themes concerning the research question(s), the correlation of identified themes to existing literature, limitations of the study, possible implications for positive social change, recommendations for further research, and a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this basic qualitative study was to examine and describe how Black mothers who have identified racial discrimination after birth perceive the individual, interpersonal, and community factors and the organizational structures and existing policies in birthing centers. The objective of this study was to provide awareness of factors that may affect Black mothers' decisions to initiate and sustain exclusive breastfeeding of their newborn infant. Additionally, awareness of Black mothers' perceptions of bias and racism within the institutional fabric and existing policies in birthing centers could promote changes in birthing center policies, practices, and procedures that disproportionately and negatively affect Black mothers. Chapter 5 contains a comprehensive synopsis of the study findings, identifying themes concerning the research question, the correlation of identified themes to existing literature, limitations of the study, possible implications for positive social change, recommendations for further research, and a conclusion.

Interpretation of the Findings

Social–Ecological Model Factors

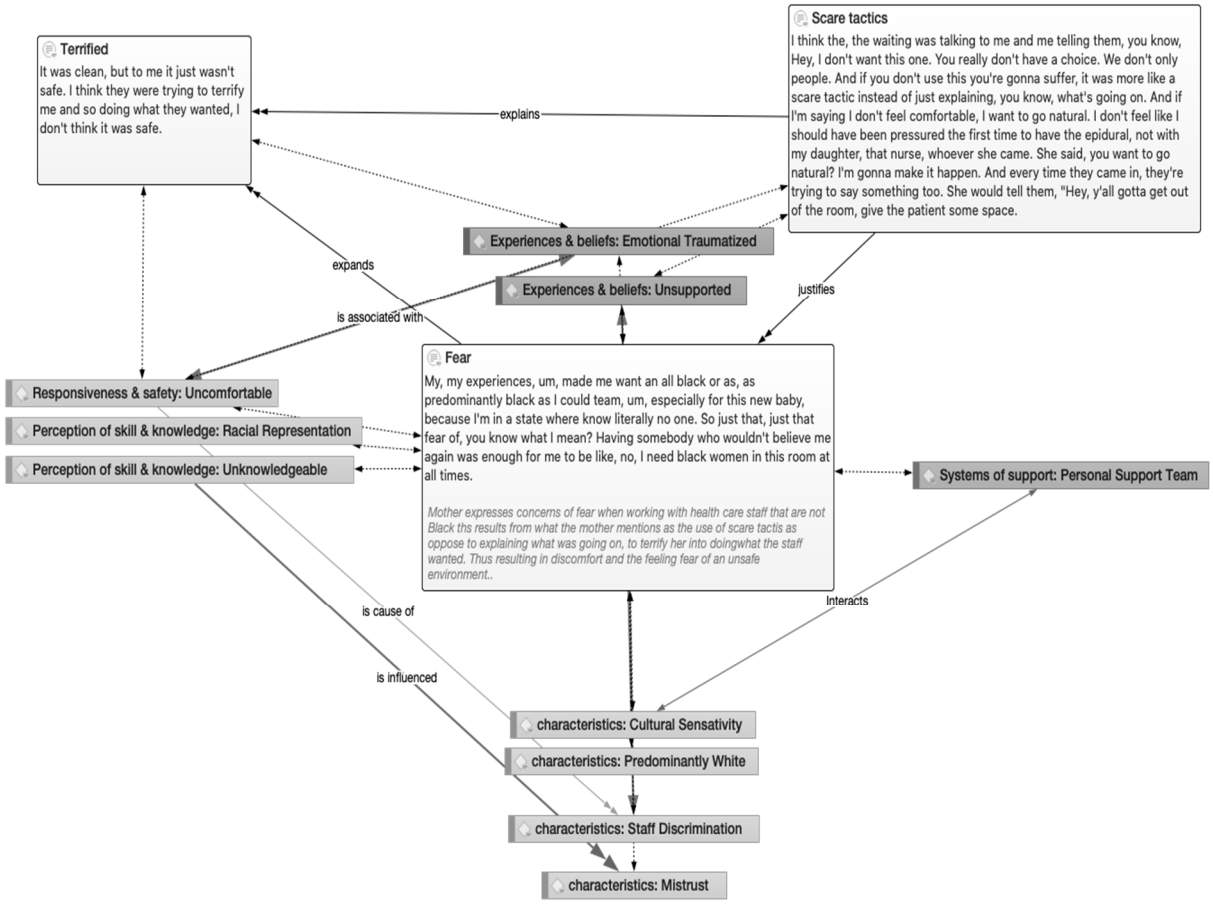
The SEM of health behavior includes visual depictions of dynamic relationships among individuals, groups, and their environments with an emphasis on environment and policy in contexts of behavior while incorporating social and psychological influences (Golden et al., 2015; McCormack et al., 2017; Sallis et al., 2015). In study the researcher examines and describes how the individual, interpersonal, and community factors and the organizational structures and existing policies in birthing centers by Black mothers. Additionally, the results of

this study provide insight into the multilevel interactions and relationships between Black mothers (individuals) and birthing centers (their environment). The experiences of racism and discrimination in birthing centers are multifaceted issues that impact Black mothers and their exclusive breastfeeding initiation and duration practices.

This study draws awareness to the various factors in birthing centers that lead to the perception of racism or discrimination and how these complex interactions influence individuals' health behaviors (Perrin, 2016; UNICEF, 2016). In addition, the researcher illustrates how Black mothers identify perceptions of racial discrimination after giving birth in a birthing center. This study consisted of 10 one-on-one in-depth semistructured video interviews of Black mothers who met the preselected criteria based on the research question. The researcher identified participants through purposeful sampling on select social media platforms. Figure 27 is a visualization of network mapping using Atlas.Ti 9 with study results illustrates multifaceted levels within the core principles of the SEM and how they apply to the findings of this study.

Figure 27

Illustration of SEM and Results



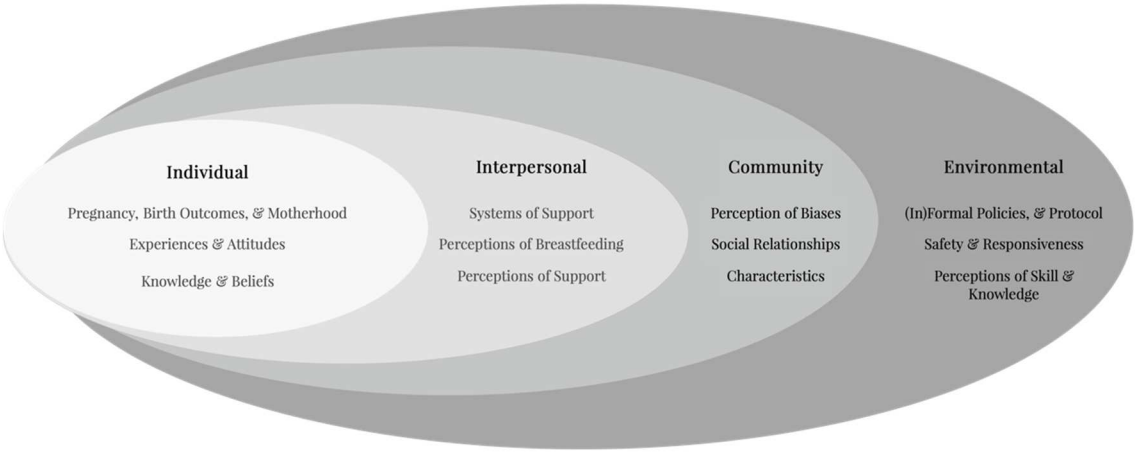
The purpose of the study was to understand better the individual, interpersonal, and community factors affecting the initiation and duration of exclusive breastfeeding practices among Black mothers who gave birth in birthing centers. Twelve themes were identified based on coding and analysis of participant responses. This study confirms findings as reported in the literature. In addition, it adds to the body of evidence emphasizing the significance of the perception of discrimination and implicit provider bias in health care settings that negatively affect Black mothers' and their infants' health and health care. Using the SEM theoretical

framework, the researcher grouped the emerging themes into categories that align with SEM characteristics.

The SEM was used to conceptualize that an individual's health is affected by the interaction between the characteristics of the individual, the community, and the environment, including the physical, social, and political components (Kilanowski, 2017; Lee et al., 2017). The inclusion of social and physical environment factors is an essential part of the SEM that shapes or constrains individual and interpersonal determinants of health behavior (Glanz et al., 2008). The use of the SEM framework for this research study helped to understand individual and group behaviors in their environment, which are the social and physical situations where behaviors occur (Hayden, 2017). The fundamental constructs of the SEM originate from the notion that multiple factors, including intrapersonal (biological, psychological), interpersonal (social, cultural), organizational/community, physical environmental, and policy influence individuals (Golden et al., 2015; McCormack et al., 2017; Sallis et al., 2015). Thus, the SEM provides a comprehensive insight into the multilevel interaction and the relationship between individuals and their environment as underlying determinants of health behaviors (Golden et al., 2015; McCormack et al., 2017; Sallis et al., 2015). Specifically, in this study, the researcher explored the hierarchical levels of SEM, including individual, interpersonal, organizational, and community/environment factors that influence Black mothers' decisions to initiate and sustain exclusive breastfeeding (Figure 28).

Figure 28

Study Categories with Themes by SEM



When considering individual and intrapersonal level factors contributing to Black mothers' attitudes and beliefs regarding exclusive breastfeeding practices, the researcher identified various dynamics that influence and encompass these interactions and relationships within birthing centers. These factors include preconception exposures to breastfeeding, pregnancy and birth outcomes resulting in physical and psychological trauma; birthing experience features associated with Black mothers' ideals of their self-concept, coping skills, and resiliency; perceptions of stigmas related to access and acquirement of adequate care and health literacy for breastfeeding commitment, self-advocacy, and determination.

Interpersonal-level factors concerning relationships and interactions between health care staff in which Black mothers had direct contact instilled unwavering values regarding exclusive breastfeeding, perceptions of support, develop Black mothers' acuity of self-motivation, and shapes whether or not those around them support breastfeeding. These factors include perception of racism or discrimination; social support systems that influenced Black mothers perceptions of comfort in their environment; companionship during the birthing experience and the perceptions

of breastfeeding support, exposure to breastfeeding, and Black mothers' discernment of normalization of breastfeeding in their environments; and access to a professional lactation consultant who has demonstrated the necessary skills, knowledge, and attitudes.

Community-level factors illustrate interactive influences on Black mothers, such as community and social networks. Black mothers identified elements of racism and discrimination in birthing centers that become a factor for exclusive breastfeeding practices as aggression, dismissiveness, and condescension. Black mothers experienced these as barriers to achieving their breastfeeding goals. The perceptions of health care biases by Black mothers were the most significant indication of support or lack of support from health care professionals. In a more diminishing nature, some participants equated the attitudes, body language, and behavior of health care professionals to an ethnic slur used most often against Black people. This slur often triggers the psychological trauma that ensues when a stigmatized group believes those negative stigmas. Environment-level factors illustrate Black mothers' perceptions of the quality of care and discrimination in birthing centers, including policies, practices, and procedures. Black mothers described violation or invasion of privacy and beneficence as prominent protocols, or practices Black mothers described as traumatic and discriminatory. Barriers to achieving breastfeeding goals included comfort level in birthing centers, safety regarding adequate working equipment, and staff attentiveness. Lastly, participants considered how their health care staff demonstrated having or showing knowledge or intelligence regarding the cultural and racial difference and the range of information or understanding involved with rendering cultural and racial proper care.

Analytic Category 1: Individual Factors

At the individual levels of the SEM, the researcher explored how the experiences of perceived racism and discrimination by Black mothers affect their attitudes, beliefs, and perceptions regarding exclusive breastfeeding initiation and duration. The findings from this study substantiate Barbosa et al.'s (2017) outcomes that despite the experiences of racism in birthing centers, Black mothers demonstrate determination, persistence, assertiveness, self-reliance, confidence, and resourcefulness in their desire to breastfeed exclusively (Barbosa et al., 2017; Kamoun & Spatz, 2017). Personal breastfeeding experiences, including exposure to breastfeeding, were associated with positive attitudes toward exclusive breastfeeding initiation and duration and Black mothers' ideals of their self-concept, coping skills, resiliency, and perception of stigmas related to accessing and acquiring adequate care. Health consciousness about breastfeeding and their overall health equipped Black mothers to advocate for themselves when they felt the health care staff was disrespectful, dismissive, and discriminatory toward them. The participants who were not first-time mothers exhibited resiliency and preparation for their birth experiences. This prior experience enabled them to vocally advocate for themselves and their expectations from the health care staff.

The Black mothers in this study expressed favorable attitudes toward initiation and duration of exclusive breastfeeding and demonstrated a wide-ranging understanding of both the economic and health advantages (Reno et al., 2018). Impacts of health literacy, regardless of the methods it was attained by the mother, including formal breastfeeding education by qualified health professionals or social media via YouTube or Facebook, is an enormous component of breastfeeding knowledge and an influential factor for breastfeeding commitment self-advocacy,

and determination. Although participants had positive attitudes toward exclusive breastfeeding initiation and duration, the perceptions of racism and discrimination in birthing centers created negative implications for health-seeking behaviors. As a result, many participants were less likely to obtain proper breastfeeding care and expressed underutilization of health services to meet their breastfeeding goals (Benjamins et al., 2019; Stepanikova et al., 2017).

Interactions between Black mothers and their environments influence health consciousness, intentions of exclusive breastfeeding initiation and duration, attitudes toward exclusive breastfeeding initiation and duration, and perceptions of exclusive breastfeeding initiation and duration. For example, when assessing Black mothers' infant feeding intentions, measures of strength of intentions to breastfeed exclusively at one month, three months, or six months, 80% of participants had strong intentions to initiate exclusive breastfeeding. Nonetheless, very few participants could not accomplish the recommended duration for exclusive breastfeeding; however, most of the participants' commitment did not wavier regarding exclusive breastfeeding. Similar to Barbosa et al.'s (2017) results, my findings expand on knowledge in the discipline of human lactation and illustrate that the prenatal intention to breastfeed and knowledge of breastfeeding empower Black mothers to demonstrate determination, resourcefulness, and commitment despite experiencing racism or discrimination in birthing centers (Barbosa et al., 2017; Kamoun & Spatz, 2017). In addition, health literacy regarding exclusive breastfeeding initiation and duration invigorates participants to endure perceived challenges or potential barriers that may have resulted from breastfeeding or the birthing process.

In addition, breastfeeding self-efficacy and education play a pivotal role in Black mothers' breastfeeding attitudes despite adversity and negative birthing experiences. Similar to the findings of Reno et al. (2018), I found that Black mothers continue to hold favorable attitudes toward exclusive breastfeeding initiation and duration and demonstrate a sound understanding of both the economic and health advantages of breastfeeding despite their experiences of racial discrimination. Thus, this study supports previous findings that are breastfeeding self-efficacy and motivation are directly influence exclusive breastfeeding initiation and duration among Black mothers (Dunn et al., 2015; Golden et al., 2015; Hayden, 2017; Munn et al., 2016).

Analytic Category 2: Interpersonal Factors

In this study, the researcher explored how Black mothers describe the interpersonal relationship regarding the behavior of health care professionals within birthing centers that Black mothers perceived as racist or discriminatory and its contribution to their exclusive breastfeeding experience. Black mothers identified social relationships between their partners and their relatives as positive contributors to breastfeeding at the interpersonal level (Dunn et al., 2015; Munn et al., 2016). The decision to breastfeed, also known as breastfeeding intentions, is often made before conception. Unlike breastfeeding attitudes, breastfeeding intention is more often associated with exposure to breastfeeding and individual values surrounding the benefits of exclusive breastfeeding initiation and duration (Barbosa et al., 2017; Kamoun & Spatz, 2017; Lok et al., 2017; Reyes et al., 2019). This study confirms the findings within the literature that both perinatal exposures to breastfeeding and seeing breastfeeding normalized before conception had a positive impact on Black mothers' attitudes, decisions, and social views of exclusive breastfeeding.

Social support systems, including biological family, workgroups, friendships, and formal support systems such as laboring doulas and midwives, play a significant role in the continued encouragement of Black mothers' decision to breastfeed. Equally important Black mothers described the importance of having the support of their families that rallied around them. These interpersonal connections provided support and were a source of information the birthing center staff failed to provide. Having the support of others who could advocate for both Black mothers and their babies and her understanding of how those around her felt regarding breastfeeding factored into the mother's decision to initiate and sustain exclusive breastfeeding. Although Black mother described their support systems as having a positive influence on the perception of breastfeeding support, systems of social support and relationship with health care professionals within birthing centers failed to demonstrate positive perceptions of breastfeeding support regarding their behavior.

Furthermore, support systems include biological family, workgroups, friendships, and personal support team or formal support systems such as laboring doulas and midwives play a significant role in the continued encouragement of Black mothers' decision to breastfeed. These findings indicate a positive association between breastfeeding exposure which included witnessing others breastfeed, such as a parent or relative, being breastfed as an infant themselves, or knowing someone who has breastfed. In addition, black mothers view exclusive breastfeeding as well as social support regarding exclusive breastfeeding. These interpersonal connections provided support and were often a source of information where the birthing center staff failed to provide this support.

The perception of discrimination and implicit provider bias in health care settings towards Black mothers negatively affects Black mothers' and their infants' health and health care. Black mothers' perception of breastfeeding support was a direct reflection of provider-patient interaction and provider behavior. Factors contributing to the perceptions of discrimination in health care include low-quality care, decision-making involvement, time spent with the provider, and communication (Attanasio & Kozhimannil, 2017; Benjamins & Middleton, 2019). In addition, black mothers described their health care staff as unsupportive of breastfeeding due to negative non-verbal interactions. Abramson et al. (2015) suggest that the perception and source of discrimination are multifaceted and include conscious and unconscious prejudice, stereotyping by providers, and potential differences in racism sensitivity, as well as verbal (non-verbal) cues. Black mothers perceived discrimination as a barrier to quality patient-provider relationships in health care settings attributed to provider mistrust and ineffective or biased communication that become apparent during patient-provider interactions (Cuevas et al., 2016).

Analytic Category 3: Community Factors

At the community level, the researcher investigated how Black mothers perceive the factors and characteristics of patient-provider relationships or interactions perceived as biased, racist, and discrimination within the birthing centers. These social relationships become a factor in Black mothers' decision of exclusive breastfeeding practices. Black mothers described racial microaggressions as the leading origin of racial and discriminatory characteristics within birthing centers among patient-provider interactions. The finding substantiates Gonzalez et al. (2018), which found that explicit racism and subtle slights in health care settings were prevalent among all participants. In addition to non-verbal behaviors that led to perceptions of provider bias,

participants also identified treatment by support staff as a prime to perceived bias (Cuevas et al., 2016; Gonzalez et al., 2018). Black mothers' descriptions of racial biases and discriminatory characteristics within birthing centers comprised aggressive, condescending, dismissive behaviors and stereotyping. The finding of this study aligns with the literature indicating providers overlooking Black mother ethnic background concerning patient-provider communication as well as the less active exchange of information and limited involvement in decision making, as factors that negatively affect the quality of care, thus increasing the perception of discrimination among Black mothers' (Cuevas et al., 2016; Gonzalez et al., 2018).

Black mothers described racial microaggressions as the leading origin of racial and discriminatory characteristics within birthing centers among patient-provider interactions. Explicit racism and subtle slights were prevalent among all participants. In addition to non-verbal behaviors that led to perceptions of provider bias, participants also identified treatment by support staff as a prime to perceived bias (Cuevas et al., 2016; Gonzalez et al., 2018). The most significant barrier was their ability to transcend obstacles resulting from the birthing process, such as cesarean section or discomfort with health care staff, to remain committed to exclusive breastfeeding. Actions and behaviors of health care staff that Black mothers perceived as being invalidating, discouraging, obstructive, or deterring were a commonality explained among participants. They described as factors that impede Black mothers' self-concept ideals, coping skills, and resiliency.

Additionally, the discernment of being unsupported during the birthing process and the subsequent hospital stay directly impacted some participants and their motivation to breastfeed exclusively. When asked to discuss their informal or formal relationships among the health care

organization, Black mothers who participated in this study identify behaviors such as aggression, being dismissive, and condescending as barriers to achieving their breastfeeding goals. Black mothers all describe their experience of health care bias as not having access to a certified IBCLC, lack of breastfeeding information, or imposing formula on the mother all factors into Black mothers' description of racism and discrimination within birthing centers. First-time Black mothers who describe having little to no guidance with breastfeeding, lack emotional and physical support and deal with racism and discrimination within birthing centers describe the experience as overwhelming and stressful. The perception of health care biases by Black mothers was the single most significant indication of support or lack of support from health care professionals. In a more diminishing nature, some participants equate the attitudes, body language, and behavior of health care professionals to an ethnic slur used most often against Black people.

The lack of racial representation and cultural sensitivity within birthing centers was another characteristic that Black mothers perceived as racially biased and discriminatory. The need for racial and ethnic representation among health care professionals provides a sense of comfort for the mothers and its importance with creating and connecting with every mother regardless of racial ethnicity. Black mothers described photographs and rendered graphics depicting, as mentioned by participant #F751, "lots of pictures of moms and babies who are blonde hair[ed] and blue eyes, big murals of white women and their babies, some of those daddies, but it was like, there is no one that looks like you." Black mothers perceived the undertone that is associated with this nature of unconscious bias as emotional detachment.

Abramson et al. (2015) suggest that the perception and source of discrimination are multifaceted and include conscious and unconscious prejudice, stereotyping by providers, and potential differences in racism sensitivity. Infant formula practices in birthing centers were very influential on Black mothers' perception of exclusive breastfeeding support from their health care staff and birthing facility. Cultural, religious competence of health care staff and birthing center policies also factored in Black mothers' perception of bias regarding racial discrimination. The lack of respect for a person's autonomy was another practice that Black mothers perceived as discriminatory. Black mothers describe not having their choices and decisions heard or simply withholding opportunities to discuss actions regarding birth or breastfeeding without deliberate obstruction. An overwhelmingly concerning was Black mothers who described their perception of racial discrimination as the failure of the health care staff to meet the needs of the mothers, or the perception of health care staff inflict physical or emotional harm by way of passive omissions of proper care or gross carelessness steaming from a lack of compassion or neglect. Moreover, these findings substantiate the current literature on this topic and suggest that racially biased educational materials may limit physicians' ability to identify and treat patients of color (Abramson et al., 2015; Massie et al., 2019).

Analytic Category 4: Environmental Factors

At the environment level, the researcher explored Black mothers' perception of health care policies, practices, and procedures within birthing centers perceived as biased and factored into their decision to breastfeed exclusively. Through societal and cultural processes created health care institutions to be racialized, demonstrating racism through policies and practices (Bailey et al., 2017; Hicken et al., 2018). Cultural, religious competence of health care staff and

birthing center policies also factored in Black mothers' perception of bias regarding racial discrimination. Another practice perceived as discriminatory was the lack of respect for a person's autonomy. Black mothers describe the lack of choices, failure to acknowledge the mothers' decisions, and refusal to discuss providers' actions regarding birthing practices or breastfeeding as a deliberate obstruction to care. An overwhelmingly concerning was Black mothers who described their perception of racial discrimination as the failure of the health care staff to meet the needs of the mothers, or the perception of health care staff inflict physical or emotional harm by way of passive omissions of proper care or gross carelessness steaming from a lack of compassion or neglect. Benjamins and Middleton (2019) and Stepanikova and Oates (2017) found that individuals reporting perceived discrimination in the health care setting have negative implications for health-seeking behavior and are less likely than others to obtain preventative care, various health screenings, postpone treatment, and underutilization of health services. The findings validate the literature that suggests that perceptions of discrimination within the health care system were linked to the type of insurance carried, which Black mothers perceived as differential treatment and influenced the quality of health care service they received (Cuevas et al., 2017; Lewis et al., 2017).

Structural facilitators correlated with exclusive breastfeeding comfort and safety represent environmental barriers or "place" (Chopel et al., 2019). As defined by Black mothers, informal and formal protocols were viewed as mandates, procedures, or practices. Also, routines typically carried out by staff are viewed as bias and perceived as the strict variance of adherence, or "by the book" unjust or prejudicial treatment of different categories, resulting in unfair treatment to certain racial groups. These structural biases woven into health care protocol result

in discriminatory treatment (Griswold et al., 2018). Violation or invasion of privacy and beneficence were described as prominent protocols or practices that Black mothers described as traumatic and discriminatory.

Factors contributing to the perceptions of discrimination in health care include low-quality care, decision-making involvement, time spent with the provider, and communication (Attanasio & Kozhimannil, 2017; Benjamins & Middleton, 2019). These findings illustrate how cues in birthing centers' physical and social environments signal both inclusion and exclusion of Black mothers and are associated with profound psychological consequences (Stangl et al., 2019). Black mothers describe the experience of health care stigmas related to stereotyping, prejudices, discrimination, behavior that result in worsening, undermining, or impeding health care and environment protocol processes; including social relationships, resource availability, stress, as well as psychological and behavioral responses that exacerbate issues that led to poor health (Stangl et al., 2019).

Limitations of the Study

Given the scope of the study, the leading limitation was the acquirement of an adequate sample size of participants willing to discuss their experiences. Therefore, the geographic location was expanded from Philadelphia, PA, to include Black mothers in the United States that met the predefined study inclusion criteria to overcome this limitation. Additionally, expanding the inclusion criteria from Black mothers who recently gave birth within the last 12 months to Black mothers who recently gave birth to infants up to 24 months. As a result, of 20 of the potential participants recruited, 10 met the rigorous study inclusion criteria.

Additional limitation for this study during the data collection phase was participants' reliability and honesty when discussing such a sensitive topic. With the inclusion criteria expanded to 24 months, many participants had another baby during this period or were currently pregnant and often spoke of both pregnancies. The researcher asked participants only to discuss one birthing experience that fell within this time frame to overcome this limitation. Future studies should consider data immediately following the birthing experience or after discharge from the hospital to avoid issues with truthfulness and accuracy.

Furthermore, an additional limitation to this study is the sampling methodology. Purposeful and snowball sampling of participants in this study was limited to participants linked with the aims of the investigation (Palinkas et al., 2015), which are Black mothers who can speak to their experience of racism and discrimination in birthing centers, including background comments and actions of health care providers and staff members, as well as policies and procedures perceived as discriminatory or racist. Expanding the inclusion criteria and geographical region reduced the sampling methodology limitation to allow purposeful sampling from a larger pool of potential participants.

Another potential limitation was that women inadvertently left out of the study who do not have access to the internet, mobile device, or wireless access. Using these technologies was the primary method used during the recruitment of potential participants and data collection practices. Self-reflection and bracketing to avoid influencing the data collection and analysis process, along with using audio recordings to ensure accuracy of responses addressed potential concerns regarding researcher bias resulting from the researchers' role as a lactation consultant and knowledge of breastfeeding support strategies as well as policies and procedures within

birthing centers (Bloomberg & Volpe, 2019). During the data analysis phase only, information collected from participates via auto and video recording were transcribed by a third-party transcription service in addition to the use of 2 research assistants for triangulation and Atlas.Ti 9 MacOS qualitative software for coding data and identifying themes. Lastly, other limitations regarding generalization are intrinsic to qualitative studies.

Recommendations for Further Research

Given the scope of the study, the leading limitation was the acquirement of an adequate sample size of participants willing to discuss their experiences. Therefore, the geographic location was expanded from Philadelphia, PA, to include Black mothers in the United States that met the predefined study inclusion criteria to overcome this limitation. Additionally, expanding the inclusion criteria from Black mothers who recently gave birth within the last 12 months to Black mothers who recently gave birth to infants up to 24 months. As a result, of 20 of the potential participants recruited, 10 met the rigorous study inclusion criteria.

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Implications for Positive Social Change

Exclusive breastfeeding rates have been on the rise with the help of health communication campaigns triggered by the Surgeon's General Call to Action to support exclusive breastfeeding and the Healthy People 2020 Maternal, Infant, and Child Health goals

(CDC, 2018c; Thomas, 2018a). Regrettably, the health gap-disparity between Black mothers and their white counterparts has not decreased regarding exclusive breastfeeding (CDC, 2018c; Thomas, 2018a). Therefore, the results of this study create social change by providing an insight into Black mothers' experiences individually, interpersonally, and within their community regarding exclusive breastfeeding. Furthermore, this study provides insight into the perception of implicit (unconscious) bias, racism, and discrimination within the institutional structure and existing policies of birthing centers that may influence the initiation and duration of exclusive breastfeeding among Black mothers. The results of this study provide insight into the perceived social and systemic barriers that exist individually, interpersonally, and within institutional structures and existing policies of birthing centers that may impede exclusive breastfeeding initiation and duration for this population.

Due to structural racism woven into the United States' social and institutional structure, racial health disparities continue to impact people who self-identify as Black negatively. Therefore, this study also provides an understanding of how the individual, interpersonal, and community factors, as well as the organizational structures and existing policies within birthing centers, are perceived by Black mothers. In addition, the study provides more insight into how Black mothers identified and characterized these perceptions of racial discrimination after giving birth within a birthing center. As a result, this study can provide insight into (a) reducing exclusive breastfeeding disparities rates that are associated with race/ethnicity and (b) assist with developing best practices for the management of exclusive breastfeeding. Subsequently, leading to strategies that yield higher breastfeeding rates among Black mothers, which would significantly impact Black maternal and child health (McGuire, 2011; NCHEC, 2015; Office of

the Surgeon General U.S. Department of Health & Human Services [HHS], 2011; Trent et al., 2019).

These findings can be integrated into breastfeeding promotion programs and seminars to increase awareness of Black mothers' perceptions of bias and racism within the institutional fabric and existing policies within and surrounding birthing centers which could promote changes in birthing center policies, practices, and procedures that disproportionately and negatively affect Black mothers. This study identifies inequities within health care protocol, care practices, birthing and breastfeeding resources, and health procedures that new mothers need to engage in positive health-seeking behavior of initiating and sustaining exclusive breastfeeding of their newborn infant. This study's new knowledge can develop new studies or begin the critical discussion of addressing bias and racism within the institutional fabric and existing policies within and surrounding birthing centers that impede exclusive breastfeeding initiation and duration practices for Black mothers. Ultimately, this awareness may promote healthy discussions within birthing centers on how to serve this population of mothers better.

This research connection with health education and promotion discipline includes the collection of primary data to determine the needs of this population and analyze the relationships among behavioral, environmental, and other factors that influence health behaviors that impact their health in addition to assessing the social, environmental, political, and other factors that may impact health education/promotion regarding exclusive breastfeeding.

Dissemination

The dissemination plan for this study consists of sharing the research findings with the population identified within this study, in addition to federal, state, and local agencies as well as

community organizations that serve this population. Specific stakeholders include local birthing and maternal child health facilities (to include WIC- Women Infant Child Nutrition Program, Philadelphia Department of Public Health, and Maternity Care Coalition), and breastfeeding support groups (Bae Café, Drexel University, and Philadelphia Department of Public Health [PDPH]). Other opportunities for the research findings in this study to be disseminated include websites, journals, various electronic media, meetings, conferences, interpersonal communications, and formal collaborations. In addition, stakeholders can benefit from understanding maternal motivation, attitudes, beliefs, and experiences regarding exclusive breastfeeding and their perception of race-based discrimination. Additional plans for dissemination include poster presentations, seminars, and lectures for organizations, community stakeholders, community councils, city councils, health departments, and community and social organizations that work with the population identified in this study. The results of this study could provide a better understanding of perceptions of racially biased and discriminatory treatment of Black mothers within policies, practices, and procedures within birthing centers that ultimately impede or hinder the initiation and duration of exclusive breastfeeding practices.

Conclusions

This study intensifies and complements literature that provides evidence linking health care practices of health care providers and racially based biases that disproportionately affect Black mothers and their infants to that of racial and ethnic health disparities (Crossley, 2016; Jones et al., 2015; Paradies et al., 2013). Utilizing the fundamental constructs of the SEM, this study draws insight into multilevel interactions within Birthing centers that impede the initiation and duration of exclusive breastfeeding practices of Black mothers (Golden et al., 2015;

McCormack et al., 2017; Sallis et al., 2015). The perception of racism and discrimination within birthing centers create negative implications for health-seeking behavior, and many of the participants were less likely to obtain proper breastfeeding care as well as expressed underutilization of health services to meet their breastfeeding goal (Benjamins et al., 2019; Stepanikova et al., 2017). Negative provider-patient interactions, including non-verbal interactions, were described as low-quality care, refused decision making, limited time spent with the provider, and poor communication (Attanasio & Kozhimannil, 2017; Benjamins & Middleton, 2019).

Racial microaggressions, explicit racism, subtle and stigmatized insults that trigger psychological trauma from a health care professional according to Black mothers' perception of biases surfaced as descriptions of provider behaviors described as inclination towards them, lack of reliable access to a certified lactation consultant (IBCLC), lack of breastfeeding resources and information, or imposition of infant formula practice, were prevalent among all participants and were described as the leading origin of racial and discriminatory characteristics within birthing centers at the community level (Cuevas et al., 2016; Gonzalez et al., 2018). Lastly, informal and formal protocols such as violation or invasion of privacy, and health care stigmas related to stereotyping, insurance, and the perception of inflicting physical or emotional harm by way of passive omissions of proper care or gross carelessness steaming from a lack of compassion or neglect as defined by Black mothers illustrates structural biases woven into health care protocol resulting in discriminatory treatment (Cuevas et al., 2016, 2017; Griswold et al., 2018; Lewis et al., 2017). Thus, this study adequately identifying Black mothers perception of racism and discrimination within birthing centers that impede exclusive breastfeeding initiation and

duration, as well as offers recommendations for future research that sufficiently addresses and remedies how racism or discriminatory practices against Black mothers during the birthing process and continued care during the immediate postpartum stay (Griswold et al., 2018; Thomas, 2018a).

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Appendix A: Qualifying Questionnaire

Research Study: Factors Within Birthing Centers that Impede Exclusive Breastfeeding among Black mothers': A Basic Qualitative Approach

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Research Study Qualifying Questionnaire
Principle Researcher:
Natashia L. Conner, MS, CHES, IBCLC, PhD-Candidate

Walden University, Doctorate Health Education and Promotion

Research Study Name: Factors Within Birthing Centers that Impede Exclusive Breastfeeding among Black mothers': A Basic Qualitative Approach

Demographic Questions

What is your highest education level?
- ☐ Did not completed high school
- ☐ High school diploma/ GED
- ☐ Some high school
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate/Professional degree (PhD, MD, etc.)

What is your marital status?
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Are you a WIC (Women's Infant and Children Nutrition Program) participant?
- ☐ Yes
- ☐ No

What type of insurance do you have?
- ☐ No insurance/ Self-Pay
- ☐ Medicaid/ Medicare
- ☐ Private Insurance

What is your household income?
- ☐ Less than $20, 000
- ☐ $20,000 - $39,999
- ☐ $40,000 - $59,999
- ☐ $60,000 - $79,999
- ☐ $80,000 - $99,999
- ☐ $100,000 and higher

Are you currently employed?

- ☐ Yes
- ☐ No

Qualifying Questions

How old are you?

- ☐ Under 18
- ☐ 18-20
- ☐ 21-25
- ☐ 26-30
- ☐ 31-35
- ☐ 36-40
- ☐ 41-45
- ☐ 46 and older

Do you identify as Black/ African American? *For the purpose of this study a persons who identify as Black/African Americans who are descendants of slaves brought to the United States involuntarily, and/or the offspring descended born in the United States from families that originally came from Africa, regardless of the ethnicity or race of the other parent that lived under institutionalized slavery in the United States.*

- ☐ Yes
- ☐ No

Have you recently had an uncomplicated delivery of a full-term well-newborn (37 weeks gestational age or older) within the last 24 months? *An uncomplicated spontaneous vaginal delivery is the most common type of birth. When vaginal labor and delivery is straightforward, it is considered an uncomplicated process. When necessary, assisted delivery methods are needed this is considered complicated. This assistance can vary from Cesarean section, blood loss, fetal injury, small baby, diabetes, high blood pressure disorders, substance abuse history, HIV+*

- ☐ Yes
- ☐ No

Have you experienced or perceived racism, discrimination, or bias in the birthing center? *Racial discrimination is a particular type of discrimination treating unfavorably or worse than another person specifically targeting members of racial and ethnic minorities, due to characteristics associated with race such as hair texture, skin color, or certain facial features as well as particular policy or work procedures that puts people of certain racial group at a disadvantage. Whereas perceived racism refers to the recognition of racism based on every-day, lifetime unfair treatment and discrimination associated with behaviors for racial and nonracial attributes, negative attitudes and beliefs toward racial outgroups (prejudice), and differential treatment of members of these groups by both individuals and social institutions (discrimination) trigger by elevated exposure to traditional and racism-related stressors, especially those linked to social and economic deprivation.*

- ☐ Yes
- ☐ No

Are you a resident within the Mid-Atlantic and Northeast region of the United States (New Jersey, New York, Pennsylvania, Illinois, Indiana, Michigan, Ohio, and Wisconsin), or did

you deliver within the Mid-Atlantic and Northeast region of the United States (New Jersey, New York, Pennsylvania, Illinois, Indiana, Michigan, Ohio, and Wisconsin)?

- ☐ New Jersey
- ☐ New York
- ☐ Pennsylvania
- ☐ Illinois
- ☐ Michigan
- ☐ Ohio
- ☐ Wisconsin
- ☐ No

Was your prenatal intent to exclusively breastfeed?

- ☐ Yes
- ☐ No

Appendix B: Recruitment Flyer

VOLUNTEERS NEEDED FOR A RESEARCH STUDY

DID YOU PLAN TO BREASTFEED YOUR BABY WHEN YOU WERE PREGNANT? ARE YOU A BLACK MOTHER WHO FEELS THAT YOU EXPERIENCED RACISM/DISCRIMINATION DURING OR AFTER GIVING BIRTH?

I am interested in understanding how a Black mother's perception of racism and discrimination affect giving birth affect breastfeeding

This voluntary study is a part of my doctoral dissertation. Virtual interviews are about 45-minute.

LOCATION:
Virtual Interviews

ARE YOU ELIGIBLE?

- You 18 years old or older
- Your baby is 12 monthsor younger
- Experienced racism or discrimination during or after giving birth

CALLING MOMS FROM

Mid-Atlantic and Northeast region of the United States (New. Jersey, New York, Pennsylvania, Illinois, Indiana, Michigan, Ohio, and Wisconsin)

SURVEY LINK BELOW
https://forms.gle/8FscQUe4th3htznVA

[redacted]

Appendix C: Interview Protocol

Study Title: Factors Within Birthing facilities that Impede Exclusive Breastfeeding among Black mothers': A Basic Qualitative Approach

PRINCIPLE INVESTIGATOR: Natashia Conner, MS, IBCLC, CHES, PhD-Candidate

INTERVIEW PROTOCOL

DATE:
LOCATION:
TIME:
METHOD OF INTERVIEW: ☐ FACE-TO-FACE ☐ ZOOM ☐ MICROSOFT TEAMS ☐ FACEBOOK
☐ GOTOMEETING ☐ SKYPE ☐ OTHER:
PARTICIPANT ID:

INSTRUCTIONS:

Hi, my name is Natashia, I'd like to thank you once again for being willing to participate in the interview aspect of my study. As I have mentioned to you before, my study seeks to examine and describe how the individual, interpersonal, and community factors, as well as the organizational structures and existing policies within birthing facilities, are perceived by Black mothers', in addition to how Black mothers' identified perceptions of racial discrimination after giving birth within a birthing center, and whether these experiences affect the initiation and duration of exclusive breastfeeding practices of Black mothers' after giving birth within birthing facilities. Our interview today will last approximately one hour during which I was asking you about your recent birthing and breastfeeding experience, your perceptions of racial discrimination during and after giving birth, as well as your perception of those around you (relatives, friends, staff, community, etc.). I will not identify you in any of my documentation, and no one were able to identify you with your answers. You can choose to stop the interview at any time.

[review aspects of consent form]

Prior to this interview, you completed a consent form indicating that I have your permission (or not) to audio record our conversation. Are you still ok with me recording (or not) our conversation today? ☐***Yes*** ☐***No***

If yes: *Thank you! Please let me know if at any point you want me to turn off the recorder or keep something you said off the record.*

If no: *Thank you for letting me know. I will only take notes of our conversation.*

Before we begin the interview, do you have any questions? **[Discuss questions]**
If any questions arise at any point in this study, you can feel free to ask them at any time. I would be more than happy to answer your questions.

Interview Questions					
		INTERVIEW QUESTIONS	**PROBING QUESTION**	**INTERVIEWER COMMENTS**	**REFLECTIVE NOTES**
I would love to start our conversation with getting to know you.					
Warm-up Background Questions		1. Please tell me about you and your family.	1a. Who lives at home with you? 1b. Can you tell me about your siblings?		
		2. Please tell me about becoming a mother.	2a. how many times has you been pregnant 2b. how many losses		
		3. Please share with me your thoughts on feeding babies.	3a. What about breastfeeding? 3b. What about formula? 3c. Is there anything else you would like to add?		
		4. What were some of the general influences on your breastfeeding intentions prior to giving birth?	4a. Please provide more detail about these influences. 4b. Why were these influences important?		
Next, I would like to ask you about your plans to feed your baby before you delivered and I would like you to please choose the answer that most closely matches your opinion, considering both your current feeding plans and the likelihood that you will carry out those plans. **INFANT FEEDING INTENTIONS SCALE**					
	Strongly agree	**Somewhat agree**	**Unsure**	**Somewhat disagree**	**Strongly disagree**

I am planning to only formula feed my baby (will not breastfeed at all).	☐	☐	☐	☐	☐
I am planning to breastfeed my baby or at least try.	☐	☐	☐	☐	☐
When my baby is one month old, I will breastfeeding without using any formula or other milk.	☐	☐	☐	☐	☐
When my baby is three months old, I will breastfeeding my baby without using any formula or other milk.	☐	☐	☐	☐	☐
When my baby is six months old, I will breastfeeding my baby without using any formula or other milk.	☐	☐	☐	☐	☐

SOCIAL ECOLOGICAL MODEL	SUB RESEARCH QUESTION	INTERVIEW QUESTIONS	PROBING QUESTION	INTERVIEWER COMMENTS	REFLECTIVE NOTES
To begin this interview, I'd like to ask you some questions about the environment where you gave birth.					
ENVIRONMENTAL	How do Black mothers' perceive health care policies, practices, and procedures within birthing facilities that could be perceived as biased affect a Black mothers' decision to breastfeed exclusively?	1. Did you feel uncomfortable with staff member for any reason?	1a. Please explain what made you feel uncomfortable. 1b Was the staff courteous? 1c. How would you describe the staffs experience level? 1d. How would you describe the staffs skill level? 1e. How would you describe the staffs behavior?		
		2. Do you think you received timely attention to your needs, including taking your needs seriously?	2a. Do you feel like you had the information you needed to be successful with breastfeeding? 2b. Did you get the assistance you requested or desired? 2c. Did you feel like you left the		

			hospital with confidence in your new role, questions answered, etc.? 2d. Did you feel prepared to leave and begin being a mother on your own?		
		3. Can you tell me about your environment (i.e., labor & delivery room, postpartum room)?	3a. Would you describe it as safe and clean? Please explain. 3b. Did your physical environment meet your cultural and physical needs after delivery?		
		4.Thinking about your last birthing experience, can you describe any specific rules, regulations, policies, or practices within the birthing facility that you perceived as racist/ discriminatory?	4a. Please explain or describe why these rules or policies are discriminatory.		
Thank you for your responses. I'd like to now ask you questions regarding your thoughts on how people around you view exclusive breastfeeding.					
INTERPERSONAL	2. How do Black mothers' describe the interpersonal relationship with health	4.Thinking about your last birthing experience, can you describe how your health care staff ***interacted*** with you?	4a. Please explain how your health care staff ***interacted*** with you.		

	care professionals within birthing facilities regarding their behavior that could be perceived as racist or discriminatory and its contribution to their exclusive breastfeeding experience?		4b. Can you provide an example?		
		5.What about their ***behavior*** gave you the perception that they were being ***racist*** or ***discriminatory***?	5a. Please describe their ***behavior***. 5b. Please give an example.		
		6.Thinking about your health care staff's ***behavior***, do you feel that you were heard?	6a. Why? 6b. Why not? 6c. Please explain.		
		7.Thinking about the health care staff's ***behavior***, did you feel comfortable with them?	7a. Why? 7b. Why not? 7c. Please explain.		
		8. Describe your health care staff's positions about exclusive breastfeeding?	8a. What about verbal and non-verbal communication? 8b. or behavior?		
		9.Thinking about your health care staff, do you feel that they were supportive of exclusive breastfeeding?	9a. Why or why not?		
Thank you for sharing information about your thoughts on how people around you view exclusive breastfeeding. I'd like to now ask you a few questions about your relationship with health care professional.					
COMMUNITY	3.How do Black mothers' perceive the community-	10.Tell me about how experiences of racism influence your relationships with your health	10a. Please explain.		

	level factors of racism and discrimination surrounding the birthing facilities in which social relationships occur to become a factor in exclusive breastfeeding practices?	care staff (i.e., Nurse, Pediatrician, Ob-Gyn, and Lactation Consultant)			
		11.How has these relationships influence your decision to breastfeed exclusively?	11a. Please explain.		
		12.Describe things and features within the birthing facilities that you perceived as discriminatory/racist?	12a. Please explain.		
Thank you. I'd like to ask you some questions about your recent birthing experience and your feelings and beliefs regarding exclusive breastfeeding.					
INDIVIDUAL	4. How do Black mothers' describe individual and interpersonal barriers within birthing facilities that affect a Black mother's attitudes and beliefs regarding exclusive breastfeeding of their infant?	13. Has ***racism*** experienced while you were in the birthing facilities affected your ***attitudes*** about exclusive breastfeeding?	13a, If so, can you tell me more about what ways has this experience affected your attitudes? 13b. Please explain, Why not?		
		14. Do any of these experiences seem ***discriminatory***?	14a. 2a. If so, how? 14b. Please explain.		
		15. How has your experiences of ***stereotyping*** while in the birth center, affected your beliefs about exclusive breastfeeding?	15a. In what ways have your beliefs been affected? 15b. If not, please explain.		

Before we conclude this interview, is there anything about your experience in the birthing facilities where you gave birth that you think influences your decision to exclusively breastfeed that we have not yet had a chance to discuss?

ADDITIONAL NOTES:

KEY RESEARCH QUESTION: R.Q.: How does the experiences of Black mother's in birthing facilities with, and the perception of racism and discrimination affect the initiation and duration of exclusive breastfeeding practice of Black mothers' with their newborn infant

CLOSING STATEMENT:
The questions that I have asked of you thus far have been to gain knowledge about your experience with breastfeeding while in birthing facilities after given birth. As mentioned early in our conversation, the purpose of this interview is to see if racism and discrimination in birthing facilities become a factor in Black mothers' decision to initiate and sustain breastfeeding.

I would like to ask you directly if you feel like you experienced racism or discrimination during your hospital stay? ☐***Yes*** ☐***No***
Did this play a role in your decision to initiate or sustain breastfeeding? ☐***Yes*** ☐***No***
Is there anything else that you would like to add or share about breastfeeding and racism or discrimination in health care?

Thank you so much for your time.

POST INTERVIEW NOTES:

FOLLOW-UP DEBRIEF WITH PARTICIPANT NOTES:

Interview Protocol Matrix

	Background Questions	Research Question	Sub Research Question 1	Sub Research Question 2	Sub Research Question 3	Sub Research Question 4
Background	X					
Background	X					
Background	X	X				
Background	X	X				
Intention	X	X				
Intention	X	X				
Intention	X	X				
Intention	X	X				
Intention	X	X				
Interview Q1		X				X
Interview Q2						X
Interview Q3						X
Interview Q4						X
Interview Q5				X		
Interview Q6		X		X		
Interview Q7				X		
Interview Q8				X		
Interview Q9				X		
Interview Q10		X		X		
Interview Q11		X			X	

Interview Q12		X			X	
Interview Q13					X	
Interview Q14		X	X			
Interview Q15		X	X			
Interview Q16			X			

Appendix D: Expert Panel Feedback and Changes to the Data Collection Instrument

Expert Panel	Feedback	Changes
Expert I	• The environmental questions first and individual questions last. Environmental questions are soft questions that allow the participants the opportunity to open up should be asked first before asking the tough questions	• The interview instrument was revised to ask all environmental questions first, and individual questions last.
Expert II	• After the [discuss questions] brackets on page 1, the part that says "if you have any questions (or other questions)" is repetitive – I think you can just say if you have any questions	• After the discussion questions, participants were asked if they have any questions
	• Probing question 1b. is awkward if they do not have siblings, may want to rephrase to something like "can you tell me about whom you spent time with growing up?" unless this is not meant to be an in-depth question	• The question was rephrased as "can you tell me about whom you spent time with growing up."
	• On the infant feeding intentions scale, #2 (I am planning to breastfeed my baby or at least try) should be two questions – I am planning to try, or I am planning to breastfeed (this way, you can get more granular detail when you analyze)	• The infant intention scale has been incorporated only to gather information on if the participants indented/ planned to breastfeed and is used as a soft question before getting to the study's nature. No changes were made as it will not impact the data intended for this particular study.
	• In the Environmental section, number 1a-1e probing questions may want to be spelled out as questions so that the questions are standardized how the researcher is asking the questions to the interviewee	Probing questions revised to be spelled out as questions so that the questions are standardized
	• Under the interpersonal questions, probing question 4a does not answer the question because the participants are already asked to describe – maybe add specifically what the researcher would like them to explain? 8b the "or behavior" should be a full sentence to standardize how the researcher asks the question	• Probing questions revised to be spelled out as questions so that the
	• When stating "please describe" or "please explain," these probing questions need to be developed. What does the researcher want the participants to explain/describe?	

	• Probing question 14b is labeled as 2b (may want to correct	questions are standardized • Probing questions revised to be spelled out as questions so that the questions are standardized • Ensured that probing questions are labeled correctly.
Expert III	• Changing birth centers to birth facilities • Move the probing question 3a to be 2c as it speaks more towards attention and needs. • Change 3b wording to "Did you feel prepared to leave and take care of your child well?" because regardless of preparedness, they have already begun to be a mother. Move it question 2 because it speaks more towards needs. • Add the probing question to question 3 "Did your physical environment meet your cultural and physical needs after delivery?"	• All mentions of birthing centers were changed to birthing facilities in the research instrument/ qualifying questionnaire only. • Probing question 3a have been moved to sub-question 2 probing question 2c • Probing question 3b have been moved to sub-question 2 probing question 2d • The question has been adopted and added as probing question 3b

Appendix E: Participant Invitation

Dear Potential Breastfeeding Study Participant,

I hope this note finds you well. My name is Natashia Conner. I am in the Walden University Health Education & Promotion doctoral program with a concentration in Behavioral Health. My research interest centers around human lactation/ breastfeeding, minority health disparities, and exploring barrier to breastfeeding in effort to increase exclusive breastfeeding rate and health outcomes for Black women and their children.

I am conducting a study focusing on barriers to breastfeeding for Black mothers called: *Factors in Birthing Centers that Impede Exclusive Breastfeeding among Black Mothers: A Basic Qualitative Approach*. The purpose of this basic qualitative study is to examine and describe how the individual, interpersonal, and community factors, as well as the organizational structures and existing policies within birthing centers are perceived by Black mothers whom have identified perceived racial discrimination after giving birth within a birthing center. The results of this study could provide awareness of factors that may affect Black mothers' decisions to initiate and sustain exclusive breastfeeding of their newborn infant, Additionally, awareness of Black mothers' perceptions of bias and/or racism within the institutional fabric and existing policies within and surrounding birthing centers could promote changes in birthing center policy, practices, and procedures which disproportionately and negatively affect Black mothers.

If you choose to be a part of this study, your participation will be kept strictly confidential. The whole interview process should take no more than 60 minutes of your time and will be conducted by telephone or video conference calling. You will be asked to complete a short Demographic Qualifying Questionnaire in addition to the interview questions. One-on-one interviews will be recorded with your permission.

Your participation in this study is voluntary and you may withdraw participation at any time. There are no anticipate risk associated with participating in this study. Please let me know if you would like to participate. If you have any questions, you can contact me by phone [redacted], e-mail [redacted]

Warmest regards,

Mrs. Natashia Conner, MS, CHES, IBCLC, PhD Candidate

Walden University

Appendix F. Letter to Request Support

Dear (Name),

My name is Natashia Conner, and I am a doctoral candidate at Walden University. I am conducting dissertation research titled, "Factors Within Birthing Centers that Impede Exclusive Breastfeeding among Black mothers'." Multiple studies focus on barriers to breastfeeding for Black mothers'. What is not known, however, are the perceptions of Black mothers' regarding their birth experience and breastfeeding outcome. This study fills a gap in research by focusing on Black mothers' experiences after giving birth within birthing centers that influence exclusive breastfeeding initiation and duration. The results of this study could provide awareness of individual, interpersonal, and community-level factors that may affect Black mothers' decisions to initiate and sustain exclusive breastfeeding of their newborn infant. Additionally, awareness of Black mothers' perceptions of bias and racism within the institutional fabric and existing policies within and surrounding birthing centers could promote changes in birthing center policy, practices, and procedures that disproportionately and negatively affect Black mothers'. Ultimately, this awareness may promote healthy discussions within birthing centers on how to serve this population of mothers better.

For this study, I am interested in recruiting 10-15 Black mothers' at least 18 years of age who have recently delivered within that last 24 months and who intended to breastfeed prenatally (regardless of current breastfeeding status). I would like your support by distributing and displaying a study invitation on my behalf within your facility, provide me with contact info for potential participants. I would like to set a time to contact you by phone to discuss further the

study and see if you have any questions. If you would like to contact me, my telephone [redacted] or email [redacted].

Warm regards,

Mrs. Natashia Conner MS, CHES, IBCLC, PhD-ABD

Certified Health Education Specialist & Board-Certified Lactation Consultant

Doctoral Candidate, Doctor of Philosophy in Health Education & Promotion

Walden University

Appendix G: Letter of Support from Stakeholder

(Community Research Partner Name Contact Information)

Date: ()

Dear Natashia Conner,

Based on my review of your research proposal, I permit you to conduct the study entitled "Factors Within Birthing Centers that Impede Exclusive Breastfeeding among Black mothers'." within (the Insert Name of Community Partner). As part of this study, I authorize you to recruit participants, data collection, member checking, and results in dissemination activities. Individuals' participation was voluntary and at their discretion.

We understand that our organization's responsibilities include said, distribute, and display a study invitation on my behalf within your facility and provide me with contact info for potential participants. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the student will not be naming our organization in the doctoral project report that is published in ProQuest.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,

Authorization Official Contact Information

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. The Uniform Electronic Transactions Act regulates electronic signatures. Electronic signatures are only valid when the signer is either (a) the sender of the email or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verifies any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix H: Codebook

Code	Code Definition	Code Includes	Code Excludes	Notes
Aggressive	obtrusive energy and self-assertiveness, forceful action or procedure (such as an unprovoked attack) especially when intended to dominate or master	impulsive, violent, unpredictable such as verbal aggression, hostility, and behaviors that are malicious in nature	behaviors that are considered passive, kindly, calm, dismissive	
AMA	Advanced Maternal Age	mother who are 35 years of age and older	Any mother under the age of 35	
Birth trauma	Any injury, medical condition, or complication resulting from labor/delivery but doesn't affect breastfeeding.	Brief NICU stay, shoulder dystocia,	congenital disease or birth defects, are conditions present from birth	
Challenges	a stimulating task or problem, a stimulating task or problem	breastfeeding difficulty or challenges related to latch, positioning, milk supply, pumping, est.	Mother express easy of breastfeeding, exclusive breastfeeding, and pumping, or the desire to breastfeed	
Commitment	The quality of being resolute, firmness of purpose, quality of being dedicated to breastfeeding and or pumping	willingness to give your time and energy to breastfeeding	self-doubt, inconsistency,	"**Commitment**" refers to the mothers willingness or adherence to an obligation / promise. i.e., a mother show "**determination**" (has firmly decided) to breastfeed, however she may not be willing to "commit ("**commitment**" or willingness to) continue breastfeeding if "**challenges**" arise

Condescending	Showing or characterized by a patronizing or superior attitude toward others	Behaviors that are considered belittling, minimizing,	supportive, compassionate, humility	"**condescending**" nature also refers to snarky body language, i.e., looking down your nose at someone, volume emphasis is a nonverbal cue to superiority, lack of eye contact, as well as mannerisms and facial expressions.
Critical Condition	Indicators are unfavorable, unstable and not within normal limits health condition	Medical condition affecting the mother to include blood pressure, wound infections from c/section,	Healthy, overall health wellness	
Cultural Sensitivity	Being aware that cultural differences and similarities between people exist without assigning them a value, ability to maintain an interpersonal stance that is other-oriented (or open to others)	respect of persons, thoughts, customs, and behaviors including communication style, values, and traditions, cultural humility, increase diversity,	racial bias, prejudice, any program or practice of racial discrimination, segregation, etc.	includes the need of cultural humility, cultural awareness, and cultural appropriateness.
Determination	the act of deciding definitely and firmly also the result of such an act of decision, firm or fixed intention to achieve a desired end	The action of continued breastfeeding despite challenges, quality of being dedicated to breastfeeding and or pumping	indecisive, inconsistency despite having shown commitment to breastfeed	"Determination" refers to an action or task that has already has a definite decision, The quality of being resolute, firmness of purpose. i.e.,
Dismissive	having or showing a disdainful attitude toward someone or something regarded as unworthy of serious attention	Not listening, attentive, or taking the mothers concerns seriously, limited interactions, poor communication	actively listening and responding to mother's concern.	

Disrespectful	Showing lack of respect or courtesy	Includes rude, impolite, ill-mannered behavior, this could include non-verbal actions "stand-offish, nonchalant, mocking, or sarcastic".	Behaviors or actions that can be interrupted as lack of support, failure to provide care, as well as improper medical care or attention	
Emotionally traumatized	extraordinarily stressful events that shatter your sense of security, making you feel helpless	Annoyed, shocked, fear, frustrated, upsetting, anxiety, emotions	feeling reassured and supported through stressful events.	
Enjoy parenting	our responsibility to nurture and protect our children	excited about breastfeeding, quick/ easy/ delightful pregnancy, planned pregnancy	unplanned pregnancy, not prepared for parenting, dislike	
Errors	The failure of a planned action to be completed as intended (an error of execution) or the use of a wrong plan to achieve an aim, Deviations from the process of care, which may or may not cause harm to the patient,	errors of execution and errors in planning, acknowledging that mental/judgmental and physical / technical failures both contribute to error, including intentional deviation of care purposely deemed error	accurate reporting, truthful acknowledgment of fault, restoring trust	
Breastfeeding	the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines	Planned on exclusively breastfeeding, only giving mothers milk either by bottle or breast, knowledge of breastfeeding, including prior breastfeeding experience	nonmedical desire to supplement with food other than mothers milk, feeding infant formula	

Exposure to breastfeeding	the state of being exposed to breastfeeding either in community, or home, acquired knowledge or wisdom received from seeing breastfeeding as normal	The mother grows up in a home where breastfeeding was observer and normal, the mother herself was breastfed	No prior exposure to breastfeeding, family did not breastfeed, no breastfeeding education, exposure to formula as normal	
Family	Interpersonal relationships that support or positively influences breastfeeding	Blood relatives, immediate and extended family members, close friends, and support systems	Individuals that are not supportive of the mother breastfeeding goals, this could be blood relatives, family members, or close friends.	
Formula	The action of being given, forced, or pressured to give formula	Staff sugging, encouraging, or forcing the use formula, when not medically necessary either partially or in lieu of exclusive breastfeeding	breastfeeding education, support, and management of breastfeeding issues to remain exclusive	"**Formula**" should be used when coding mentions of formula despite the usages of or by the mother to include staff suggesting, encouraging, or forcing formula when not medically necessary in lieu of supporting or providing encouragement for the mothers decision to exclusively breastfeed.
Health conscious	awareness, concerned and knowledgeable about how healthy one's diet and lifestyle are	concerned about how healthy health seeking behaviors such as diet and lifestyle including benefits of exclusive breastfeeding for mother and infant	health indifferent, unknowledgeable about healthy lifestyle and health seeking behaviors that promote optimal health	"**Health conscious**" relates to the mothers acknowledgement, knowledge level, and awareness of her/her infant health

IBCLC	a health care professional who specializes in the clinical management of breastfeeding.	International Board-Certified lactation consultant	paraprofessional's not otherwise credentialed by the International Board of Lactation Consultant Examiners, postpartum nurses with basic lactation understanding	
Insurance	insurance-based discrimination in health care settings, the unfair treatment that patients receive from health care providers because of the type of insurance they have or because they do not have insurance	Mothers that have Medicaid/ Medicare report different treatment based on their insurance, perception of racial bias based on insurance, discrimination in health care	Other forms so perceived discrimination, racism, or bias including health insurance/ lack of insurance bias	
Kind	of a sympathetic or helpful nature	Includes nice gestures, considered friendly	rude, disrespectful, and condescending behavior	
Knowledgeable	having or showing knowledge or intelligence, the range of one's information or understanding	college degree, assumed knowledge based on career status as doctor, nurse, well-informed about breastfeeding, skilled in necessary field to preform job duties	not well informed or educated.	"**Knowledgeable**" - for staff vs the mother: Team agrees to use **"knowledgeable" / "unknowledgeable"** in terms of assessing the skill, or knowledge level of staff or health care staff. Excludes anything related to the mother.

Large Family	Family size	Families with 4 members or more family members	Families with 3 members or less family members	
Left AMA	the patient is leaving before their treating physician recommends discharge or despite medical advice to the contrary.	self-discharge, mother leaves facility before medical recommendation length of stay	remain under the care and treatment of medical professionals until deemed safe for discharge	
Malfunctioning	to function imperfectly or badly : fail to operate normally	(of a piece of equipment or machinery) fail to function normally or satisfactorily, failure, defects, breakdown, not working	functioning with normally standards	
Miscarriage	A **miscarriage** is the loss of a baby	com	the deliberate termination of a human pregnancy, most often performed during the first 28 weeks of pregnancy.	
Mistrust	a lack of confidence, to doubt the truth, validity, or effectiveness of health care professionals	To include mistrust of staff, OB/GYN, physicians, RNs, est.	confidence in staff.	
Motivation	Mothers that exhibit the strong desire and willingness to exclusively breastfeed	Mothers that exhibit the strong desire to exclusively breastfeed and individuals around her who	Mother that exhibits a firmness of purpose, or lack thereof regarding breastfeeding initiation and duration	

		encourages her to breastfeed		
Multip	multiparous and is called a Multip pregnancy	A woman who has given birth two, three, or four times	A woman who has given birth once is primiparous	
Neglect	the failure of a designated care giver to meet the needs of a dependent, health care staff to inflict physical or emotional harm, passive omissions, gross carelessness or a lack of compassion or competence	Not being involved in mothers care, overlooking mothers concerns or ignored, to include prolonged, minimal quality and quantity of work wait time, and lack of attention to the mothers concerns or needs, improper care	Proper patient care, attentive to patient needs, performing job as required	
Non-IBCLC	Breastfeeding support personal not certified as a lactation consultant/ IBCLC	paraprofessional's not otherwise credentialed by the International Board of Lactation Consultant Examiners, postpartum nurses with basic lactation understanding	a health care professional who specializes in the clinical management of breastfeeding.	

Normalized breastfeeding	breastfeeding is more accepted,	physically see breastfeeding, beliefs all over Facebook, unashamedly nursing in public	The act of discouraging breastfeeding in public, lack of support for visual displays of breastfeeding without covering, forced to hide breastfeeding	
Personal support team	companion who is not a health care professional and who supports another	Hired medical/ non-medical support team that are not related to the mother Midwife, Doula	lack of birthing support either paraprofessional or lay person, family, or friends	
Predominantly white	Greater than 50% white, lack diversity	little to no people in the community, environment, facility that are from other ethnic or racial backgrounds	diverse population and racial representation across different racial groups	
Prejudice	an unreasonable dislike of a particular group of people or things, or a preference for one group of people or things over another.	Judged, bias, predilection, and prepossession	fairness, impartiality, advantage, not having or showing unfair bias	
Primip	Primip is a woman who has given birth once also called primiparous	A woman who has given birth once is primiparous	A woman who has given birth two, three, or four times	

Protocol	detailed plan for a medical treatment, or procedure that is to provide detailed structure for how to manage the patient and how to perform the procedure.	Strict, by the book, even when resulting in unfair treatment to certain racial groups, structural bias woven into health care protocol resulting in discriminatory treatment	adherence to protocol for all persons regardless of race or ethnicity, fairness in implementing procedures	"**Protocol**" can include but not limited to inform or formal rules, mandates, procedures, or practices. These are also routines typically carried out by staff. This includes the strictness and adherences to health care practice rather formal or informal, medical treatments and management of patients and how practice as well as daily procedures are carried out.
Racial representation	the lack of diversity, lack of favorable images, overrepresentation of white women, infant, children,	Black representation at nonselective and selective environments, transform our cultural landscape into one that puts forward people of color in all of their complicated humanity, rather than relying on tired stereotypes	racial representation among staff, essential personnel, marketing images, visual images that justly represent Black mothers, infants, children, and families	
Racism	the belief that peoples of some races are inferior to others, and the behavior which is the result of this belief, feelings or actions of hatred and bigotry toward a person or persons because of their race	Racial bias, prejudice, any program or practice of racial discrimination, segregation, etc., specif., such a program or practice that upholds the political or economic domination of one race over another or others	racial fairness, acceptance, social justice, including cultural sensitivity and cultural humility	

Readmitted	describe situations in which patients return to the hospital within days or months of their initial hospitalization	readmitted to a medical facility after being admitted for treatment, this could also be due complication related to surgery	hospitalization resulting from an unrelated issue	
Build Repour	develop mutual trust, friendship and affinity with someone, a close and harmonious relationship in which the people or groups	connection or relationship with someone else, harmonious understanding with another individual or group,	Showing lack of respect or courtesy	"**repour**" refers to the creation close and harmonious relationship with patients and health care providers.
Resources	physical material that humans need and value such as land, air, and water, a source of supply or support,	Breastfeeding supplies and equipment necessary to support exclusive breastfeeding	an insufficiency, shortage, or absence of something required or desired. something that is required but is absent or in short supply	"**Resources**" relates the access or lack of access, as well as the ability to attain necessary resources to meet optimal health such as education, supplies, equipment, health care, and health facilities, this can also include internet and transferable skills or assets.
Self-Advocacy	the action of representing oneself or one's views or interests, the ability to speak-up for yourself and the things that are important to you	demand proper care, seeking a second opinion about care plan, speaking up on the behave of herself (mother) and/or her infant	unable to articulate one's needs, make informed decisions, or seek additional support	
Self-Educated	educated largely through one's own efforts, rather than by formal class or instruction	mother who without guidance sought out breastfeeding knowledge, by way of social media, online resources, videos, and books	Formal breastfeeding class taught or guided by a certified breastfeeding/ lactation professional	

Small Family	Family size	Families with 3 members or less family members	Families with 4 members or more family members	
Social Media	websites and applications that enable users to create and share content or to participate in social networking.	YouTube, Facebook, Twitter, Instagram, Pinterest, Est	Formal facilities in which to network and exchange information, ideas, career interest, Est	
Staff discrimination	practice of treating one person or group of people less fairly or less well than other people or groups, partiality, or bias, in the treatment of a person or group, which is unfair, illegal, etc.	the unjust or prejudicial treatment of distinct categories of people or things, especially on the grounds of race, age, or sex.	racial fairness, acceptance, social justice, including cultural sensitivity and cultural humility	
Stereotyping	a belief that associates a group of people with certain traits or characteristics.	Preconceptions, assumptions, mocking, insulting, and well as being insensitive towards mother, which can affect health care efficacy and even prompt some patients to avoid care altogether	racial fairness, acceptance, social justice, including cultural sensitivity and cultural humility	"**Stereotyping**" includes perceptions of behaviors that affects the mothers willingness to seek health care or her perceptions of experiences that triggers the avoidance of health care all together.
Stranger	a person whom one does not know or with whom one is not familiar.	Unfamiliar staff, students, interns, or trainee's that has not been previously introduce or identified to the mother	Blood relatives, immediate and extended family members, close friends, and support systems	
Supportive	to promote the interests of breastfeeding, to uphold or defend as valid or right to breastfeed	Compassion, concerned,	contradictory, contrary, counter, opposing breastfeeding	

Teaching hospital	a hospital that's affiliated with a medical school and instructs medical students, resident physicians and perhaps other learners.	hospital, or academic medical center, is a hospital that partners with medical and nursing schools, education programs and research centers to improve health care through learning and research	community hospitals primary mission generally involves meeting the primary or essential health and medical needs of its community	
Teen Mother	a woman under 20 gets pregnant. It usually refers to teens between the ages of 15-19. But it can include girls as young as 10. It's also called teen pregnancy or adolescent pregnancy.	a woman who becomes a mother at 19 years of age and younger	a woman who becomes pregnant and gives birth at 20 years of age and older	
Traumatized	lasting shock as a result of an emotionally disturbing experience or physical injury, resulting from Trauma is the response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope, causes feelings of helplessness, diminishes their sense of self and their ability to feel a full range of emotions and experiences.	Test subject (the involuntary act of conducting care/treatment in health care through research investigator (whether a professional or a student) obtains data through intervention or interaction with the individual)	calming, comforting, soothing encouraging, heartening cheering, heartwarming, inspiring gratifying, pleasing, rewarding, satisfying fortunate, happy, lucky	

Typical birthing room	Normal, within expected standard for a birthing facility,	clean, roomy, spacious,	Cold, dirty, freezing, unclear, crowded birthing environment	
Uncomfortable	causing discomfort or annoyance,	Cold, dirty, freezing, unclear, crowded birthing environment	Normal, within expected standard for a birthing facility,	"**Uncomfortable**" refers to the causing of discomfort or annoyance and describes not only the environment such as the conditions of the environment but also things around the mother within her environment that fosters or creates discomfort for her.
Unknowledgeable	not well informed or educated.	Mother perception of skill, knowledge, experience, based on ability or acquired education	having or showing knowledge or intelligence, the range of one's information or understanding	"**Knowledgeable**" - for staff vs the mother: Team agrees to use **"knowledgeable" / "unknowledgeable"** in terms of assessing the skill, or knowledge level of staff or health care staff. Excludes anything related to the mother.
Unsupported	not providing encouragement or emotional help.	Actions that can be perceived as invalidating, discouraging, obstructive, or deterring	to promote the interests of breastfeeding, to uphold or defend as valid or right to breastfeed	"**Unsupported**" when using this code remember to code the "why" or "what" has caused the feeling or nature of being unsupported or providing encouragement or emotional help. The mother is not being "supported" but or by (what)...? i.e., the staff "**non-IBCLC**" is "**Dismissive**", or the staff "**non-IBCLC**" is encouraging "**Protocol**" "**Formula**"

Violation Privacy	Intrusion of personal privacy without seeking or given verbal consent or permission from the patient	invasion of privacy, intrusive actions, whether intentionally or by mistake, directly violates their training and as such doesn't meet the standard of care.	giving mother space and privacy. Asking permission, knocking or the door, and announcing oneself before entering a patient's room	
Unprepared	not ready or able to deal with something, mothers do not feel prepared to start journey as a new mom, or have confidence in her ability to successfully breastfeed	unplanned pregnancy, not prepared for parenting, dislike	excited about breastfeeding, quick/ easy/ delightful pregnancy, planned pregnancy, prepared and knowledgeable about parenting and breastfeeding	

Appendix I: Confidentiality Agreement

Organization Name:

Representative/Person Signing:

During the course of my activity during the data collection and/ or analysis process for this Research Study: "*Factors Within Birthing Centers that Impede Exclusive Breastfeeding among Black mothers': A Basic Qualitative Approach"* I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**

Appendix J: REV Client Non-Disclosure Agreement

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+1 (415) 801-0500 | sales@rev.com | www.rev.com

CLIENT NON-DISCLOSURE AGREEMENT

This CLIENT NON-DISCLOSURE AGREEMENT, effective as of Jan 1, 2020 (this "Agreement") is entered into by Rev.com, Inc. ("**Rev**") and Customer identified below ("Customer", "Client") is made to set forth Rev.com's agreement with respect to certain proprietary information being provided to Rev.com and/or Temi.com by the undersigned Client for the purpose of performing translation, transcription, captioning and other document related services (the "Rev.com Services"). In consideration for the mutual agreements contained herein and the other provisions of this Agreement, the parties hereto agree as follows:

1. Scope of Confidential Information

1.1. "Confidential Information" means, subject to the exceptions set forth in Section 1.2 hereof, any documents, text or other files supplied by Client to Rev.com for the purpose of performing the Rev.com Services.

1.2. Confidential Information does not include information that: (i) was available to Rev.com prior to disclosure of such information by Client and free of any confidentiality obligation in favor of Client known to Rev.com at the time of disclosure; (ii) is made available to Rev.com from a third party not known by Rev.com at the time of such availability to be subject to a confidentiality obligation in favor of Client; (iii) is made available to third parties by Client without restriction on the disclosure of such information; (iv) is or becomes available to the public other than as a result of disclosure by Rev.com prohibited by this Agreement; or (v) is developed independently by Rev.com or Rev.com's directors, officers, members, partners, employees, consultants, contractors, agents, representatives or affiliated entities (collectively, "Associated Persons").

2. Use and Disclosure of Confidential Information

2.1. Rev.com will keep secret and will not disclose to anyone any of the Confidential Information, other than furnishing the Confidential Information to Associated Persons; provided that such Associated Persons are bound by agreements respecting confidential information. Rev.com will use reasonable care and adequate measures to protect the security of the Confidential Information and to attempt to prevent any Confidential Information from being disclosed or otherwise made available to unauthorized persons or used in violation of the foregoing.

2.2. Notwithstanding anything to the contrary herein, Rev.com is free to make, and this Agreement does not restrict, disclosure of any Confidential Information in a judicial, legislative or administrative investigation or proceeding or to a government or other regulatory agency;