2022

Exploring African American Women's Experiences with Breastfeeding Support in Health Services

Jennifer Johnson
Walden University

Walden University

College of Health Sciences and Public Policy

This is to certify that the doctoral dissertation by

Jennifer L. Johnson

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Nazarene Tubman, Committee Chairperson, Health Services Faculty
Dr. Kim Sanders, Committee Member, Health Services Faculty
Dr. Suzanne Richins, University Reviewer, Health Services Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2022

Abstract

Exploring African American Women's Experiences with Breastfeeding Support in Health Services

by

Jennifer L. Johnson

MPhil, Walden University, 2021

MBA, Tiffin University, 2013

BSBA, Bowling Green State University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

May 2022

Abstract

Breastfeeding provides complete nutrition to infants and reduces the risk of many chronic diseases among infants and their mothers, yet disparities exist. African American mothers have the lowest breastfeeding rates compared to other ethnic groups in the United States. There is limited qualitative research on health services support from the African American mother's perspective. Understanding health behaviors may improve programming, reduce racial and ethnic disparities, and address social determinants of health. The purpose of this study was to explore African American women's beliefs, experiences, perspectives, and opinions around breastfeeding support provided in healthcare settings by healthcare professionals. From a conceptual framework of the social ecological model, research questions explored (a) the experiences of African American women who chose to breastfeed their child(ren) and those who refused breastfeeding, and (b) what effect breastfeeding support provided in healthcare settings has on African Americans women's decision to breastfeed or not. Interpretive phenomenological analysis was conducted on interview data collected from 10 African American mothers living near Atlanta, Georgia, with infants born from 2015 to 2020. This study describes barriers to breastfeeding and experiences of support. Findings show mothers are influenced by provider interactions, need increased knowledge of benefits and barriers, and need stronger support throughout the breastfeeding continuum. These findings add to the body of knowledge for health service providers and have implications for positive social change, including the potential to increase breastfeeding rates, increase maternal support, and reduce the risk of infant mortality, morbidity, and chronic disease.

Exploring African American Women's Experiences with Breastfeeding Support in Health Services

by

Jennifer L. Johnson

MPhil, Walden University, 2021

MBA, Tiffin University, 2013

BSBA, Bowling Green State University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

May 2022

Dedication

This work is dedicated to all the mothers seeking the best for their babies. Support comes in various forms and looks different depending on who you ask. One thing that does not change is that mothers need to be supported- especially mothers within the most vulnerable populations. This is work is also dedicated to my own babies, Christian and Jonah. I pray that you will reap a mighty harvest from the seeds we sow. I hope to be your role model and remind you that you can accomplish each and every one of your dreams. I love you.

Acknowledgments

To Father God, I thank you for it all. To my husband, best friend, and biggest supporter, Christopher, I thank you. I love you and could not have accomplished this work without your encouragement, support, and belief in me from day one. For the many days and nights where you stepped in so that I could step away, I thank you. We are the best team. You always told me I could do it, even when I was unsure. Thank God for perseverance. We did it! Christian and Jonah, thank you for patience, love and encouragement. You two will forever be my why! I thank my mother, Linda, for always being a voice of faith, love and optimism. I also thank my mom and mother-in-law, Yolanda, for always caring for and sowing into my children, enabling me to work, research, and accomplish my dreams. I thank the participants of this study for sharing their personal experiences, as we move the needle for positive social change. I also thank my Chair, Dr. Tubman and committee member, Dr. Sanders for the guidance, patience and feedback provided throughout the process. My final acknowledgement is to my grandmother, Lucille McAfee Hogue, my angel, thank you and our ancestors! You taught me to be strong and wise. I hope I made you proud.

Table of Contents

List of Tables v

List of Figures vi

Chapter 1: Introduction to the Study 1

Background 5

Problem Statement 6

Purpose of the Study 7

Research Questions 8

Conceptual Framework for the Study 8

Nature of the Study 12

Definitions 12

Assumptions 13

Scope and Delimitations 14

Limitations 15

Significance 16

Summary 17

Chapter 2: Literature Review 18

Introduction 18

Literature Search Strategy 20

Conceptual Framework 21

Systems Thinking Approach 23

SEM in Health Promotion 29

Literature Review Related to Key Variables and/or Concepts 36
Benefits of Breastfeeding 36
Benefits to Mother and Child 37
Adverse Risks to Mother and Child 38
Breastfeeding Occurrence and Inequities 39
Programs Currently Available to Promote Breastfeeding 45
Health and Healthcare Disparities 48
Healthcare Disparities in African American Breastfeeding Support 49
SEMHP to Guide BF Health Promotion Policy and Environmental Change 50
Summary and Conclusions 52
Chapter 3: Research Method 56
Research Design and Rationale 56
Role of the Researcher 58
Methodology 60
Participant Selection Logic 60
Instrumentation 62
Procedures for Recruitment 63
Procedures for Participation 64
Procedures for Data collection 65
Issues of Trustworthiness 65
Ethical Procedures 66
Summary 67

Chapter 4: Results 68
Setting 69
Demographics 69
Data Collection 71
Data Analysis 71
Evidence of Trustworthiness 74
Results 74
Theme 1: Knowledge of Benefits 75
Theme 2: Knowledge of Barriers 78
Theme 3: Accessibility to Additional Support 80
Theme 4: Infant Feeding Intentions 83
Theme 5: Feeling Supported 85
Theme 6: Practitioner Influence on Decisions 87
Summary 89
Chapter 5: Discussion, Conclusions, and Recommendations 90
Interpretation of the Findings 90
Knowledge of Benefits and Barriers 93
Accessibility to Additional Support 96
Infant Feeding Intentions 97
Feeling Supported 98
Provider Influence 99
Limitations of the Study 101

Recommendations 102

Implications of Positive Social Change 104

Conclusion 106

References 108

Appendix A: Semistructured Interview Questions 126

Appendix B: Demographic Form 127

Appendix C: Prescreening Questions 128

List of Tables

Table 1. Participant Demographics 70

Table 2. Table of Themes 73

List of Figures

Figure 1. The Social-Ecological Model of Health Promotion (SEMHP) 32

Chapter 1: Introduction to the Study

Breastfeeding provides protection against infant and maternal mortality and morbidity, explaining why health equity is critical. In 2021, the U.S. House of Representatives Black Maternal Health Caucus expressed the need to increase awareness on the elevating maternal health crisis facing African American women and push forward policies that improve maternal health outcomes and end disparities (Black Maternal Health Caucus, 2021). Calling for an end to racial disparities in maternal health, the caucus along with many other advocates suggested investments be made to comprehensively study unique populations and invest in the social determinants of health (SDOH) impacting maternal outcomes. Scholarly research on the experiences of social support networks for breastfeeding mothers is necessary. A mother's social network has a direct influence on her breastfeeding decisions (Carlin et al., 2019; Moon et al., 2019). Health services providers have an opportunity and obligation to provide all mothers with breastfeeding support. When breastfeeding is not within a mother's cultural norm, having even one social network supporter can increase positive outcomes (Carlin, 2019). It is important that all mothers are provided with equal access to healthcare and education to make the best health and nutrition decisions for themselves and their infants. Maternal health equity in breastfeeding may create social change and increase overall population health in the United States.

Breast milk provides essential and complete nutrition for infants and as such, breastfeeding provides many benefits for mothers and infants (Anstey et al., 2017; Food and Nutrition Services, 2021; Lawrence, 2022). Benefits extend beyond nutrition;

however. Researchers found that breastfeeding is an essential component of postpartum health and wellness because it provides nutritional, physiological, immunological, and developmental advantages for infants (Asiodu et al., 2017; Becker et al., 2018; Kraut et al., 2017; Yang et al., 2018). Furthermore, breastfeeding fosters bonds between mother and child and may lead to stronger family ties, robust interpersonal relationships, and sturdier intrapersonal relationships (Abbass-Dick et al., 2017; Becker et al., 2018; Calloway et al., 2017). The World Health Organization (WHO, 2017) has recommended that mothers exclusively breastfeed infants for the first 6 months of life and then continue breastfeeding and adding supplemental foods for 2 years. Although there are a vast number of benefits to breastfeeding, only 2 out of 3 infants are breastfed according to physician recommendations (WHO, 2021).

Research has shown not only that breastfeeding has a host of benefits for mother and child but also that not breastfeeding comes with risks. For example, researchers found correlations between infants who were not breastfed and increased risks of childhood mortality, childhood morbidity, elevated risks of childhood obesity, leukemia, sudden infant death syndrome, and Type 1 and Type 2 diabetes (Asiodu et al., 2017; Becker et al., 2018; Kraut et al., 2017; Yang et al., 2018). In addition to health risks, there are economic risks to not breastfeeding. Breastfeeding provides monetary savings compared to other feeding methods, including financial savings to the healthcare system, which contributes to the sustainability of health services over time (Santacruz-Salas et al., 2018). Breastfeeding is a continuing public health concern.

A growing body of literature recognizes the importance of breastfeeding disparities as a risk to national public health initiatives. Disparities are the differences in experience with genetics, social networks, economic status, and environment that are connected to negative health outcomes (Office of Minority Health [OMH], 2021b). Based on the scientific evidence identifying the benefits of breastfeeding and the risks associated with not breastfeeding, it is imperative that breastfeeding support be made accessible to all mothers in various healthcare settings and be provided by healthcare professionals using evidence-based public health tools (WHO, 2017). The Healthy People 2030 objectives regarding the overall healthcare of Americans (provided by the Centers for Disease Control and Prevention [CDC]) include goals to increase the proportion of infants who are breastfed exclusively through 6 months of age from 24.9% in 2015 to 42.4% in 2030 and to increase the proportion of infants who are breastfed at 1 year from 35.9% in 2015 to 54.1% in 2030 (CDC, 2021). Previous breastfeeding objectives from Healthy People 2020 included a target rate of 81.9% for breastfeeding initiation among new mothers (CDC, 2018). This large growth requires strategic support for some mothers to achieve the goal. During the Healthy People 2020 timeframe, African American breastfeeding initiation rates were only 64.3% in 2016, with minimal growth to 69.4% in 2017, still substantially lower than recommendations (CDC, 2017, 2018; James, 2017). National Immunization Survey-Child (NIS-Child) data analyzed by the CDC determined a 14.7% difference between African American and non-Hispanic White (henceforth referred to as White) mothers in duration and exclusivity of breastfeeding with infants 3 to 6 months old (Beauregard, 2019). The disparities in breastfeeding rates and reduced

breastfeeding may account for an increased incidence of disease and higher infant mortality rates among African American infants relative to White infants (Hemingway, 2021). According to the U.S. Department of Health and Human Services Office of Minority Health the mortality rate for African American infants is 2.3 times higher than for White infants, and the leading cause of death for African American infants was low birthweight (Office of Minority Health [OMH], 2021a). Because research has shown breast milk provides premium nutrition to infants, breastfeeding must be protected and supported. Disparities impact societal health and wellness; therefore, it is essential that researchers continue to explore women's experiences with breastfeeding support from healthcare providers.

There are a vast number of effective interventions used to support breastfeeding mothers; however, they are not one-size-fits-all in their application. Unsupportive health services practices and policies have a known impact on initiation and duration of breastfeeding (CDC, 2018; Louis-Jacques et al., 2020). Furthermore, there may be barriers to breastfeeding for African Americans that have not been addressed through traditional breastfeeding support systems provided in healthcare settings and healthcare professionals (Anstey et al., 2017). Researchers found that decreased support and poor training regarding breastfeeding technique results in lower outcomes for African American women (Comess, 2017). This study aims to better understand those barriers so that evidence-based public health tools can be created which address the lived experiences of African Americans who breastfeed and who experience barriers to breastfeeding.

This chapter includes an overview of the background of the study and the problem statement, followed by the purpose of the research and research questions. A presentation of the conceptual framework, rationale for the study's nature, definition of terms, and assumptions will follow. The chapter concludes with scope and delimitations, limitations, identification of the significance, and a summary.

Background

The best practice standard of breastfeeding is indisputable among researchers. The value of breastfeeding has long been established in the field of maternal and child health (Comess, 2017; WHO, 2018). There are long longitudinal studies of breastfeeding, even of mothers who chose not to breastfeed (Beauregard et al., 2019). As such, the correlation between breastfeeding support, breastfeeding initiation, and duration has also been long established (Segura-Perez et al, 2021). However, researchers have repeatedly documented that African American woman in the United States are less likely to breastfeed their infants than mothers in other racial and ethnic groups (Beauregard et al., 2019; CDC, 2017). A systematic review on the impact of breastfeeding interventions on minority women concluded that system-level interventions, based on the social-ecological model and from the perspectives of minority women, have the propensity to increase positive public health outcomes in breastfeeding (Segura-Perez et al., 2021). The social-ecological model addresses the spheres of influence on an individual's decision-making process. Outside of the individual, there are interpersonal, community, and policy levels of influence on behaviors. The experience of support within the macrosystem/policy level and community level may look different for every mother

(Hinson, 2018; Segura-Perez et al., 2021); therefore, the type of support received by African American breastfeeding women may vary as well (Patchen et al., 2020). As breastfeeding is fundamental to infant nutrition, continued research may play a key role in understanding why some African American women refuse breastfeeding. Currently, a gap exists in the body of research related to African American women's decision to breastfeed or refuse breastfeeding and social support from healthcare providers. This study is needed to further explore African American women's experiences of support with healthcare providers and to add to the body of knowledge to reduce racial and ethnic disparities, increase maternal support, and increase breastfeeding rates in the African American community.

Problem Statement

The problem addressed in this qualitative study was that African American mothers are making the decision to not initiate breastfeeding. Researchers have documented the relationship of breastfeeding behaviors to interactions and experiences with healthcare professionals (Schindler-Ruwisch et al., 2019; Smith, 2018). There is a need to evaluate the potential increased risk of chronic disease, damaging effects to the mother-baby dyad, increased healthcare costs, infant mortality, and other quality of life factors (CDC, n.d.-a; James, 2017; Segura-Perez et al., 2021; WHO, 2017). African American mothers are familiar with the benefits of breastfeeding, but they are not often willing to do it because it is not a cultural norm and is not always acceptable (Kim et al., 2017). Studies have shown that most breastfeeding support initiatives fail to address the social, cultural, and economic vulnerabilities of women of color (Hogan et al., 2018).

Previous research on breastfeeding in the African American community illuminate significant disparities from breastfeeding initiation to support by the healthcare industry (CDC, 2018a; Office of Disease Prevention and Health Promotion, 2021; WHO, 2021). African American women's breastfeeding experiences of support with health care providers must be further explored to address disparities and gaps in the research.

In my review of the literature, no research was located that specifically addressed experiences with breastfeeding support systems provided in healthcare settings by healthcare professionals during postnatal visits, where African American women interacted with doctors, nurses, or breastfeeding coaches. In one similar study focusing on the African American women's perception of support from healthcare professionals in a healthcare setting, the researchers also included non-African American healthcare workers' perspectives. The study did not compare the breastfeeding mother's experiences to the non-breastfeeding mother's perception of support. In addition, there appeared to be no research that compared the similarities and differences of breastfeeding and non-breastfeeding African American women in relation to their experience with breastfeeding support. Further research was warranted that could examine this acknowledged research gap to address the disparities in African American breastfeeding rates (Anstey et al., 2017; Comess, 2017).

Purpose of the Study

The purpose of this qualitative research study was to explore the participants' perspectives, opinions, beliefs, and experiences around breastfeeding support provided to them in healthcare settings and explore how that level of influence impacts breastfeeding

decisions. The aim of this study was to contribute to the existing body of literature surrounding why some African American mothers breastfeed while others do not adhere to the national breastfeeding recommendations, although both may have access to the same healthcare services support and education. The study explores the experiences of both groups of mothers. Information from this research can be used to design better health services, outreach, and education materials to assist African American women with their decision to breastfeed and identify barriers to breastfeeding for this group that researchers have not previously addressed.

Research Questions

Research Question 1: What are the experiences of African American women who chose to breastfeed their child(ren) and those who refused breastfeeding, with breastfeeding support systems provided in healthcare settings that supported breastfeeding initiation and/or duration?

Research Question 2: What effect does breastfeeding support provided in healthcare settings have on the African Americans woman’s decision to breastfeed or not?

Conceptual Framework for the Study

With positive social change in the forefront of this research, a conceptual framework that addresses the SDOH is important. The SDOH include healthcare access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environment (CDC, 2021). This breastfeeding study has implications to positively impact each of these areas. Access to healthy foods and

increased education are both linked to better health outcomes under the SDOH (CDC, 2021). The SDOH are linked to most health inequities in the United States and addressing these issues through the research model may be beneficial to improving healthcare (CDC, 2021). The social ecological model (SEM) will serve as the theoretical framework for this study, as it has been widely used to address the relationship between individuals and various levels of influence surrounding them. The versatility of the SEM allows the researcher to deep dive into a specific level of influence addressing specific components of the SDOH, as needed through the research questions.

The SEM can be used to explore the influence of the SDOH on access to healthcare services. Bronfenbrenner (1994) found that individual conduct and mindsets are affected by SEM and are viewed in terms of spheres classified within two distinct systems: (a) microsystems and (b) macrosystems. Microsystems consist of family and interpersonal relationships, including community and social networks (Shipp et al., 2021). Macrosystems are cultural customs and beliefs (Shipp et al., 2021). All the layers of the model are not applicable to this study. This study will focus on the support within the microsystem where community and social networks are located. The SEM proposes that human progression, and ultimately patterned actions, are best understood when all environmental systems are acknowledged. Intrapersonal, interpersonal, community, organization, and policy phenomena further designate a complexity that influences human behavior and change. By following the SEM, I asked participants in this research study about experiences of support, barriers, and contributing factors to their

breastfeeding decisions within the multilevel framework to address the research questions.

In a study focused on field-based professionals' assessment of barriers and positive contributions to breastfeeding, researchers found there are opportunities to educate mothers as well as their support systems through the lens of the SEM, reinforcing support for the framework in current breastfeeding studies (Ma et al., 2018). McCormick et al. (2017) concluded that the model is appropriate when seeking to improve low health literacy and patient outcomes. SEM can be used in a multitude of research for health services and can be referenced to answer research questions surrounding African American breastfeeding experiences of support from health service providers. Researchers showed the importance of understanding the intersecting nature of systems, including introducing multilevel interventions on the individual, interpersonal, institutional, community, and policy levels to behavioral change (Cisco et al., 2017, McCormick et al, 2017). SEM is the conceptual framework to be used in the research, though it is not the only framework used in healthcare to better understand breastfeeding.

A variety of foundational theories have used by researchers to examine breastfeeding behaviors. Breastfeeding patterns have been examined with theoretical frameworks, including the theory of reasoned action, also called the theory of planned behavior (Lau et al., 2018); positive deviance (Gross et al., 2017); social cognitive theory (Edwards et al., 2018); and more recently the SEM (Ma et al., 2018; Segura-Pérez et al., 2021). Social support models have been applied to various healthcare topics, including breastfeeding (Schindler-Ruwisch et al., 2019). With calls to action in the United States

to further protect, promote, and support breastfeeding within vulnerable populations, the SEM provides a lens for a deeper understanding of breastfeeding support and barriers from a system thinking perspective (Segura-Pérez et al., 2021).

The SEM conceptualizes the overlapping spheres of influence on breastfeeding decisions and experiences (Ma et al, 2018). The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), a public health program that serves about half of all infants born in the United States, provides a vast amount of breastfeeding education and promotion. The program, which implements intrapersonal, interpersonal, and policy influences, affecting long- and short-term nutritional behavior changes of program participants, has utilized the SEM as the basis for their breastfeeding support efforts (Bronfenbrenner, 1994). This illustration highlights SEM's application to breastfeeding research and the field of knowledge. The CDC also uses the SEM, comprised of societal, community, social relationships, and individual factors, to better understand the effect of prevention strategies in healthcare, acknowledging how individuals are influenced by overarching spheres or levels of influence in their decision-making process (CDC, n.d.-b.). Therefore, the SEM is an appropriate theoretical framework for this study as it focuses on the various levels of influence that may impact the decision to breastfeed or not to breastfeed. The key research questions are also aligned with the study approach to address SDOH which have significant implications for health outcomes in the United States. Research using semistructured interviews is also aligned with the conceptual framework of the SEM. More thorough discussion of the implications of the framework will follow in Chapter 2.

Nature of the Study

This study used a qualitative design to characterize the lived experiences of African American women who breastfeed and those who refused to breastfeed regarding the support received from healthcare providers. The generic qualitative approach should be used when the focus of the research is outward of the individual, such as experiences of real-life events or reflections of past events (Dodgson, 2017). The generic interpretive design renders an evidence-based approach, which was used to discover answers to the research questions and allow comparison between the two groups of mothers.

A study on the microsystem environment influence on past breastfeeding experiences would be appropriate for generic qualitative research. For this study, I conducted individual semistructured interviews with each participant. The participants were African American women that experienced professional breastfeeding support and chose to breast feed or refuse breastfeeding their infant. This approach was appropriate to understand the participants' perspectives, opinions, beliefs, and experiences around the breastfeeding support provided to them in healthcare settings such as hospitals, birthing centers, and physician offices during postnatal visits, where African American women interacted with healthcare professionals such as doctors, nurses, and breastfeeding coaches. The generic interpretive design renders an evidence-based approach. After all data were collected from interviews, I used NVivo data analysis software to determine, manage, and analyze data; transcribe data; and support conclusions.

Definitions

Terms used throughout this study are defined as follows:

African American: Participants who self-identify as African American or Black.

Breastfeeding: Provision of human milk to an infant, whether by breast or bottle (WHO, 2021).

Breastfeeding duration: The period from the initial breastfeeding until weaning.

Exclusive breastfeeding: The provision of only human milk for the first 6 months of life (WHO, 2021).

Health services: Multidisciplinary subsystem of medical providers and interventions available in either private or public sectors to address health care needs (Wasserman et al., 2019).

Social support: The multidimensional impact of relationship resources to fulfill an individual's basic social needs (Wilson, 2021).

Assumptions

There are assumptions made specifically for this generic qualitative research study. One assumption is that the African American women participating in the study are willing to share open and honest responses surrounding their breastfeeding experiences for this research study. Breastfeeding is an intimate experience, and mothers may not want to detail this sensitive topic with someone they do not know. Perception varies from one individual to the next, highlighting the importance of one-on-one interviews to build rapport and provide a safe space for private listening. The focus is on mothers who did and did not choose to breastfeed. One group is not considered superior to another in infant care. It is also assumed that participants will respond to the survey accurately. Any survey instruments that were used are culturally sensitive and appropriate. All interview

protocols were correctly followed to ensure trustworthiness and diminish the risk of bias. Finally, it was assumed that data analysis would occur throughout the entire research study (Castleberry & Nolen, 2018). These assumptions were necessary in the context of this study because it was imperative that participants have experience that can be used to further understand the impact of provider support to breastfeeding decisions, adding meaningfulness to this study.

Scope and Delimitations

The scope of this study was to examine the experience between maternal support in health service settings, breastfeeding outcomes, and adult African American women in the state of Georgia. Women included in this study will have given birth from 2015 to 2020 to a single delivery, full-term, healthy body weight infant. Primary data for this study were collected using semistructured interviews from criterion sampling, which allows the researcher to select participants with experience related to the nature of this study (Bloomberg & Volpe, 2018). These participants are the experts, and there is no attempt to generalize their experiences (Bloomberg & Volpe, 2018); instead, they take a deep dive into their experience with the phenomenon. Women who do not self-identify as African American or Black, or who gave birth to multiples, low birth weight, or premature infants were excluded from this study. It is important that the scholarly research meet transferability criteria. Transferability is met when results from the study are meaningful to those outside of the study in a way that they can be applied to their own experiences (Bloomberg & Volpe, 2018).

Limitations

This study was based on U.S. health services specifically, making literature based in other countries more challenging to apply directly to this study. Though all study participants were in Georgia, the women are not likely to be culturally representative of all African American mothers. This study used a framework that may provide further knowledge to increase breastfeeding outcomes for this population and provide more insight into future public health initiatives. Although the SEM framework provides a multilevel framework to understanding multifaceted public health issues, it is limited by the complexity of evaluating factors at multiple levels of influences and may therefore decrease understanding of the impact at specific solitary levels (Preiser et al., 2018). Another methodological limitation to the qualitative study is the relatively small sample size, as phenomenological studies are usually not generalizable (Bloomberg & Volpe, 2018). The transferability of this research was limited by the small sample size of African American mothers, and conclusions reached may apply only to this specific population. A final limitation of this research may be participants' recall bias based on the retrospective perspective of the study. Probing may be used to encourage sharing and clarification when needed, provide higher quality responses, and address limitations to the research (Voutsina, 2018).

Considering there may be limitations to the study, understanding reasonable measures to them ahead of time is key. An example of reasonable measures includes removing researcher bias including one's own thoughts and breastfeeding experience. Although it is important to establish trustworthiness and rapport, personal information

regarding my own breastfeeding experience was withheld from study participants to ensure there is no perception of influence on answers to the research questions.

Significance

This study is significant to the body of research on breastfeeding, health service professionals, and public health initiatives. The intention is to better understand the participants' perspectives, opinions, beliefs, and experiences around breastfeeding support in health services settings by healthcare professionals and why some African American women refuse breastfeeding. Implementation research is used to address real-world health challenges focusing on context-specific experiences (Theobald et al., 2018). This study is unique because research will focus on African American breastfeeding mothers' lived experience and perspective to understand how support within health services environments influences their breastfeeding outcomes. There is also the potential to support professional healthcare practices in these healthcare settings around breastfeeding by increasing knowledge on the similar and different ways breastfeeding support used by maternity care practitioners can be evaluated to increase breastfeeding initiation and duration in the African American community. The generic interpretive qualitative study research design is appropriate for this study since it can be used to address an under-researched topic in maternity care related to African American mothers (see James, 2017; Kim et al., 2017). There are many implications for positive social change, including increased protection and promotion for breastfeeding, increased breastfeeding rates within the African American community, reducing risk of infant mortality, morbidity, and chronic disease.

Summary

Breastfeeding is the gold standard of infant nutrition, though many African American mothers do not breastfeed according to their practitioner's recommendation. Existing research has suggested the need for exploration of breastfeeding support at various spheres of social influence (Bueno-Gutiérrez et al., 2021). This study utilized the SEM to fill the gap in current research and explore the impact of breastfeeding support systems provided in health services settings on breastfeeding outcomes for African American mothers. Chapter 1 was an overview of the study. The following chapter will introduce a literature review related to key variables and concepts.

Chapter 2: Literature Review

Introduction

The physiological and psychological benefits of breastfeeding are known and acknowledged around the world. Protection and promotion of breastfeeding is critical among vulnerable populations and supports increased maternal and infant health outcomes. According to the U.S. Surgeon General, breastfeeding advocacy must be a priority for our nation's healthcare system (Eunice Kennedy Shriver National Institute of Child Health and Human Development, 2017) as breast milk has been shown to be a source of essential nutrition for infants (Anstey et al., 2017; Becker et al., 2018; WHO, 2017). When breastfeeding does not occur, there are many potential risks to maternal and infant health and wellness (Office of the Surgeon General, 2019; WHO, 2017). Researchers have found a steady increase in overall breastfeeding in the United States (CDC, 2018a). However, disparities in breastfeeding rates between ethnic groups continue (Anstey et al., 2017; CDC, 2018a). Mothers in the United States who have historically had issues breastfeeding have been young, single, low earning, under/uneducated, and African American (Anstey et al., 2017; WHO, 2017). Being African American increases the likelihood that breastfeeding will not occur by 2 times in comparison to Caucasian women (Anstey et al., 2017). Continued research may increase breastfeeding initiation and duration among African American mothers, specifically.

In this study, to support initiatives aimed at increasing breastfeeding initiation and duration for this group, I explored (a) experiences of African American women who chose to breastfeed their children, (b) experiences of African American women who

chose not to breastfeed, (c) shared experiences between the two groups, and (d) differences between the two groups. Understanding the role health services providers have concerning breastfeeding success in the African American community is essential when trying to reduce disparities and barriers (DeVane-Johnson et al., 2017; Louis-Jacques et al., 2017). The generic interpretive qualitative research design was used to provide a closer look into the shared and differing experiences from healthcare providers by African American mothers in health services settings. This approach offers an innovative way to integrate the strengths of established qualitative methodologies while maintaining room for adaptation regarding the researcher, discipline, and research questions (Azungah, 2018). Exploring the experiences of both breastfeeding and non-breastfeeding mothers allowed for comparisons in these experiences through themes.

It is crucial to gain a deeper understanding of the experiences that shape breastfeeding decisions made by women, especially in groups whose rate of breastfeeding fall below health service provider recommendations. Choosing not to breastfeed has been linked to increased risks of chronic diseases for the child, mother and baby bonding-attachment difficulties, increased healthcare costs, and escalated infant mortality rates (James, 2017; WHO, 2017). The purpose of this research was to explore the participants' perspectives, opinions, beliefs, and experiences around breastfeeding support systems provided by healthcare professionals in healthcare settings such as hospitals, birthing centers, physician offices and during postnatal visits, where African American women interacted with doctors, nurses, breastfeeding coaches, and other providers.

In this chapter, I present an overview of the issues of African American women and breastfeeding, and support in health service environments. The introduction provides a synopsis of current literature to establish the importance of this research, followed by an explanation of the literature search strategy used and key search terms and term combinations. A detailed description of the theoretical framework used to shape the research and research questions is provided, as well as a review of the literature related to key concepts to support the current study.

Literature Search Strategy

Several literature searches were used to develop a review of the theoretical framework and literature review for this study. To discover the theoretical framework for the study, I conducted a search of scholarly texts stemming from literature published between 1996 to the present. Databases were searched extensively and included Academic Search Premier, CINAHL and MEDLINE Combined Search, Complete ProQuest Medical Library, Google Scholar, PsycINFO, PubMed Central, Sage Journals Online, Sage Research Methods, and the Walden University Library Health Sciences discipline subject research tool. Boolean search terms including *and*, *or*, and *not* were used to maximize and streamline search results. Search terms contained within this study were used in a multitude of combinations and included *African American, barriers, African American women, breastfeeding, breastfeeding benefits, breastmilk, breastfeeding rates, breastfeeding risks, choice, chronic disease, contraindications, culture, decision, disparity, duration, ecological model, ecological systems theory, efficacy, ethnicity, feeding, health policy, healthcare, health services support, infant,*

influence, *initiatives*, *initiation*, *interventions*, *literacy*, *medication*, *milk*, *mother*, *morbidity*, *mortality*, *nutrition*, *qualitative*, *peer-support*, *prevention*, *programs*, *psychology*, *public health*, *race*, *self-efficacy*, *social change*, *social ecological change model (SEM)*, *support*, *systems theory*, and *special supplemental nutrition program for women, infants, and children (WIC)*. From the 389 results returned, selection criteria for this literature review included peer-reviewed literature on breastfeeding, breastfeeding interventions, breastfeeding policy, breastfeeding support, factors influencing breastfeeding behavior in African American women, ecological systems theory, SEM, and historical research, leaving 73 articles as a foundation to support this research.

Conceptual Framework

The systems theory is foundational to this research. Derived from Emile Durkheim's study of social systems, systems theory explores internal and external conditions that may be biological, psychological, sociological, or spiritual, and the dynamics of the individual to interpret problems and create intervention strategies made to enhance the relationship between the individual and the environment around them (Barnwell, 2018). Systems theory enables researchers to organize a particular conceptual model with the goal of understanding a problem without directing the study to a particular intervention strategy (Preiser et al., 2018). In this study, systems theory connects an ecological model to the research questions.

Ecological models can be applied in a variety of disciplines and fields, including public health, biology psychology, sociology, and education (Kilanowski, 2017). Ecological models are highly regarded in research science and have been for many

decades. Early research from psychologist Kurt Lewin suggested the field theory, which states that all interdependent dynamics within the environment or field must be considered as an influence on behavior (Richard et al., 2011). Further work by Roger Barker determined that settings are connected to our actions; furthermore, child psychologist Urie Bronfenbrenner developed an ecological framework of human development based on environmental levels of influence (Richard et al., 2011). One can understand the spectrum of ecological models by examining literature in an assortment of disciplines (Richard et al., 2011). The SEM has been continually utilized by researchers to further the understanding of the elements and experiences that influence human development (Bronfenbrenner & Evans, 2000). Therefore, the SEM can also be used to further the understanding of how support from health service providers influences African American mothers' decision to breastfeed.

Social science understanding developed over time. Previously, researchers focused on the continued growth of scientific research tools such as theories, research designs, and empirical evidence (Bronfenbrenner & Evans, 2000). For the first time, social development was at the forefront of science as opposed to emotional and cognitive development studies, which long stood as the primary focus. Given the ability of the SEM to aid the understanding of relationships between micro and macro influencing levels of support and how the interactions during support may be perceived in similar and different ways, the SEM is the most appropriate framework to be utilized in this study. A more detailed explanation of the interrelationship between the environment,

microsystems, and macrosystems, as they relate to breastfeeding and health service providers, is annotated in subsequent sections.

Systems Thinking Approach

Systems thinking approach focuses on the development of behaviors and is used in many research disciplines. The SEM is derived from the early works of Bronfenbrenner in the 1970s (Bronfenbrenner, 1994). The model ascertains that human development is intertwined by a set of system levels surrounding cultural, economic, political, and social elements (Bronfenbrenner, 1994). It is also focused on the proximal processes between people and the environment around them (Bronfenbrenner, 1994) and the context in which those systems exist (Eriksson et al., 2018). The environmental system levels are divided into macrosystem influences and microsystem influences (Bronfenbrenner, 1994; Bronfenbrenner & Evans, 2000). Two theoretically interdependent propositions define the general ecological model to include the understanding that (a) human development occurs in phases through interactions between people, places, and things in the surrounding environment; and (b) the results of those interactions reflect the characteristics of the person involved (Bronfenbrenner, 1994). Bronfenbrenner (1994) called into question the synergistic effects of behavior genetics and environmental variation. The evolution of society created a structure where there are daily incorporations of macrosystems and microsystem influences on decision-making, establishing the need to delve deeper into understanding the formation and progression of social development (Bronfenbrenner & Evans, 2000). These interwoven influencing relationships explain why it is essential to address various system levels simultaneously

to effect change to the individual (Eriksson et al., 2018). The SEM allows cross-level analyses of various systemic levels (such as personal and community), allowing researchers to explore the impact of conditions within a multitude of settings (Schindler-Ruwisch et al., 2019; Stokols, 1996). Bronfenbrenner realized there were limitations for use of the ecological model in child and family policy as well as educational practice. With these limitations acknowledged, the SEM has continually been used in health services to explore complex behaviors.

The best opportunity to apply the SEM into actual research would be when the design of the hypothesis is not to determine answers, but rather a theoretical framework that can guide researchers into further understanding the impact of influence on the decision-making process (Bronfenbrenner, 1994). The SEM provides a theoretical framework to understand the dynamics amid each level of influence (Bronfenbrenner & Evans, 2000), making it an essential tool to explore intervention strategies specific to each level. Conventions regarding the social ecology theory include the understanding and acceptance that influences to human health are not only interwoven by a multitude of physical and environmental influences, but also by various interpersonal elements including ethnicity, personality, and health-related behaviors (Eriksson et al., 2018; Stokols, 1996). These elements may affect the well-being of the individual directly or through environmental sources (Eriksson et al., 2018; Stokols, 1996). The SEM illustrates macrosystems and microsystems levels of social influence and provides a complete understanding of all influencing forces.

Macrosystems

Macrosystems are the relationships developed with the community, public institutions, ideologies, and societal policies, and they represent the outermost level of influence (Bronfenbrenner, 1994; Bronfenbrenner & Evans, 2000). Macrosystems encompass the societal blueprint of relationships as they contain societal customs, core skills, and political constructs (Bronfenbrenner, 1977, 1994; Bronfenbrenner & Evans, 2000). Macrosystems are related to the creation of personal beliefs based on what others believe. According to the WHO (n.d.), social and economic inequalities, norms that support unhealthy behaviors, legislation, and the power for immediate social change occur within the macrosystem at the social level. Community-level influence occurs within organizations, schools, neighborhoods, health service facilities, and informal networks. It is at the community level where prevention strategies may include social and physical environments (CDC, n.d.-b; Stokols, 1996). Social and cultural values are contained within the macrosystem (Bronfenbrenner, 1994) and have a direct impact on individual-level decisions, highlighting the interdependence of the system levels (Bronfenbrenner, 1994; Stokols, 1996). Culture is what makes involvement among general populations unique, according to Bronfenbrenner (1977). Culture is not displayed within an individual's daily social practices but frequently through behaviors or actions. Therefore, when healthcare programs aim to change behaviors, culture should be considered, which addresses the macrosystem and microsystem simultaneously (Hvatum & Glavin, 2017).

Microsystems

Microsystems are the interpersonal systems within the immediate environment that result in social relationships (Bronfenbrenner, 1977). Bronfenbrenner (1977) determined that relationships with members of the family, peers, and members of society shape development and influence behaviors. Usually, in face-to-face settings, microsystems create an involvement that incorporates continued complex interactions (Bronfenbrenner, 1994; Bronfenbrenner & Evans, 2000). Healthcare prevention strategies that focus on these system levels include family-focused programs as well as peer programming, facilitating a direct interpersonal relationship (CDC, n.d.-b; Stokols, 1996). Individual-level influencing factors are determined by biology, demographic factors, personal experiences and behaviors. Prevention strategies directed toward the individual level may include specific initiatives to provide education and skills training (CDC, n.d.-b; Stokols, 1996). One of Bronfenbrenner's (1986) most notable conclusions regarding microsystems was that individuals could have a shared ecological system and have different environmental influences. In other words, it is not the microsystem alone, which determines behavior but macrosystem (or outside) systemic levels as well.

Public Health Microsystem

Research focused using the SEM is often used in public health research and interventions. Richard et al. (1996) created an original concept founded on the SEM that proposed the two most critical levels of influence concerning health promotion initiatives are at the intervention settings and individual target levels. Using a descriptive study design from a social ecological approach, 44 unique federally funded Canadian health

promotion programs from the Ministry of Health, calculated and compared the results of program effectiveness when SEM approach was integrated into the health programs (Richard et al., 1996). Intervention environments included in the research encompassed societal, organizational, and community levels. Aiming to explore the degree of core ecological principles incorporated into program design and implementation, the authors determined there was minimal incorporation of political or community-level influence while there was an overwhelming focus on the social and individual levels (Richard et al., 1996). By the same token, others have suggested the use of the SEM for application in single-setting health service environments to shape health promotion (Reis-Reilly et al., 2018; Richard et al., 1996), supporting the Canadian design. Richard et al. (1996) concluded that researchers must consider the dynamics between the individual and community/organizational levels.

Additional research has used the SEM to explore more multiple levels of influence simultaneously (Gallo et al., 2019; Shipp et al., 2021). Shipp et al. (2021), applied the social ecological framework to study the dynamics between health services programs and macro level/micro level connections. The researchers found that qualitative studies to address disparities in African American breastfeeding rates were limited (Shipp et al., 2021). The objectives were to further understand the experiences and factors of social support that influence breastfeeding and identify knowledge to support successful African American breastfeeding (Shipp et al., 2021). Study participants reported many factors from micro- to macro-level influences that supported and discouraged breastfeeding. Although they found the opportunity to create change at each level, the

researchers highlighted the community and environmental levels as a priority as they were able to support the momentum achieved with macro-level factors (Shipp et al., 2021; Bronfenbrenner, 1986). Community and environmental level breastfeeding services include breastfeeding support in the hospital immediately after birth. The period immediately after birth is the most pivotal point to establish breastfeeding. Research found that hospitals can help or hinder breastfeeding (CDC, 2021). One example of hindering breastfeeding initiation and duration is the provision of formula to mothers that can breastfeed. Health services settings, including hospitals, which provided free formula to women had lower breastfeeding rates than those that did not provide free formula (Miller et al., 2017). Providing free formula in the hospital during a critical time when a mother should be supported to initiate breastfeeding is an illustration of the implication and power behind hospital policies and practices on the woman's experience of perceived support. Research on the lived experiences of African American mothers may provide additional information The importance of ethnographic data to enhance intervention efforts is encouraged, supporting further research on the matter (Louis-Jacques et al., 2017). A closer exploration of participants may further develop an understanding about how personal beliefs, lifestyle, and physical environment relates to the decision to breastfeed or not (Edwards et al., 2018). The research represents comparative studies in public health and the capacity to obtain further understanding from demographic and ethnic groups.

SEM in Health Promotion

The SEM has been influential upon many disciplines and has continued to evolve within health services. Stokols (1996) conceptualized and integrated the ecological model as it relates to environmental influences on population health outcomes. This model explains how environmental influences, such as support from health service providers can influence breastfeeding decisions among African American women, which subsequently influences United States population health outcomes. The SEM is a phenomenological framework that has long been used among health service organizations to guide health behaviors of individuals from an environmental and social level perspective (Eriksson et al., 2018; Stokols, 1996). Linking health outcomes as a product of people and experiences within their environments is becoming a trending concept among healthcare professionals (Richard et al., 1996; Stokols, 1996). In this study, breastfeeding outcomes were linked as a product of African American mothers and their experiences of support within health service environments. Behavioral change and environmental change models of health promotion are integrated within the SEM to health promotion (Stokols, 1996). One of the advantages of using the SEMHP in this qualitative research study, is that behavioral change can be studied as a variable to determine the relationship between behavioral change, the environment, and breastfeeding outcomes. The main assertions categorizing the SEM and the development of community health programming includes the incorporation of specific factors (Stokols, 1996). These factors contribute to a set of health outcomes and the analysis of those specific factors to determine the likelihood that intervention within the levels of influence may reduce the prevalence of adverse health

outcomes (Stokols, 1996). The SEMHP may aid in determining which factors of support from health service providers is likely to influence the breastfeeding decisions in African American mothers to reduce the prevalence of the adverse health outcomes that occur when breastfeeding does not.

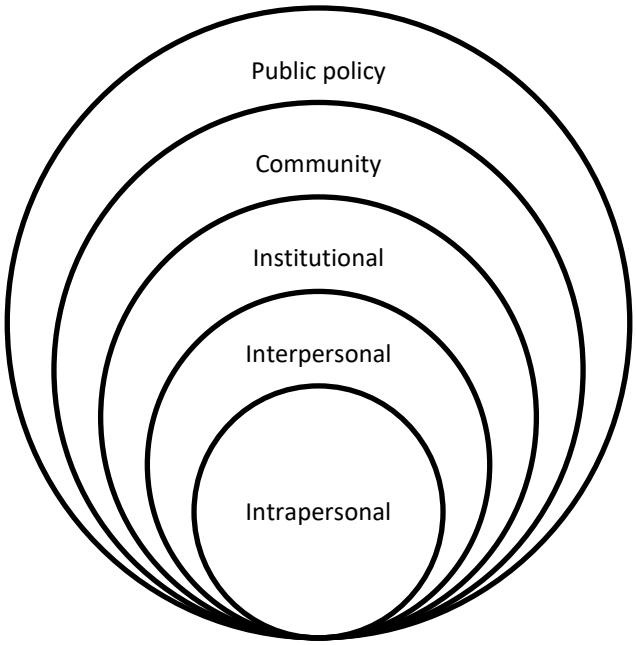
The concept of shifting from chronic disease and injury prevention efforts developed into efforts of changing individual-level decisions is consistent with the SEMHP framework. There are five levels of influence in the SEMHP. Breastfeeding support from health service providers may occur at various levels of influence. The interpersonal level is equivalent to the SEM individual level in concept and intervention. Likewise, the interpersonal processes and primary groups consist of concepts similar to the relationship level of the SEM. Interpersonal processes and groups are social networks (American College Health Association [ACHA], 2018). This group of informal and formal networks may impact on the decision-making process. The interpersonal level includes networks from social media, family and friend groups, and other relationships. The intuitional level consists of more formal networks. It is within the institutional level of influence were the SEMHP begins to evolve from the SEM. Unlike the microsystems and macrosystems explored by Bronfenbrenner or the four-level SEM, the SEMHP develops the SEM into health service-specific factors of influence. The community level of influence from the original SEM is broken down to reflect institutional factors as well as community factors. Institutional factors related to health services may include access to care, availability of services, and social climate with providers. Community factors may consist of relationships within health service organizations and programs, local

infrastructure, and other local networks. Like the SEM societal levels, the SEMHP public policy level of influence is located at the outermost level and focuses on public policies, laws and rules of order aimed to influence entire populations and the interventions that support them (ACHA, 2018).

Bronfenbrenner (1996) found the interdependent relationships between organisms and their environments mirror the relationship between the individual level and the surrounding environmental levels (see Figure 1). Health services facilities such as hospitals are critical to chronic disease prevention and positive health outcomes; therefore, it is vital to explore these types of environments and their relationship to healthy child outcomes (Bronfenbrenner, 1996). While there are several levels that have a direct impact on behavior, the model can be analyzed from a perspective encompassing an individual versus environmental level (everything outside of the individual including social and interpersonal environments, physical/community-level environments, and societal/policy environments). The environment has a critical role in human well-being, which is why it is essential to align health promotion efforts to environmental enhancement initiatives for an individual level of lifestyle modification (Stokols, 1996). Likewise, environmental factors such as health services support are essential in the promotion of breastfeeding in the African American community.

Figure 1

The Social-Ecological Model of Health Promotion (SEMHP)



Note. Interdependence between public policy, community, institutions, interpersonal, and individual levels of influence synergistically correlate to determine decisions, as represented in this stacked Venn diagram. Adapted from "An Ecological Perspective on Health Promotion Programs," by K. R. McLeroy, D. Bibeau, A. Steckler, & K. Glanz, 1988, *Health Education Quarterly*, *15*(4), Article 351377 (https://doi.org/10.1177/109019818801500401).

The SEMHP is growing in use by scholarly researchers as many realize public health challenges are so complex, they can only be adequately analyzed using a comprehensive approach by incorporating cultural, community planning, organizational and other perspectives (Stokols, 1996). With six assumptions for proper application of the theory it is imperative to remember: (a) the effect of environment on well-being; (b) the correlations between personal and environmental factors on health; (c) the relevance of fit and environmental controllability; (d) leverage points; (e) interdependencies among levels; and (f) the value in combining other approaches to create a multimethod, interdisciplinary approach for evaluating health promotion (Stokols, 1996). One of the significant components supporting the SEM is that it can integrate strategies of individual behavioral change and environmental levels across a broad theoretical framework. The social ecological theory encompasses multi-level analyses of healthcare influencing factors and the system levels in which those behaviors occur (Stokols, 1996, p. 287).

Researchers continued to support the implementation of change throughout various levels of influence as an effective method to improve behaviors; more federal policies and community-level organizations are incorporating the framework (Wold & Mittelmark, 2018). In 2011, *The Surgeon General's Call to Action to Support Breastfeeding* recommended the health care community adhere to WHO's guidelines regarding breastfeeding and provide better tracking mechanisms to monitor breastfeeding rates and the factors which affect breastfeeding (Office of the Surgeon General, 2011), such as breastfeeding support systems. In 2013, the model was incorporated to represent the National Breast and Cervical Cancer Early Detection Programs' approach to

prevention, also addressing the multi-level effect of influence to maximize impact. The Healthy People 2020, a correlation of evidence-based public health recommendations, emphasizes use of the SEM in predicting factors to influence the determinants of health, as health outcomes are interconnected (Pierce & Kealey, 2021).

McLeroy et al. (1988) addressed the nationally ballooning interest in determining the extent to which individual-level change has on community and environmental level chronic disease and injury prevention while offering a multifaceted perspective on campus ecology. Figure 1 identifies factors that may influence change to affect individual health behaviors utilizing five levels to include the institution and public policy (McLeroy et al., 1988). Figure 1 also illustrates the evolution of the SEM as it relates to health services and provides a more profound understanding of the differing influencers at various levels. The SEMHP helps to facilitate understanding about the great need to examine the impact of formal and informal institutional policies as well as societal practices (Wold & Mittelmark, 2018). Public policies, laws, and regulations have a direct impact on the extent of health services provided in healthcare settings by healthcare professionals. Glanz et al. (2008) applied the SEM to explore superior practice in health care sponsorship and health care procedures and showed the importance of understanding the nature of systems, which include the importance of introducing multilevel interventions on all levels to create behavioral change.

The Surgeon General made suggestions for action at each of SEM levels to support breastfeeding, with emphasis on the community, society, and policy levels. The health services community must incorporate global breastfeeding recommendations and

provide more breastfeeding education to health care professionals supporting breastfeeding women (Office of the Surgeon General, 2011). Societal level education on the health and economic benefits of breastfeeding, as well as the obstacles mothers encounter, including access to support services, must be addressed (Office of the Surgeon General, 2011). Policymakers should promote organizations within the African American community that support breastfeeding, increase funding for scholarly research on breastfeeding, and improve data collection methods (Office of the Surgeon General, 2011).

McCormack et al. (2017) also incorporated the SEMHP to address health literacy needs in their research. Addressing the individual, interpersonal, organizational, community, and environmental (macro) levels, the authors listed their most influential factors as well as interventions that may be solutions. Determining additional levels of influence provides researchers with a broader social ecological perspective to be used for individual interventions. Although the SEMHP is useful in incorporating multilevel interventions, study findings have suggested an intervention target range of only one or two levels, and further development of theoretical guidance on ways to design multilevel interventions is warranted. Incorporation of health service assessments and research theory should be combined to identify the components of community-level systems that will create the most influential impact to social change (Richard et al., 1996; Stokols, 1996). Researchers like Ma et al. (2018) sought to further understand breastfeeding within the context of the SEM and determined further studies may be necessary to address disparities which still exist in the general population and slow positive social

change. The preliminary research supports the use of the SEM in research aimed toward increasing the positive health outcomes of individuals through interventions at the societal level and by providing support at the individual level (McLeroy et al., 1988). Therefore, the SEM approach was utilized in this health science research to understand the various settings and social constructs that affect breastfeeding success (Shipp et al., 2021; Reis-Reilly et al., 2018).

Literature Review Related to Key Variables and/or Concepts

In this section, key topics are reviewed to provide context and understanding on breastfeeding, barriers to breastfeeding, health services support influence on healthy behaviors, and preceding research on similar concepts. Lack of support and barriers perpetuate disparities in quality health care access and treatment (Segura-Pérez et al., 2021). Research on lived experiences of African American mothers in the Southeastern United States may uncover barriers to increasing breastfeeding initiation and duration (Hemingway et al., 2021; Segura-Pérez et al., 2021). As a part of the review, research studies denoting the experiences of African American breastfeeding women and sociocultural influencing factors are also examined to help determine where further research is necessary. The following research will provide an overview of literature of the issues surrounding this research.

Benefits of Breastfeeding

Breastfeeding has many benefits. There are a variety of reasons to encourage and support breastfeeding such as the fundamental role in maternal, infant and child health (American Academy of Family Physicians [AAFP], 2018; WHO, 2017). Historical

literature and research suggest breastfeeding is clinically significant because from the moment an infant is born, the physical and emotional benefits of breastfeeding are apparent (WHO, 2017). Breast milk, specifically colostrum (the nutrient-dense milk that first appears after delivery), begins to immediately protect infants much like a vaccination (American Academy of Pediatrics [AAP], 2019). With few exceptions, breastfeeding is a physiological process that all mothers can perform, though it may take acquired skill to perfect (Krol & Grossmann, 2018). The term breastfeeding as it relates to the following studies is defined as providing breast milk. An infant does not have to nurse at the breast to be provided breast milk exclusively. Breast pumps allow the removal of milk to be stored and provided through a bottle. Breastfeeding is also termed "nursing," but for purposes of the following studies, the term breastfeeding was used.

Benefits to Mother and Child

Breastfeeding provides benefits to the mother and the child. Historically, researchers alongside a plethora of national and international governing agencies, acknowledged the connections between breastfeeding and the reduction of chronic health conditions such as asthma, breast and ovarian cancer, cardiovascular disease, diabetes, ear infections, obesity, and sudden infant death syndrome (Louis-Jacques et al., 2017; UNICEF, 2018; WHO, 2017). Mothers, who breastfeed, are an economic asset to the workforce because breastfed infants are less likely to get sick, causing a parent to miss less work (WHO, 2017). Breastfeeding supports physical and psychological health, economic development (Stube, 2020; WHO, 2017), and fosters an emotional bond between mother and baby dyad (Becker et al., 2018; James, 2017; Office on Women’s

Health, n.d.; WHO, 2017). Breastfeeding is one of the most cost-effective methods of ensuring a strong economy and healthy community (UNICEF, 2018; WHO, 2017) and should be protected by all entities encompassing the mother's micro and macro systemic levels of influence. Breastfeeding should be viewed as a holistic experience because it incorporates physical, emotional, psychological, social, and cultural levels of influence (Stube, 2020). There are many established benefits to breastfeeding, and there are few, if any, disadvantages addressed in the research.

Adverse Risks to Mother and Child

There are harmful risks to the mother and child when breastfeeding does not occur. Because breast milk provides complete infant nutrition, the risk of nutrient deficiencies and food aversions are increased when infants are not provided breast milk (Smith, 2018). Breast milk provides such excellent nutrition that mothers are encouraged to breastfeed regardless of smoking tobacco (WHO, 2017), or taking certain medications (McClatchey et al., 2018). There has been documented evidence that short and long-term postpartum health risks to infectious diseases, obesity, and type 2 diabetes (Smith, 2018) increase when women do not breastfeed. Benefits of breastfeeding for the mother and child substantially outweigh any documented risks. There are many misconceptions about breastfeeding (Segura-Pérez et al., 2021; McClatchey et al., 2018). It is essential for health service providers to have a better understanding about evidence-based contra-indicators to breastfeeding so that they can better support mothers to initiate or continue breastfeeding (McClatchey et al., 2018). According to the CDC (2018b), there are only a few circumstances when mothers should not provide their breast milk, whether from

nursing or expression to their infant. A mother diagnosed with the human immunodeficiency virus (HIV), a mother infected with human T-cell lymphotropic virus type I and/or type II, a mother using illicit street drugs (i.e., phencyclidine or cocaine), a mother with confirmed or suspected Ebola virus, and infants diagnosed with classic galactosemia are the only contraindications to breastfeeding (CDC, 2018b). Breastfeeding is so beneficial to infant nutrition, marijuana use (once widely considered contraindicated to breastfeeding) is now being reconsidered concerning the adverse risks related to infants (Gross et al., 2019). Gross et al. (2019) stated there is a need for unbiased, culturally informed health service providers to influence mothers on all associated risks associated to improve decision making and long-term health of the infant (Gross et al., 2019). There were studies focused on reasons why mothers do not breastfeed; however, there is no scholarly evidence to support the decision not to breastfeed, nor any studies that suggest a mother should not provide breast milk, as that would be unethical because breast milk is essential for infant nutrition (UNICEF, 2018; WHO, 2017).

Breastfeeding Occurrence and Inequities

Breastfeeding initiation and duration are a world-wide focus. However, health disparities still exist which prevents any country in the world from achieving success by meeting the global health recommendations (Arts et al., 2017; Gross et al., 2019; UNICEF, 2018; WHO, 2017). The phrase “health disparity” is used almost exclusively in the United States, while more terms that are common like “health inequity” and “health inequality” are referenced among health service professionals from other nations and in

scholarly research from around the world (Duran & Pérez-Stable, 2019; Forde et al., 2019;). Though most academic references would use the three terms interchangeably, the phrase "health disparity" has taken on its context in the fields of social science and public health (Duran & Pérez-Stable, 2019). A health disparity related to research on breastfeeding should be an order of events that create differences in that population's environment, access and utilization of health services, health status, or a specific negative outcome (Duran & Pérez-Stable, 2019). Inequities that contribute to determinants of poor health must be the focus of the body of health services professionals and scholars and avoided at all costs (Duran & Pérez-Stable, 2019; Forde et al., 2019; UNICEF, 2018; WHO, 2017). Breastfeeding support is essential to achieve increased breastfeeding rates (AAFP, 2018; Anderson et al., 2019; National Institute of Child Health and Human Development, n.d.; WHO, 2017).

While mothers believe breastfeeding is beneficial, many women find that breastfeeding is much different than they anticipated and need support to provide breast milk as recommended. Research from past studies determined there is usually some level of disappointment with initiation support and mothers expressed a serious deviation between their lived experience and prior expectations (Edwards et al., 2018; Elder et al., 2021). Access to breastfeeding support comes down to an issue of equity and social justice, reinforcing the importance of continued research and development to increase breastfeeding occurrence (Smith, 2018). Further studies by Hughes, Saiyed, Roesch, Masinter and Sarup (2019) sought to understand local level racial/ethnic breastfeeding disparities in Chicago, IL. Partnering with Mount Saini hospital, 641 women completed

the survey. Among the surveyed population 51% (95% CI 45-57%) initiated breastfeeding and 31% (95% CI 24-38%). The researchers found there is need for targeted interventions for specific communities and highlight the need for increased support from healthcare professionals (Hughes et al., 2019).

Global History and Trends in Breastfeeding

Breastfeeding is one of the most effective methods to reduce infant mortality (WHO, 2017) and has been an essential component of human infant nutrition since the beginning of humanity. Breast milk is the "gold standard" for infant nutrition worldwide (Asiodu et al., 2017; Segura-Pérez et al., 2021; Smith, 2018; WHO, 2017). UNICEF and the WHO have collaborated their resources to support global advocacy for breastfeeding and raise awareness of the critical importance for increased initiation and duration around the globe (Arts et al., 2017; Reno, 2017). Breastfeeding advocacy from large institutions provides visibility for issues surrounding these mothers, as breastfeeding women are marginalized worldwide (Arts et al., 2017; Reno, 2017). Public breastfeeding is not a global norm and is seen as a taboo in many countries (Kim et al., 2017). Morris et al. (2020) conducted an international study in United Kingdom and found that breastfeeding generally makes people uncomfortable. The study determined that negative attitudes towards breastfeeding is a barrier to continuation (Morris et al., 2020). This sentiment is all too common. Another study based in the United Kingdom looked at financial incentives to increase breastfeeding support, believing that it would incentivize mothers to breastfeed (Becker et al., 2018). While the monetary cost of choosing to breastfeed or not may spark research interest for government organizations and big business (Becker et

al., 2018; James, 2017; Carroll et al., 2018), it has not been reported in scholarly research as a motivation for mothers anywhere in the world. Breastfeeding remains a global healthcare initiative.

U.S. History and Trends in Breastfeeding

The popularity of breastfeeding in the United States went through many changes. Breastfeeding was customary practice in the United States before the 20th century (Martucci, 2017). During colonial times, there were no breast milk substitutes. Mothers utilized a wet nurse when they could not breastfeed. It was World War II that pushed movement towards optional feeding methods, as mothers went to work while many fathers went to war (Runjic Babic, 2020). Breastfeeding became politicized and was used as a social status symbol by the wealthy to express their financial affluence (Louis-Jacques et al., 2020; Martucci, 2017; Wolf, 2018). The breasts had also become sexualized in western society (Grant, 2021; Morris et al., 2020), supporting the notion that breastfeeding in public was offensive (Morris et al., 2020). Transitioning from wet nurses to bottles, to formula, the practice of breastfeeding substantially decreased in the 21st century (Green et al., 2021; Martucci, 2017). Breastfeeding continued to decline across the nation. It was during the 1970s when healthcare practitioners and leading health service agencies noticed the increase of adverse health outcomes related to non-breastfeeding and began researching ways to bring the practice of breastfeeding back to the mainstream (Martucci, 2017). Researchers found that breastfeeding rates varied by race and by region (Hamner et al., 2021; Ma et al., 2018; Zhang, 2021). Culture is varying throughout geographic regions in the United States, and there are regionally

unique environmental contributors, which influence perceptions on healthcare, including breastfeeding practices (Ma et al., 2018). United States breastfeeding rates remain below federal goals (CDC, 2017). There are, however, several leading agencies continue to fund and support research and programming to support breastfeeding (ACHA, 2018; Reis-Reilly et al., 2018) and increase health promotion for all.

African American History and Trends in Breastfeeding

Many factors influence cultural views of breastfeeding in the African American community. For generations when African Americans were forced into slavery, lactating slaves were forced to wet nurse the slave owner's children and African American women were subjected to many harmful experimental reproductive procedures throughout United States history (Louis-Jacques et al., 2020; Louis-Jacques et al., 2017; Reno, 2017). The African American woman's body is often hypersexualized by society (Reno, 2017), and African American women experience the highest rates of sexual violence (DuMonthier et al., 2017; Reno, 2017). It is not surprising that African American women in the United States had the lowest rates of self-efficacy, compared to African born women, an Afro-Caribbean woman (Louis-Jacques et al., 2017) and other racial groups (Ma, 2018). African American women have the lowest initiation and duration rates for breastfeeding, and that needs to improve (Louis-Jacques et al., 2017; Reno, 2017; DeVane-Johnson et al., 2017). Sociodemographic information for African Americans is much different from that of other ethnic groups. Age, gestational age, income, education, marital status, employment, insurance, and even prenatal care were all significantly different compared to White women (Gallo et al., 2018). These different demographics may contribute to the

systemic racism within the United States healthcare system (Hemmingway, 2021), considering African American mothers experience barriers at nearly all levels including social support, peer support and support within health care settings (Beauregard et al., 2019). Barriers to support are widespread. Providers tend to have fewer positive attitudes when working with marginalized populations in a study about interpersonal experiences with healthcare providers and race (Quinn & Tanis, 2020). Many of the previously mentioned variables are known contributors to lower breastfeeding rates (Gallo et al., 2018); however, because Whites make up a majority of supportive service participants (due to overall population rates in the United States), many of the health service programs were created for the majority population and are not culturally representative of African Americans (DeVane-Johnson et al., 2017).

Inequalities occur when comparing the rates of African American breastfeeding and other racial groups in the United States. This includes the economic disinvestment of health services that support breastfeeding in low-income communities, directly affecting African American mothers (Reno, 2017). The indicators used to measure the Healthy People 2020 objectives come from baby-friendly hospital initiative facilities, which represented only about 40% of live births over 12 states (CDC, 2018a). This number does not represent live births in other health service environments, which may also influence bottom-line numbers. Economic barriers are not the only factor influencing the differences between groups. African Americans disproportionately experience health disparities and have the highest mortality rates overall (DeVane-Johnson et al., 2017; WHO, 2017). Many of the barriers are connected to cultural differences (Gallo et al,

2019; Reno, 2017; DeVane-Johnson et al., 2017), which is why programs must be culturally inclusive to all.

Programs Currently Available to Promote Breastfeeding

According to the CDC (2018a), everyone in society should play a supportive role in providing high-quality support for breastfeeding practices whether in community-based centers, hospitals, clinics, workplaces, or home, support is critical. There are institutions at each of the SEM levels intended to support breastfeeding (Gurley et al., 2017; Ma et al., 2018; Louis-Jacques et al., 2017). The SEM was adapted for public policy implementation (Reis-Reilly et al., 2018; Reno, 2017) and evolved into the SEMHP. Health promotion programs like the Baby-Friendly Hospital Initiative, the Affordable Care Act, and the Family Medical Leave Act are all societal level policies to promote breastfeeding among the general population. The WIC program is another federal program to support breastfeeding; however, since program participation has limits on income, it does not serve the general population. Le Leche League and Mocha Moms are organizations providing breastfeeding support throughout the United States as well and are membership based. At the community level, there are a host of support groups and hospital policies that are designed to provide mothers with help close to home and bridge the gap of support (Reis-Reilly et al., 2018). Clinicians in healthcare service settings also provide breastfeeding support, but often the quality of this support is linked to the services provided at the hospital (Pyles et al., 2021) and the mother's ability to pay or be insured for these services (Kapinos et al., 2018; Hawkins et al., 2017). Most of the

knowledge gained on breastfeeding stems from these sources, yet none of these resources or facilities are inclusive of all mothers (Segura-Pérez et al., 2021).

Many of the programs to support breastfeeding were put in place to remove inequities in breastfeeding rates and increase mutual support. One example is the provision of breast pumps and lactation consultants help to support those who may not otherwise be able to afford them, like those that were uninsured (Gurley et al., 2017). Social support was also determined to be critical for breastfeeding mothers (Asiodu, 2017; Gross et al., 2017; Ma, 2018) and should be provided through these programs. Breastfeeding initiatives were also created to address the costs related to overall poor health and chronic diseases, which are less susceptible when breast milk is provided to the infant (Becker et al., 2018) and to promote national health (Arts et al., 2017). Though there are many programs available, each reveals successes and failures of United States breastfeeding goals.

Success and Failures of Existing Programs/Support

Breastfeeding rates increased through the implementation of health service initiatives (CDC, 2018a; Kim et al., 2017). Interventions are happening at the local, regional, state, and federal levels (Reis-Reilly et al., 2018). The Baby-Friendly Hospital Initiative provides an immediate resource to postpartum mothers within the most critical period of support (CDC, 2018a; Louis-Jacques et al., 2017), and the programs use evidence-based guidelines to create impact (Louis-Jacques et al., 2020; Louis-Jacques et al., 2017;). However, data collected through these evidence-based programs may not always be shared across agencies. To capture a significant portion of the population,

programs need a concentrated effort on messaging, social media, and technology (Gross et al., 2017). Understanding culture is essential to ensure program objectives will relate to implementation. There have been laws intended to support breastfeeding, but they were determined to be significantly less helpful to African American mothers (Griswold et al., 2018). Many breastfeeding programs target individuals that are least likely to initiate or maintain successful breastfeeding (Edwards et al., 2018; Louis-Jacques et al., 2017; Kim et al., 2017). There also needs to be substantive ethnographic data captured (Asiodu et al., 2017; Ma et al., 2018) to ensure strategies to support mothers meet their specific needs. Ethnographic data will help to address cultural differences. Many breastfeeding support programs fail to address culture (Kim et al., 2017; Reno, 2017). Ethnicity is a critical predictor of intention to breastfeeding and actual breastfeeding (Hamner et al., 2021), which is why it should be a focus in research. While some intervention strategies provide increased positive outcomes, failure to acknowledge differences among populations may lead to inadequate programing and support.

There are inconsistencies in programming concerning racial groups. The primary research used to address African American breastfeeding disparities stems from the WIC program (Gross et al., 2017; Gurley et al., 2017; DeVane-Johnson et al., 2017). The WIC program targets low-income women of all races but fails to capture information for mothers with higher incomes. African American mothers also lack African American role models in health services breastfeeding support programs (Gross et al., 2017; Kim et al., 2017). Many health service professionals are not culturally sensitive, carry unconscious bias, and even emit prejudice towards African American women in their perceptions of

mothers' breastfeeding success (Smith, 2018; Reno, 2017). Researchers found that African Americans were less likely to receive support from providers to breastfeed (Schindler-Ruwisch et al., 2019; Louis-Jacques et al., 2017; Reis-Reilly et al., 2018), though support was requested.

There is an overarching theme among researchers to utilize participants of the WIC program as key informants or experts regarding African American breastfeeding barriers. According to United States population data from the American Community Survey reported in 2014, 25.4% of African American women over age 18 lived below poverty, compared to 15.2% of all women (DuMonthier & Dusenbery, 2017). WIC program participants must have an annual household income that does not exceed 185% of the federal poverty guidelines (Food and Nutrition Service, 2018). Historically research and health service programing has focused on the majority population groups within the United States and overlooked opportunities to address smaller populations. Most of the current research and scholarly data on breastfeeding stems primarily from White mothers (Louis-Jacques et al, 2020) and is missing key components that may reach other groups.

Health and Healthcare Disparities

Disparities in healthcare still exist and are a public health issue as described in the previous literature (DeVane-Johnson et al., 2017; Gallo et al., 2019; Louis-Jacques, 2020; Reno, 2017). Healthcare disparities have a direct impact on the SDOH. The SDOH are the economic and social conditions in the levels of influence around the individual aimed to promote protective factors in health status (CDC, 2021). The five determinants are:

built environments (influencing factors to community and individual health behavior, community-clinical linkages (influencing from healthcare systems and community-based health agencies), food and nutrition security (nutrition that supports quality health), social connectedness (support), and tobacco-free policy. Rather than focus on risk factors, the SDOH seeks protective factors within the individuals living and working environments. SDOH seeks to increase the distribution of health through environmental support and policies to increase population health and health equity (CDC, 2021). CDC research data highlighted inconsistencies between racial background and a wide range of serious chronic health conditions and shortened life expectancy (CDC, 2021). The COVID-19 pandemic is yet another example of the disproportionate impact felt among racial minority populations in health services (CDC, 2021).

Healthcare Disparities in African American Breastfeeding Support

Schindler-Ruwisch et al. (2019) showed linkage between social support and barriers within women's immediate environment. In a study on the perspectives of recent mothers, Schindler-Ruwisch also suggested continued researched which would provide resources for social support for African American women (2019). Schindler-Ruwisch (2019) integrated elements of social support and social cognitive theory to understand influencing factors to breastfeeding initiation and duration in the African American community from 24 semistructured interviews from Washington, DC, WIC recipients. Results found breastfeeding is influenced on the community, interpersonal, and individual levels (Schindler-Ruwisch, 2019). Studies showed that health services providers can provide positive support and influence at these levels. Further research is

needed to understand lived experiences of recent mothers with support from these health service providers.

Hinton et al. (2018) researched the factors that influence breastfeeding initiation among 34 African American women in Pennsylvania. The researchers found that the decision to breastfeed is contingent on various external factors (Hinton et al., 2018). Both internal (individual) and external (interpersonal, organizational, community and public policy) factors influence breastfeeding (Hinton et al., 2018). Both breastfeeding and non-breastfeeding mothers participated in focus groups with questions with a specific focus on socio-environmental factors of the Conceptual Model for Breastfeeding Behavior. The study determined the need to increase breastfeeding rates through multilevel strategies involving the community, providers, perceptions, and practices that do not support breastfeeding (Hinton et al., 2018). The authors call for additional research to explore the effectiveness of multilevel strategies to increase breastfeeding rates in a timely manner (Hinton et al., 2018). The study acknowledges the limitation of a focus group and suggest that individual viewpoints may have been influenced by fellow participants (Hinton et al., 2018), supporting the need for individual interviews like those used in this study to further address disparities.

SEMHP to Guide BF Health Promotion Policy and Environmental Change

According to Ma et al. (2018) there are limited health promotion frameworks to illustrate the multifaceted relationships between individuals and the various spheres of influence around them including efforts resulting from policies on the individual level and community level. There is limited research based on the interview review on studies

on breastfeeding support experiences from the perspective of the SEMHP to address the intrapersonal, interpersonal, institutional, community, and public policy factors affecting implementation and duration respective to African American. SEMHP is a framework to examine known factors to influence breastfeeding decisions and examine level-specific outcomes. Using the SEMHP in this study may offer useful lens to gain better understanding to address gaps in the research of support by breastfeeding health services providers. The SEMHP addresses SDOH, healthy behaviors, and population health inequities and frames health services providers as an integral part of the breastfeeding support experience. Founded from both social science and public health disciplines, the SEMHP can be used to explore risk for certain health concerns and understand support systems.

Reich et al. (2021) applied the SEMHP is used to understand counselor's relationship to improved athlete help-seeking behaviors. In research to understand risk factors for student athletes towards seeking professional psychological help, Recih et al. (2021), found that counselors are often trained from an interpersonal lens with limited perspective and a narrow focus. Reich et al. (2021) sought to address the athletes' barriers to support from trained health service providers (counselors). The study found barriers at various levels of the SEM including lack of health literacy, expectations around seeking help, stigma, social norms, access, and lack of policies (Reich et al., 2021). These limitations created a gap in counselor training addressed by the SEM identify was to support the mental health of the athletes and redefine culture norms. In similarity, this

study aims to conceptualize the role health services providers have on African American breastfeeding decisions.

Summary and Conclusions

Addressing SDOH in targeted interventions increases heath equity for all by addressing disparities that cause chronic disease and promote unhealthy health behaviors (CDC, 2021). The literature supports a need for increased breastfeeding promotion and support in groups with low initiation and duration rates (Bueno-Gutiérrez et al., 2021; Schindler-Ruwisch et al., 2019), and by addressing the SDOH this can be achieved through this study. Many studies reinforce the necessity for continued research on breastfeeding in the African American community. As breastfeeding is a national health priority in the United States, it is vital to increase breastfeeding in all populations, but especially in populations faced with disparities that may be avoided through the provision of essential nutrition from birth (Ma, 2018; Schindler-Ruwisch et al., 2019). In countries reporting significant increases in breastfeeding rates, there were strategic programming initiatives put in place, strong support from the national leadership, support within health service settings, community support, and public policy backing (Arts et al., 2017; Shipp et al., 2021). Further research may improve existing efforts by taking lessons from successful African American breastfeeding mothers (Segura-Pérez, 2021) and applying that to future programming. It is essential to study health services interventions through the lenses of the affected population. Future studies should highlight the voice and experience of mothers (Edwards et al., 2018; Gross et al.2019).

Good nutrition should begin at birth and span a lifetime. Access to good nutrition is a predictor of good health (CDC, 2021). Understanding food insecurity is a present-day concern for many African American families living at or below poverty levels in the United States (DuMonthier & Dusenbery, 2017), brings us closer to understanding the socio-economic struggles still faced in the African American community. Food deserts, where affordable fresh foods are scarce, are vast in the minority, low-income neighborhoods (CDC, 2017). From infancy until adulthood, disparities appear to influence the nutrition decisions in African American women. Institutions like the WIC program are supposed to support breastfeeding but often provide conflicting messaging by the promotion and provision of formula to mothers that can breastfeed without supplementation (Schinder-Ruwisch et al., 2019). Breastfeeding may empower African American women to overcome systemic inequities in United States health services (DeVane-Johnson et al., 2017). Breastfeeding can decrease the risk of adverse health outcomes, increase psychological function, and strengthen relationships (Becker et al., 2018; James, 2017; OWH, n.d.; WHO, 2017). The provision of breast milk is essential when aiming to provide best nutrition from birth.

Supporting mothers to provide this essential nutrition is not the same for all women. It is understood through historical research, that there are variances within a race, such as culture. Culture can contribute to the inconsistencies of interventions within the same group (DeVane-Johnson et al., 2017; Kim et al., 2017). Cultural differences can also affect the truthfulness of research results if the participant feels uncomfortable (Louis-Jacques et al., 2020; Ma, 2018). Culture is affected by socioeconomic status, and

WIC is an income-based program. The continued utilization of WIC as the primary means of recruitment for research on African American women's breastfeeding experiences with relation to health services fails to include most of the African American breastfeeding population that does not qualify for the WIC program. There are many African American women's' experiences missing from the body of knowledge when only low-income African Americans are observed in research. Health professionals are not providing culturally relevant breastfeeding support to all African American mothers that will influence them towards healthy behaviors (Segura-Pérez, 2021). It is essential to promote health services professions in the African American community, as there is a great need for more cultural representation of African Americans (Gross et al., 2017). There is a need to address cultural norms in scholarly research (Gross et al., 2017; Louis-Jacques et al., 2017). Research should continually seek new breastfeeding predictors (Griswold et al., 2018). Research must be inclusive of the entire target population to create social change.

There may be increased breastfeeding rates in the African American community when interventions address social and cultural barriers and when health services are provided without bias (Smith, 2018). The literature's major themes were that disparities continue to exist in vulnerable populations with socioeconomic indicators that qualify them for programs which offer breastfeeding education like WIC. This study may add to the body of literature and existing knowledge by exploring the lived experiences of a variety of heath service organizations and how their support impacted breastfeeding. The literature provides evidence to support a qualitative study to better understand the lived

experience of African American women and breastfeeding support experiences in health service settings. The literature also supports the need for qualitive research using one-on-one interviews for a deep understanding of the phenomena that influence the way support is experienced. The SDOH are multisectoral and multilevel, which is why the multilevel SEMHP is the best framework to address level-specific experience stemming from the research questions and research gaps. This study addresses gaps in the literature by providing insight into the African American women's experiences of support through the lens of the SEM. A deeper understanding may offer insight to create positive social change and explore culturally competent measures of support to increase breastfeeding initiation and duration (Hamner et al., 2021; Reno, 2017). Chapter 3 contains a detailed discussion on the research methodology used in this study to help understand how African American women's experiences with breastfeeding support from health services provider influences their decision to breastfeed or refusing breastfeeding.

Chapter 3: Research Method

This qualitative research study focused on the experiences African American women have with healthcare breastfeeding support systems in the United States. The purpose of this qualitative research study was to explore the participants' perspectives, opinions, beliefs, and experiences around breastfeeding support provided to these mothers while in healthcare settings such as hospitals, birthing centers, physician offices during postnatal visits, where African American women interacted with doctors, nurses, breastfeeding coaches, and other health care professionals. This research may help explain the extent to which health service support influences breastfeeding decisions in African American mothers. A generic qualitative inquiry was used to fill the gap in existing literature and answer the research questions in this study. This chapter provides the research design and rationale for the study, the role of the researcher in this study, the methodology that was used, issues of trustworthiness, and a summary of the chapter.

Research Design and Rationale

Generic qualitative research design can be particularly useful in healthcare. The generic qualitative research design allows the researcher to identify patterns and themes from self-reported perceptions of the target population's experiences (Merriam & Grenier, 2019). I used this design to identify patterns and themes of providers of breastfeeding support. Qualitative researchers are interested in the way individuals interpret the experiences, the way individuals construct the environment around them, and the meaning individuals attribute to an experience (Castleberry & Nolen, 2018). The goal in using this generic qualitative study design is to discover how people make sense

of the relationships influencing their decisions and interpret meanings associated with those experiences (Merriam & Grenier, 2019).

Using generic qualitative inquiry, I interviewed African American women to uncover their experiences with healthcare breastfeeding support systems. This study helps fill the gap in the existing literature by exploring similar and differing perspectives from African American mothers who do and do not breastfeed to determine the level of support from healthcare systems implemented to encourage breastfeeding. African American women have the lowest breastfeeding rates of all ethnic groups in the United States, and additional research may assist in determining why this phenomenon is occurring even though African American mothers may have the same breastfeeding resources available to them as other groups. Generic qualitative research studies investigate an individual's subjective attitudes, opinions, beliefs, or experiences of events occurring in their surrounding levels of influence (Dodgson, 2017). I analyzed the collected data through thematic analysis and inductive coding. Thematic analysis is essential to qualitative research by allowing the researcher to examine patterns that do not adhere to a particular theory or explanatory framework for human experiences (Castleberry & Nolen, 2018). Though it is growing in popularity with other notable methodologies, Braun and Clarke (2021) made it clear that thematic analysis is an analytic method and not a methodology, like other qualitative approaches. Two research questions were explored in this study:

- Research Question 1: What are the experiences of African American women who chose to breastfeed their child(ren) and those who refused breastfeeding,

with breastfeeding support systems provided in healthcare settings that supported breastfeeding initiation and/or duration?

- Research Question 2: What effect does breastfeeding support provided in healthcare settings have on the African Americans woman's decision to breastfeed or not?

To explore the experiences of African American mothers, I used the SEM as the theoretical framework. As previously stated, the model ascertains human development is intertwined by a set of system levels surrounding cultural, economic, political, and social elements (Bronfenbrenner, 1994). Interpretive phenomenology can be used to further understand of how individuals may have similar events occur in their lives and yet have different experiences (Azungah, 2018; Bloomberg & Volpe, 2018). Interpretive studies focus on the relationships between individuals and the world around them. In this case, the focus was between African American breastfeeding mothers and healthcare support systems. The interpretive phenomenological tradition is a tool to discover how breastfeeding support in health services settings may be interpreted differently through the lived experiences of the individual. Rationalized with Bronfenbrenner's (1997) ecological systems theory, participants will consider breastfeeding support from varying levels of influence with healthcare professionals and how that support impacted their breastfeeding experience.

Role of the Researcher

In this qualitative study, my primary role as the researcher included collecting data from research participants in an ethical and effective manner. Providing a

comfortable and distraction free environment is important (Merriam & Grenier, 2019). I was responsible for analyzing and collecting all the data, which included recording participant interviews and taking notes, transcribing the notes, and sending transcripts of interview sessions to participants to ensure accuracy. There were no personal or professional relationships that could have caused any ethical concerns between me and any participant. It is important that researchers be clear of distracting influences, and the research environment should be an appropriate setting for participants also (Merriam & Grenier, 2019).

Interviews with the women at the local public library or the local career resource center would have been ideal. A researcher conducting a study in a completely public environment such as the library is considered a complete observer (Merriam & Grenier, 2019). However, the women participating in this study were within a postpartum period and had infants to care for during a pandemic, so I conducted interviews by phone. The interviews were recorded for accuracy and subsequent analysis. In addition, I took hand-written field notes to capture any additional data or details to recall information about a participant later.

I also used interview protocols to uphold the integrity of the research and to ensure there are no threats to reliability. Reliability in qualitative research is influenced through the interview protocols (Yin, 2017). Interview protocols include gathering informed consent from participants, obtaining a neutral location for interview to be conducted, arranging a set of interview questions that will assist in obtaining information during the entire interview, gathering, and sharing detailed information about the

interview process with participants, and providing transcripts to participants to ensure their statements were accurately represented. All these protocols were followed.

It is beneficial to the researcher to have some prior knowledge of the community in which participants derive. According to Thorpe et al. (2018), researchers benefit from having knowledge about participants' norms and cultural influences. As an African American mother having breastfed children, I have firsthand knowledge of participant norms and the cultural influences that influence breastfeeding experiences in the target population. Familiarity or inclusion of the group studied is beneficial in gaining access to the target population and obtaining reliable information as an insider rather than an outsider (Merriam & Grenier, 2019). My connection to the research also allowed me to connect with participants in a deep and meaningful way.

Methodology

Participant Selection Logic

The participants in this study included women that self-identify as African American, have given birth to a living child born from 2015 through 2020, and living in Atlanta, Georgia, and surrounding cities. Mothers who gave birth in 2021 would not have had the opportunity to breastfeed for 12 months as recommended by the AAP (2019); in which time they may request additional breastfeeding support from health service professionals. The Affordable Care Act passed in 2010 provided many beneficial laws to breastfeeding mothers; therefore, I limited the study to mothers having had a child since the Affordable Care Act was passed, and within a reasonable period for such a study as this. In addition, only women of childbearing ages 18 to 45 years old were incorporated

into this study. African American women included in this study must have had a single birth, full-term, healthy body weight infant. Participants must have had at least one interaction with a healthcare professional related to the decision to breastfeed or not, current breastfeeding, and/or weaning either during pregnancy or postpartum.

Specific inclusion criteria were necessary for this study to be purposeful. Therefore, nonprobability, selective, snowball sampling was used. Selective sampling ensures the participants have a unique or differing perspective regarding the phenomenon being studied (Parker et al., 2019). Snowball sampling is a recruitment strategy where participants recommend others they know, who also fit specific inclusion criteria, to participate in the study; thereby advertising and recruiting on the researcher's behalf (Parker et al., 2019). Snowball sampling is especially helpful when the topic being researched is stigmatizing (Parker et al., 2019). Snowball sampling is also beneficial because it incorporates others from the participants' levels of influence. There may be a large response of participants, so a prescreening questionnaire was created. The sample was drawn from individuals who provided informed consent, completed the prescreening questionnaire, and met specific selection criteria. All participants who completed the informed consent process received remuneration for participating in this study. A $10 Target electronic gift card was provided to the 10 study participants for a total cost of $100.

Sample size is influenced by the theoretical framework and by practical considerations (Parker, 2019). An appropriate sample size is one that allows a researcher to answer the research questions. The sample size is adequate when information

redundancy, also known as saturation, occurs and there are no additional themes or codes recurring in the data (Braun & Clarke, 2021). When considering sample size, the study group should be large enough to make inference, while reducing time and minimizing resources (Braun & Clarke, 2021). There are many factors that affect sample size with the most important among them being saturation (Braun & Clarke, 2021). According to Creswell (2017), the typical size for a generic qualitative study is around 10–12 participants. The relatively small sample size will allow the researcher to gain in-depth understanding of a phenomenon (Braun & Clarke, 2021). In this study, there were 10 participants—five of whom that breastfed and five of those who did not. As in-depth and insightful interviews were the critical to the research, one-on-one interviews were offered which encourage open conversation, diverse enough to gauge similar and different experiences between healthcare providers and African American mothers, both breastfeeding and non-breastfeeding.

Instrumentation

I used a generic qualitative design in this research because this methodology incorporates semistructured interviews as a tool, providing study participants a platform to share their experiences of the phenomena through their understanding of individual norms, values, and beliefs (Dodgson, 2017). Semistructured interviews offer flexibility and encourage participants to share their story at their own pace, while allowing the researcher to remaining on topic (Merriam & Grenier, 2019). An interview guide comprised of the two primary research questions and a list of open-ended interview questions was used to create a dialogue with participants individually. In-depth

interviews were scheduled for 60 minutes to have sufficient time to explain the process to the participant, conduct the interview, and provide an overview about how the information will be used and follow-up steps, if necessary. It is common for phenomenological studies to have lengthy encounters with a limited number of participants (Bloomberg & Volpe, 2018). Interview questions focused on the perceptions and experiences of African American mothers surrounding healthcare professional support regarding breastfeeding decisions.

Using a qualitative methodology and a semistructured interview format, I asked participants a list of open-ended questions (see Appendix A) created to address the research questions. Open-ended interview questions are designed to elicit a free-flowing response from the participant without constraints. It was also important to ensure that participants were provided enough time during the interviews to provide rich, in-depth responses for future analysis. In addition to the interviews, I used a demographic form (see Appendix B) to ensure that participants accurately represented the target audience of the study. Furthermore, field notes were used to express any nonverbal communication which may be analyzed later as well.

Procedures for Recruitment

Participants were recruited through a variety of health service settings within Georgia including obstetrician offices, pediatrician offices, public health centers, baby-friendly hospitals, birthing centers, pregnancy resources centers, breastfeeding cafes, lactation centers, and primarily through word of mouth. A flyer can be used as promotion from people with knowledge of the study and participants. The flyer may be shared

within social networks, among friends and to healthcare providers, aligning with the snowballing method previously mentioned. Flyers may be also shared in public places such as bulletin boards. Staff at several area health service locations stated that posting flyers for research recruitment would be no problem in their offices, as they are open for public use much like the library. Participants could choose to share the flyer within various healthcare services settings. There were no partner organizations used for this study. Recruitment continued until there were enough qualified participants to complete the research. After receiving Walden University's institutional review board (IRB) approval for the study, flyers were shared with social networks, and recruitment began using word of mouth. The recruitment flyer contained the study's purpose, potential benefits of the study, expected duration of the interview, and my direct contact information.

Procedures for Participation

It is critical to the study representation of your target audience be as accurate as possible. I also provided participants with a consent form to be returned via email, prior to the interview. Once an individual provided consent, they were provided with prescreening questions to ensure best fit. Pre-set interview times were offered to participants and flexibility in scheduling was also extended. If an individual was not cleared to participate or did not provide consent, they were still thanked for their willingness to participate and for their time.

Procedures for Data collection

Serving as the primary instrument for the research, I collected the data using semistructured interviews. Interview sessions were scheduled for 60 minutes, which provided enough time for thorough reflection of the participants' past experiences. Data were collected from participants by phone during their scheduled interview appointment. Before the beginning of the interview, the importance of confidentiality and consent was reiterated. Participants were informed of their right to stop the interview at any point and withdrawal from the process. The participants were informed for a second time that they would be recorded for accuracy and later transcription of the semistructured interview. After the interviews, I transcribed and analyzed the recordings from the semistructured interviews by hand using categories and themes.

Issues of Trustworthiness

It is important to recognize research bias to uphold credibility in research (FitzPatrick, 2019). As a breastfeeding advocate seeking positive social change within underrepresented groups, I focused my research on the experiences of African American mothers and their experiences of support by health service professionals around breastfeeding their infant. Trustworthiness and accuracy are crucial to the integrity of qualitative research (FitzPatrick, 2019). Trustworthiness is not a reference to the researcher, but to the data. Confidence in the data is paramount (FitzPatrick, 2019). It is critical that the researcher also acknowledge confirmability. Confirmability is about neutrality ensuring the interpretation is grounded in data (FitzPatrick, 2019). Reflexivity is an important part of qualitative research ensuring self-awareness of the researcher and

reflexive thought regarding the assumptions, collection, analysis, and data interpretation. Reflexivity is a validation that the researcher has explicitly acknowledged bias, feelings and assumptions within the study. (FitzPatrick, 2019). Dependability, confirmability, transferability, and authenticity are all components of trustworthiness which increase transparency and rigor (FitzPatrick, 2019).

Dependability and credibility can be established through engagement, consistent observation, and triangulation. Data saturation provides further validation by conducting interviews and collecting data until major themes from the interviews are apparent.

Ethical Procedures

One of the most important ethical procures in conducting this study was to obtain approval from Walden University's IRB. Participation in the study was voluntary, and participants had the ability to end the study and/or interview during any point of the process. In preparation for this study, Walden University's IRB office hours were utilized to ensure all ethical matters pertaining to doctoral research within clinical settings are considered. Approval from Walden's IRB was then requested and received. It is critical for the qualitative researcher to protect all participants, garner trust, promote integrity, and avoid impropriety (Castleberry & Nolen, 2018). Data collected for this study will be stored on a password-protected home computer for a period of 5 years prior to it being destroyed. To address the privacy, data sharing and confidentiality of study participants, a confidentiality agreement is included within this study.

Summary

To capture a comprehensive description of the experience between African American mothers and health service providers, a qualitative research approach was paramount. The purpose of the interviews was to collect an accurate picture of the support African American mothers feel from health service professionals regarding breastfeeding. Chapter 3 provided detailed information to be captured within the study if it were to be duplicated including the design, methods to retrieve such data, and specific data on the target population. A generic qualitative design was applied to answer the two research questions and served as the basis for exploring the experiences of African American mothers. Chapter 4 will contain detailed information regarding the data collection process used in this study and the results achieved in the statistical analysis.

Chapter 4: Results

The purpose of this generic qualitative phenomenological research study was to explore the participants' perspectives, opinions, beliefs, and experiences around breastfeeding support provided to them in healthcare settings and explore how that level of influence impacts breastfeeding decisions. This study served to explore similar and differing perspectives from African American mothers who do and do not breastfeed to determine the level of support from healthcare systems implemented to encourage breastfeeding. Two research questions guided this study:

- Research Question 1: What are the experiences of African American women who chose to breastfeed their child(ren) and those who refused breastfeeding, with breastfeeding support systems provided in healthcare settings that supported breastfeeding initiation and/or duration?
- Research Question 2: What effect does breastfeeding support provided in healthcare settings have on the African Americans woman's decision to breastfeed or not?

In this chapter, complete details are provided on the research setting and demographics of the participants. I describe participant demographics to support relevance of the study. This chapter also provides data collection, data analysis, evidence of trustworthiness, results, and a detailed summary of the results including quoted responses to the semistructured interview questions.

Setting

After receiving the IRB approval notification (Approval number 11-18-21-0584522) with an expiration date of November 17, 2022, data collection began. I collected the data for this study from participants through an audio call recorded with Zoom (https://zoom.us). Zoom is a secure communications platform and easily accessible tool for data collection (Archibald et al., 2019) that allows for conferencing and phone interviews. I recruited participants through direct email and social networking sites. Potential participants were sent recruitment messages directly and were asked to share the information with other individuals meeting the study parameters. After receiving notification of an individual's interest to participate, I emailed them a copy of the consent form. Participants were instructed to read the consent form and reply to the email with "I consent" to indicate that they wished to participate in the study. After receiving consent, I contacted participants to answer prescreening questions (see Appendix C), ensuring eligibility for the study, and scheduled an interview. Interviews occurred over a 3-week timeframe to meet participants' availability. Each interview was recorded, and an audio file was transcribed. To ensure confidentiality, individual participants will be referred to a Participant 1 (P1), Participant 2 (P2), and so forth.

Demographics

All participants self-identified as female African American mothers, living in Atlanta, Georgia, and surrounding areas, who had given birth from 2015 through 2020. In total, 10 participants consented and received a semistructured interview. Participants' ages primarily fell between 36 and 40. Specific inclusion criteria were necessary for this

study to be purposeful. All participants live within the surrounding Atlanta area and have similar access to the same types of community breastfeeding support providers. All participants had a single birth, full-term, healthy body weight infant, and at least one interaction with a healthcare professional related to the decision to breastfeed or not, current breastfeeding, and/or weaning either during pregnancy or postpartum. It was worth noting that one of the participants had multiple separate births within the timing criteria and provided information about both of those experiences simultaneously. Demographic data from the research participants are detailed in Table 1.

Table 1

Participant Demographics

Participant	BF/NBF	Age	Year	Ethnicity	Location
P1	BF	39	2020	Black	Atlanta Area
P2	BF	37	2018	Black	Atlanta Area
P3	BF	40	2020	Black	Atlanta Area
P4	BF	39	2019	Black	Atlanta Area
P5	BF	39	2016, 2019	Black	Atlanta Area
P6	NBF	37	2018	Black	Atlanta Area
P7	NBF	37	2018	Black	Atlanta Area
P8	NBF	37	2015	Black	Atlanta Area
P9	NBF	40	2018	Black	Atlanta Area
P10	NBF	36	2019	Black	Atlanta Area

Note. Breastfeeding status is categorized as either breastfeeding (BF) or non-breastfeeding (NBF). Year in the table refers to the year a child was born.

Data Collection

The data collection process for this study went from November 2021 through December 2021. Of the 10 study participants, five self-identified as breastfeeding and five self-identified as non-breastfeeding. Each of the participant's interviews were scheduled for 60 minutes in length; however, none of the interviews lasted more than 30 minutes. I conducted each of the interviews in the privacy of my home office. Participants were encouraged to also find a quiet and private location to ensure confidentiality and comfort while discussing sensitive information. All participants were asked the same semistructured interview questions (see Appendix A), as well as additional questions to probe for clarity, connections, or further details, when necessary. Participants freely shared their experiences and seemed comfortable in their responses. During the interviews, common themes began to form among participant responses. Upon completion of the final interview, evidence of data saturation appeared, as there were no additional themes emerging from the data (Braun & Clarke, 2021). Participants were provided a copy of their individual transcribed interview to ensure accuracy. None of the participants indicated dissatisfaction with the transcription and no changes were made.

Data Analysis

The data collected for this study were analyzed using a generic qualitative research design, which allows a researcher to identify patterns and themes from self-reported perceptions of the target population's experiences (Merriam & Grenier, 2019), which may be similar or different. Data analysis included reviewing audio recordings of

the interviews and transcriptions of the interviews multiple times and selecting transcription excerpts that support and correspond with identified patterns, meaningful explanations and common themes expressed in the interviews. The initial coding from the review of the data was the starting point for the coding process. NVivo software was used to organize, manage, and transcribe and the data. Microsoft Word and Excel were also used to organize and code the data. In Word, I collected notes from each transcript and then examined them with close analysis to determine information deemed relevant to the study. Excel was used in the process of inductive coding to manage the data and to structure participant responses. After reading the transcripts and notes, I organized the data to discover how participants make sense of the relationships influencing their decisions and interpret meanings associated with those experiences (Merriam & Grenier, 2019). Replicated codes and codes with similar meanings were generated to create themes.

Six themes emerged from analysis of the semistructured interview transcripts. These themes included knowledge of benefits, knowledge of barriers, accessibility to additional support, infant feeding intentions, feeling supported, and practitioner influence on decisions (see Table 2).

Table 2

Table of Themes

Themes	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Knowledge of benefits	x	x	x	x	x	x	x		x	
Knowledge of barriers	x	x	x	x	x		x			
Accessibility to support		x	x		x		x			x
Feeding intentions	x	x	x		x		x		x	x
Feeling supported		x	x		x		x			x
Provider influence				x	x			x	x	

The first theme, knowledge of benefits, pertains to the education participants received on the benefits of breastfeeding. This theme is used to describe the information provided to women during any time throughout the prenatal and postnatal periods. The second theme, knowledge of barriers, pertains to the education participants received on the barriers to breastfeeding. This theme is also used to describe the information provided to women during any time throughout the prenatal and postnatal periods. The third theme, accessibility to additional support, pertains to the participants experience of obtaining additional or continued support for breastfeeding at 3 months and 12 months postpartum. This theme connects the community-level support experience related to the SEM and breastfeeding support. The fourth theme, infant feeding intentions, pertains to early or initial infant feeding decisions to breastfeed or not breastfeed. The fifth theme, feeling supported, pertains to the participants feeling of support by their health service practitioner. The sixth, and final theme, practitioners influence on decision, pertains to the effect of health services support on the mother's infant feeding method. Each of these

themes are used in the Results section of this chapter to provide final study results relative to the study purpose and address the two study research questions.

Evidence of Trustworthiness

The rigor of this qualitative study was promoted by maintaining credibility, transferability, dependability, and confirmability (Johnson et al., 2020). Prior to conducting the study, I did thorough research to ensure the highest research quality possible. Credibility and confirmability of the study were upheld by validating themes through multiple sources of data collected from participants. Confirmability was also established through transcript review. Should there be any competing themes, it is critical to disclose this information to ensure credibility of the study (Johnson et al., 2020), though no competing themes presented in this study. Transferability of this study was communicated through the provision of factors including research method, location of the study, number of participants, participant characteristics, and timing of data collection and analysis. Dependability and credibility were implemented through engagement, consistent observation, and triangulation. Furthermore, the study provides dependability with thorough details provided to ensure proper research was conducted and enables future replication of the study.

Results

The purpose of this study was to explore the participants' perspectives, opinions, beliefs, and experiences around breastfeeding support provided to them in healthcare settings and explore how that level of influence impacts breastfeeding decisions. Ten interviews were conducted with African American breastfeeding and non-breastfeeding

mothers. The interviews were guided by the semistructured interview questions (see Appendix A). The following section presents findings of the data analysis to answer the research questions:

- Research Question 1 (RQ1): What are the experiences of African American women who chose to breastfeed their child(ren) and those who refused breastfeeding, with breastfeeding support systems provided in healthcare settings that supported breastfeeding initiation and/or duration?
- Research Question 2 (RQ2): What effect does breastfeeding support provided in healthcare settings have on the African Americans woman's decision to breastfeed or not?

The data that resulted from these research questions led to the emergence of six themes: knowledge of benefits, knowledge of barriers, accessibility to additional support, infant feeding intentions, feeling supported, and practitioner influence on decisions.

Theme 1: Knowledge of Benefits

Understanding the benefits associated with breastfeeding can shape mothers' perceptions and attuites towards breastfeeding and support initiation and duration. Whether during pregnancy or after delivery, it is important that mothers be informed. Studies have shown that health services providers can provide positive support and influence (Segura-Pérez et al., 2021). It is known that protection and promotion of breastfeeding is critical among vulnerable populations and supports increased maternal and infant health outcomes (WHO, 2021).

Many participants spoke similarly about information shared with them on the benefits of breastfeeding, while 2 out of 10 (20%) stated that the provider did not well inform them. P2 stated,

> They [the providers] were a big resource and a big support because they were telling me kind of like the real deal. So not the, you know, the clinical information that would be needed, but more so based off of experience and how to deal with certain things.

P3 noted,

> So yeah, I had the conversation. I had a couple of conversations. … there was a location consultant that did come into my room when I was at the hospital, and they did offer me help with whatever I needed.

P4 described her experience as follows:

> Prior to having the baby, I did go to a baby basics class from my doctor, my doctor suggested it. My doctor's office. And in that class, they kind of went over breastfeeding and formula. I also went to a breastfeeding class from my doctor that was strictly about breastfeeding. But they were both like, not volunteer, but you had to pay for them. It's like your doctor said, these are the classes we offer. And then I signed up for them.

P5 provided examples of the types of information she was given:

> So, yes, they talked about the benefits for mom, as well as the benefits for baby, the nutritional value of breast milk, how the nutrition of the milk changes with the progression and growth of the baby. So, you start with the colostrum and then

> transition to your full milk, and how those different types of milk are essential for that particular time for the baby. They also talked about the lower risk of breast cancer and how the breastfeeding helps reduce the uterus, the uterus shrinking after contracting back down after birth.

P6 stated,

> Yes, I do recall, having a conversation with a lactation expert that came to one of our appointments, just to discuss the importance of breastfeeding. Kind of how the process works, how the baby needs to latch on, and kind of demonstrating what I would need to do if I decided to breastfeed.

P7 answered that, "Yes, um, I was told that it does help them gain weight, it's nutritious. It helps them to gain immunity from mom." Similarly, P9 stated,

> The information was more like, you know, immunity immune system boasted, it's definitely better it's coming from the mother. They gave me a lot of stats and statistics, I guess about those that are breastfed versus those that are not, and that it's more natural, holistic.

P8 and P10, both shared experiences where the providers did not provide education to them on the benefits of breastfeeding for mother or infant. P8 described the lack of breastfeeding information provided to her:

> I felt like the hospital is like you had a decision to breastfeed or give formula. If you made the decision to breastfeed then "come on, let's get it done." It wasn't really information about then benefits or anything like that.

P10 also experienced a lack of thorough information provided:

> Honestly, it wasn't really stressed, it was more stressed that your child was fed, whether that was through breastfeeding or through formula. They did kind of try to push breastfeeding a little bit more. But the reasoning wasn't necessarily discussed. Because they at the hospital, they did also offer the option of you know, providing my child with formula. So, it was more so that your child is happy and healthy and eating, whether it was a breastfed baby or a formula baby. I don't remember having someone pushing me either way, but because I did want to breastfeed, they were trying to do what they could to help me through that journey.

Theme 2: Knowledge of Barriers

Awareness of breastfeeding barriers can shape mothers' perceptions and attuites towards breastfeeding and support initiation and duration, much like understanding the benefits of breastfeeding. Likewise, this education should be delivered during pregnancy or soon after delivery so that mothers can make informed choices and have to tools available to be successful. Of the participants, 6 out of 10 (60%) reported information shared to them regarding barriers to breastfeeding from their health service provider. However, 4 out of 5 (80%) of non-breastfeeding mothers reported that information on barriers to breastfeeding was not shared with them. Understanding challenges or barriers to breastfeeding before they occur is an initiative-taking approach to increasing breastfeeding protection among mother and infant. Many mothers, both breastfeeding and non-breastfeeding spoke of common barriers such as pain, medications, inadequate milk production, employment, and lack of time. P2 was informed of barriers to extended

breastfeeding in her experience with the health services provider. She stated, P2: “I breastfed my child well after he was two. So, there were some concerns with the length of breastfeeding and whether it would cause different, opportunities or challenges with teeth. So how it would affect teeth, whether it’d be decayed or not.”

P3 stated she felt knowledgeable: “They gave me written documentation that showed what kind of issues that a woman who wish to nurse could have and also possible solutions to it.”

P5 stated,

> Absolutely. So, the biggest one that we discussed was the pain. Many women feel pain during breastfeeding. The importance of immediate initiation, so that golden hour, trying to feed within the first hour. So, with my second child, I was not able to initiate skin to skin breastfeeding for three days. And so, for some women, that is a barrier, so baby separation, and just having the patience to learn the process because it’s new for mom and baby. So, learning the process, learning with trial and error what positions work for you, just having that patience to push through and continue with the process that tends to be a huge barrier for a lot of women.

P6: “They kind of steered away mainly, I think for not for the purpose of not to discourage the mother.”

P8 described the knowledge provided to her as follows: “Never got any.”

P9: “They would gloss over it. As if to say that’s not really a barrier, you can work around that don’t let that be a hindrance. They weren’t necessarily solution oriented about those barriers. They would just kind of, you know, blow it off if you will.”

P10:

Honestly, it wasn't really stressed, it was more stressed that your child was fed, whether that was through breastfeeding or through formula. They did kind of try to push breastfeeding a little bit more. But the reasoning wasn't necessarily discussed. Because they at the hospital, they did also offer the option of you know, providing my child with formula. So, it was more so that your child is happy and healthy and eating, whether it was a breastfed baby or a formula baby. So, I don't remember having someone pushing me either way, but because I did want to breastfeed, they were trying to do what they could to help me through that journey.

Theme 3: Accessibility to Additional Support

Mothers must feel that support is available to them when they need it most. The SEM explains how environmental influences, such as support from health service providers can influence breastfeeding decisions among African American women, which subsequently influences United States population health outcomes. When participants were asked about the ability to get the support needed to give only breast milk to their baby for three months and garner support for continued breastfeeding at 12 months postpartum, 5 out of 10 participants said that there was some level of difficulty. When breastfeeding status what considered, 2 out of 5 (40%) breastfeeding women felt a lack of support, and 3 out of 5 (60%) on non-breastfeeding mothers perceived a lack of support during those timeframes. When health services providers are not supportive there is a known impact on initiation and duration of breastfeeding (CDC, 2018; Shipp et al.,

2021). While some mothers felt support, an equal number of women perceived none. P8 specifically highlighted the difficulty many mothers encounter feeling uncomfortable to share that they are struggling with breastfeeding and need help.

P2 stated,

> I don't think it would be difficult at all. I think the same resources that were provided from the lactation consultant, the pediatrician, and then the resources- I guess the pediatrician kind of partners with different lactation consultants if the mother is having issues and troubles to be a resource for that. And then you know, in today's day and age, with social media, there's a lot of different platforms and communities that you're able to kind of tap into for support, and for guidance, if needed, so I don't think it would be difficult.

According to P3 gaining accessibility was "Not hard at all"

P5:

> I think the biggest thing is having that support system. Being educated beforehand, doing your background research, asking your questions, taking your breastfeeding classes, doing your research beforehand. But also having those people around you from the minute the baby is born throughout that process, because even once with both of my children, once I established breastfeeding, and established in my mind that this was happening I still needed that encouragement throughout.

P7: "It actually would not have been very difficult at all because the hospital is really good about providing information for ways for you to get milk for your baby."

P10 described her experience as follows:

> I don't think it would have been too difficult. I did have access to lactation consultants. I don't believe it was necessarily covered completely by insurance, for example, but I did have access to those resources. So, I think that if I wanted to continue getting help, I could have done that. But I think it was it was my choice to pull the plug and not to breastfeed
>
> P1:
>
> I will say, as the months go on, it is more difficult to find people in support of your continued journey and breastfeeding. Because so many say, oh, well, you did the beginning. That's all that matters. Or, oh, you know, you gave them what was most important that colostrum, you know, people don't realize that there's still added benefits and essential benefits to go the full year.

P4 recounted,

> For me, I think it was more of a mental barrier. It's very draining. For me. It was a very draining experience. So, I think because I work in a supportive place, basically, when I went back to work, I went back to work for like 3 months. And then it was the pandemic.

Similar to the challenges experienced by P4, P6 stated the following:

> [Accessing additional support was] very difficult. I would say either your child either it's going to be something that you can do or not. You usually know that within the first few weeks of breastfeeding. So, so for long term, I think it would be a lot more difficult. Because I mean, I don't think people usually do it after a

> few weeks either. It doesn't work at that point. It's easier to give up and just go to the formula. Because you either have success with it, or you don't. It's, it's just a lot. It's a lot of work.

P8 stated,

> I know that there's classes that you can take or a public health place you can go to. I guess it's easy if I wanted to reach out to someone about it. But it's an uncomfortable conversation a lot of the times. I guess it's not difficult. But um, a lot of times it's an uncomfortable conversation. So, I guess overcoming that- not being uncomfortable, it might be easier to get that support.

P9: "Very. At the time I was actually working retail. I was doing merchandising. So, no office, no set place to be able to necessarily pump."

Theme 4: Infant Feeding Intentions

When a woman finds out that she is pregnant there is a wealth of information provided and many expectations about delivery and the postnatal period begin to form. It is common for mothers to an advanced intention of their infant feeding method. Some participants in this study shared that they had decided to breastfeed before delivery while others used information shared on the benefits and barriers to aid in making their choice. It is often said that experience is the best teacher and some mothers in the study intended to do one thing and found themselves doing another. One of the significant components supporting the SEM is that it can integrate strategies of individual behavioral change and environmental levels across a broad theoretical framework. The experiences shared under this theme connect individual-level decisions to the effect of environmental factors that

may change behavior. In this study, 7 out of 10 (70%) mothers had set an intention on how they would feed their baby, though some of these mothers also acknowledge that their plan had changed.

P4 stated,

> I decided to breastfeed because I had gotten a lot of information, I would say like, almost kind of like peer pressure type information. […] The doctors were saying breastfeeding has so many benefits. When I actually did it, I stopped sooner than I would say, a lot of people who were also breastfeeding with me. I breastfed for six months. And I think it was just because for me, it was very draining because I think it made my baby be more attached me than everyone else.

P6 answered that,

> I started out breastfeeding. […] And I ended up after the longest I went, I would say would be six or seven weeks. And then I decided not to go through with the breastfeeding because of the painfulness and the discomfort of it. I decided to switch over to formula.

P7: "This baby in 2018 was my third baby. The first one I did try to breastfeed, but it was difficult because of the breast augmentation I spoke of."

P8:

> I guess bringing pressured, you know. It's the pressure of it as the best thing to do for your child. And if you don't do it, you know, you're, you know, babies that's breastfeed or smarter or this or that. I think it's just a lot of pressure to do it. Like you're a bad mom, if you don't breastfeed, or whatever if you don't even try.

> You're a bad mom or looked down upon. So yeah, I guess I was pressured to do it.

P9 provided examples of how intentions can be difficult to achieve, noting,

> Okay, my decision was to not breastfeed, because of my job at the time. I didn't necessarily want to, in the beginning anyway. For a couple of different reasons, one of them was I have seen the breast after the babies are done with them wasn't very appealing. But then it was more of the actual, what my lifestyle was. I knew I was going directly back to work. It really wasn't going to be feasible; it was going to require not just me to be flexible, but I would have to have an employer and a life that was flexible to allow me to do that kind of stuff. And I knew that just wasn't going to work.

P10 answered that,

> My decision came from just having difficulties. I wanted to and I tried. I would say he breastfed for maybe the first week and then I was pumping throughout the first four weeks. But from I would say within that first week, he was drinking formula to supplement what I was not able to produce. So, my decision was more so I would rather have a healthy, healthy, happy child who's eating and not hungry, then to continue trying to squeeze out what I could, but you know, I didn't I didn't have enough for him.

Theme 5: Feeling Supported

When mothers feel that they are not supported it can be difficult to accomplish what you intend to do. Feeling supported encourages self-efficacy and tenacity through

adversity. As this study aims to address support provided from health practitioners within the community-level breastfeeding support system, all participants were asked if they were well supported by their provider. From the participant, 5 out of 10 reported that they were did not feel well supported. Most would equate a fifty-percent success rate with failure. Both breastfeeding mothers and non-breastfeed mothers felt that they were not well supported. Breastfeeding rates increase when support is provided (WHO, 2014). Recounting whether she felt supported P1 stated "No ma'am"

> P6: "No"
>
> P9: "For the choice that I made? Not really."

P5 stated,

> Um, ah, yes, and no. I think I was well prepared. I think I was well supported in the hospital. But I feel like when I got home, um, there could have been a little more follow up. While I didn't have issues to the point that I stopped nursing, as a new mom and even a new mom with my second child, I would have appreciate and feel like I would have benefited from some check ins here and there.

P8 also experienced feeling a lack of support like many of the other participants recalling:

> I was in a hospital after delivering him and, um, it was just a struggle to pump or to be encouraged to pump when you are in so much pain. And then the medicines that they wanted to give me, I kept stressing. Is it safe for my baby to have these medicines while I'm breastfeeding? And it just wasn't their concern.

Theme 6: Practitioner Influence on Decisions

As outlined in the social ecology model, influence can come from many spheres around the individual level. Practitioners supporting maternal and child health at the community level include lactation counselors, doulas, nurses, doctors, midwifes and others. Participants were asked if the experience they had with the provider had an influence on their decision to breastfeed or not breastfeed, to aid in exploring if there is an effect on the African Americans woman's decision to breastfeed or not breastfeed. In this study, both breastfeeding mothers and non-breastfeeding mothers reported the same level of practitioner influence on their decisions.

P1 answered, "No ma'am. It was a personal decision. It was something that I chose and wanted to do."

P2: "No, it was a decision that I was committed and determined to do either way. I just think it was an added bonus for them to provide the support and additional resources and answer questions as needed."

P3 stated,

> Like I said, I had always I'd already planned on doing that. Only so that was pretty much the only option I that I had. I mean, if of course, there was something that happened where I could not possibly, you know, breastfeed my child naturally than I would definitely do that. You know, it's more important for my kids to be fed than anything. But I'd always planned to give them the best thing absolutely possible which is, you know, milk that comes directly from my body

> for him. So, yes, nobody, nobody had to convince me. Nobody had to you know, I was already kind of in there.

P4: “Yes, I think that with the doctor’s sort of suggesting that breastfeeding was more healthy, was better for the baby.”

P5 recalled that in her experience the provider support was influential:

> It confirmed, strengthened and solidified my choice to breastfeed, yes. It just further reinforced the things that I was already thinking and considering. And knowing that I had these resources that were available to me, made it even more comforting in that decision. Because I made the decision, you know, a long time ago before I even got pregnant. And even though I’m someone that’s worked with other women to help them with breastfeeding, being a new mom and doing it for myself for the first time. It’s one thing to be the to be the support. But it’s a very different thing to be the one that needs the support. So having those resources available and knowing they were available was kind of like the cherry on top.

P6 noted, “No, it was through my own. It was my own decision.”

P7 expressed, “No, I totally made that decision prior to even going to deliver him. I wasn’t swayed either way by them. Oh, I didn’t feel pressured either. They were respectful of my decision.”

P8: “Oh, yeah, probably won’t try breastfeeding again.”

P9:

> It did. They were very pro breastfeeding, but they were not very good at alternatives, you know, for someone who did not have a lifestyle where they were

not just going to be home with their baby the whole time. You know, they didn't have any other alternatives other than you should do it, you know, but after that they didn't recommend anything.

P10: "No. I didn't feel pressure from them to breastfeed or not breastfeed. I would say they were, you know, pretty supportive either way. But there was definitely no pressure that I needed to do one or the other. I never felt that."

Summary

The research questions in this study led to the culmination of a rich body of data pertaining to the perspectives, opinions, beliefs, and experiences around breastfeeding support provided to African American mothers in healthcare settings and explore how that level of influence impacts breastfeeding decisions. This chapter explored key findings and presented themes which reflected participant experiences of support of 10 African American mothers whether they breastfeed or chose not to breastfeed. Using the SEM, the findings of this study made inferences between support and breastfeeding and the decision to breastfeed or not. While the decision to breastfeed is individual-level, barriers to breastfeeding have an impact to initiation and duration when a mother does not feel supported by community-level health services providers, according to the experiences of the breastfeeding and non-breastfeeding mothers in this study. Mothers also shared that support from their provider did have on breastfeeding success. In the final chapter, the interpretations of the findings are presented, limitations of the study are discussed, recommendations are made, implications to positive change are addressed and the overall significance of this study summarized.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this generic qualitative study was to explore the African American women's perspectives, opinions, beliefs, and experiences around breastfeeding support provided to them in healthcare settings and explore how that level of influence impacts breastfeeding decisions. The literature review revealed limited studies on the target population. There was limited research focused on the experiences of both breastfeeding and non-breastfeeding women with support from health service professionals within the community-level sphere of influence according to the SEM. The study findings uphold the notion that breastfeeding support does have a significant effect on breastfeeding rates in the African American community. Both breastfeeding and non-breastfeeding women reported feeling unsupported and that their breastfeeding decision was influenced by their health services provider. Information from this research may be used to design better health services, outreach, and education materials to assist African American women with their decision to breastfeed and identify barriers to breastfeeding for this group that researchers have not previously addressed. In this chapter, I present an interpretation of the findings, limitations of the study, recommendations, implications, and a conclusion to capture the key essence of the study. Data collected and analyzed from the interviews will be interpreted as they relate to peer-reviewed literature described in Chapter 2.

Interpretation of the Findings

The breastfeeding and non-breastfeeding African American women in this study were clear and confident when sharing their experiences with systems that support initiation and duration, and how that support effected their decision to breastfeed. The

participants were open and direct about their experiences, and all recounted a time when they interacted with community-level health service providers for breastfeeding support. Researchers have determined there are opportunities to educate mothers as well as their support systems through the lens of the SEM (Ma et al., 2018), reinforcing support for the framework in breastfeeding current studies. Participants shared their personal breastfeeding experiences based on microlevel and macrolevel spheres of influence. Within the context of breastfeeding, the SEM posits that there are common factors, microlevel (interpersonal) and macrolevel (community, institutional, society), influences to breastfeeding decisions and practices. Individual-level breastfeeding decisions needs to be contextualized within other factors (Tran, 2021). A great deal of participants provided information that parallels the peer-reviewed literature described in Chapter 2, confirming the need for increased provider support.

As the CDC (2021) has called for data on the SDOH to be used as a catalyst to improve community health and wellbeing, this study provides data focused on health services support including access to care and health literacy, key areas of SDOH. The findings in this study were consistent with what previous researchers had identified as barriers to breastfeeding and the impact of support on breastfeeding decisions (Ma et al.,2018). This study helps to confirm what was found in the literature whereas, data analysis from the lens of the SEM provides a deeper understanding of breastfeeding support and barriers from a system thinking perspective (Segura-Pérez et al., 2021). The study findings show that participants found difficult accessing support during critical breastfeeding phases. Six themes emerged from the semistructured interview questions,

addressing each of the research questions. Research Question 1 provided insight into the experiences of African American mothers' experiences of support for initiation and duration, whereas Research Question 2 looked to explore the effect support had on the decision to breastfeed. Based on the analysis of the data from five breastfeeding and five non-breastfeeding mothers in the Greater Atlanta area, we can understand more about their experiences of health services support with initiation and duration, as well as the effect of provider support on the decision to breastfeed or refuse breastfeeding.

The participants' responses provided data that gave voice to the complexity of social influence on breastfeeding decisions for African American mothers. This was highlighted by breastfeeding mothers who said, "You absolutely have to have a support system" and "I always felt that there was somewhere that I can go and people who I can talk to if I had an issue" and "I think the biggest thing is having that support system. … once I established breastfeeding, and established in my mind that this was happening, I still needed that encouragement throughout." The complexity of provider support was also highlighted by nonbreastfeeding mothers, who felt there "wasn't any encouragement" and "they were very pro breastfeed, but they were not very good at alternatives, you know, for someone who did not have a lifestyle where they were not just going to be home with their baby." The findings reveal that when mothers felt supported by community-level health care practitioners, they were more likely to choose breastfeeding.

Knowledge of Benefits and Barriers

Findings from this study indicated that knowledge on the benefits of breastfeeding was associated with choosing to breastfeed. Most of the study participants were able to describe an experience of being provided information on the benefits of breastfeeding from their health care provider. However, this information was not provided to everyone. When asked about information shared regarding barriers to breastfeeding, P9 stated,

> They would gloss over it, as if to say that's not really a barrier you can work around that. Don't let that be a hinderance. You know, they weren't necessarily solution oriented about those barriers. They would just kind of you know, blow it off, if you will.

According to P6, "they kind of steered away mainly, I think for the purpose not to discourage the mother." In addition, P4 shared that "I don't think the health care providers really painted that picture of how it would really be." The findings show that some women were not provided information that may have supported breastfeeding. These findings confirm research in prior studies highlighting the inequities knowledge and support (Smith, 2018). Study participants highlighted additional costs and time attributed to prenatal and breastfeeding classes. Economic status must not be a barrier to health education. Study participants shared that breastfeeding classes were optional. However, in order to ensure inclusivity, benefits must be provided to 100% of mothers throughout pregnancy and the postpartum periods. The Georgia Department of Health WIC program promotes breastfeeding education and promotion to all pregnant women during visits and provides breastfeeding education and support during early infant visits,

like many other states. Many of the previous studies around breastfeeding are formed around WIC participants, which offers breastfeeding support for all mothers during the prenatal periods. Those findings show that not all mothers are receiving that same level of knowledge from health service providers. When mothers are not enrolled in the program or do not quality for WIC services, it is critical that health service providers fill in critical knowledge gaps and ensure that all mothers are educated on the benefits of breastfeeding to mom and baby. While many of the study participants cited knowledge of physical and psychological benefits of breastfeeding, they may not have been supported with practical knowledge of breastfeeding to support initiation and duration.

Findings also revealed there was little knowledge of breastfeeding barriers presented to study participants. Participants noted that barriers arise throughout the entire breastfeeding experience. P1 stated, “I will say, as the months go, it is more difficult to find people in support of your continued journey of breastfeeding.” P9 stated, “I have seen the breast after the babies are done with them wasn’t very appealing.” These findings support previous literature on community and cultural level barriers African American women face to exclusive breastfeeding including sexualization of the breasts, social bias against breastfeeding and breastfeeding in public (Segura-Perez et al., 2021). Findings of this study reveal that retuning to work was another major barrier to breastfeeding. P1 stated, “I think the main barrier was that it’s an incredible hassle and drain to continue to pump for that long when you’re not at home. I think it was much easier for me to breastfeed when I’m in the same place with the baby.” P2 stated, “I was

actually working retail. I was doing merchandising. So, no office. No place to be able to necessarily pump."

Knowledge of barriers allows mothers to plan and account for issues that may make breastfeeding for one year more difficult. Participants noted the unique challenges mother and baby face during the often-overwhelming postpartum period. These barriers included problems with proper latch, supply concerns, pumping as an extra task, exhaustion, and pain, making the start to breastfeeding that much more challenging. Being properly prepared with support can ease the anxiety many mothers feel about delivery and the critical days preceding birth. Study participants also noted barriers such as lifestyle, medications and mothers' milk, juggling multiple children, lack of partner support and return to work, as barriers. This confirms and supports previous study findings that providers need a better understanding of breastfeeding barriers to support mothers to continue breastfeeding (McClatchey et al, 2018).

Study findings show that participants found difficulty in pumping and storing breast milk as they had returned to work. This confirms previous research that determined return to work is commonly considered a barrier due to the need to pump and store milk in the absence of the infant (DeVane-Johnson et al., 2017). Early knowledge of breastfeeding barriers allows time for questions to be asked to the provider, further understanding or education to be offered, or other accommodations to be considered. Although some participants planned to breastfeed, they found it difficult to implement. Provider support from a peer counselor, lactation consultant, doula, or midwife would be a very appropriate support resources for these issues. When more clinical breastfeeding

support is necessary a nurse or doctor may provide a more detailed assessment of the problem. As mentioned by a study participant, technology allows for virtual communication from a variety of providers, making access to support more convenient and support for breastfeeding barriers more accessible.

Accessibility to Additional Support

Findings from this study indicated that there is a need for increased accessibility to additional support. Access to health services is one of the core components of the SDOH (CDC, 2021). This confirms research that identifies emotional, informational, and tangible support as necessary interventions for health service providers providing support for breastfeeding. Although a plethora of health service providers offer breastfeeding education and support, half of the participants in this study felt that it would be difficult to access this support for continued breastfeeding. According to the American Academy of Family Physicians, human milk goes through many transitional phases. During those periods mothers may experience more frequent barriers, including stress, pain, and fatigue (Westerfield et al., 2018). Healthcare organizations recommend only breast milk for the first 3 months of infant life, and continued breastfeeding for at least 12 months (WHO, 2018). When asked about the difficulty of getting the support needed to continue breastfeeding at 3 and 12 months, study participants recalled the mental drain of breastfeeding during these periods, trouble balancing other children and return to work responsibilities, the decreased support from providers, and the uncomfortable nature of asking for help. These transition periods are common for mothers as they align with growth and development periods of the newborn. Therefore, providers should have

follow-up assessments as routine support, a standard of care for all mothers throughout the first year of motherhood and maintain an open line of communication to ensure ease of accessibility to support.

Infant Feeding Intentions

Findings from the current study also indicated that setting an intention to breastfeed was associated with positive breastfeeding outcomes. Like the findings of Tran (2021), although individual intentions may have an impact on breastfeeding, education or knowledge of breastfeeding and awareness of individual-level barriers were identified as protective factors for breastfeeding.

While breastfeeding is a natural process, it takes time to develop technique for both mom and baby. There are times when a pregnant woman intends to breastfeed and has a different outcome after delivery. Likewise, there are times when a mother has decided not to breastfeed and decides to try it after all. Findings of this study show that, although many mothers set intentions to breastfeed during pregnancy, breastfeeding intentions are fluid. Research has shown that intention to breastfeed does not vary significantly by race (Hamner et al., 2021). Noting that African Americans intent to breastfeed is the same as other racial groups, researchers suggest that these mothers have unique barriers that affect breastfeeding intentions (Tran, 2021). Mothers in this study reported changes from their initial intent, and according to research breastfeeding self-efficacy and breastfeeding intention were positively correlated with breastfeeding behavior (Wu et al., 2018). Therefore, it important that women with known disparities in

breastfeeding rates be prioritized and targeted with specific interventions to promote, educate, and support their intention to breastfeed.

Feeling Supported

Findings from this study indicate that women have better breastfeeding outcomes when the feel supported. Several participants noted difficulty in accessing breastfeeding support as time went on. Previous research revealed that breastfeeding behaviors are linked to interactions and experiences with healthcare professionals (Smith, 2018). Participants in this study who did not feel supported were associated with choosing to not breastfeed. The study findings show that availability and quality of social support for breastfeeding mothers receive can significantly affect their decision to breastfeed and how effectively they are able to maintain breastfeeding. This finding supports research from Reis-Reilly et al. (2018) which found that breastfeeding rates in the African American community were largely influenced by social and systemic barriers within their spere of influence but outside of their sphere of power.

The idea that a mother wanted to breastfeed but was not supported with her goal is unacceptable. When mothers feel comfortable and feel supported, they are more likely to reach out for help from someone they trust. It is important to note that it may be difficult to feel supported when postpartum mothers are dealing with physical, emotional, hormonal changes, added responsibility, and lack of sleep. These mothers should feel overwhelmed with support to breastfeed; however, half of the mothers in this study, breastfeeding, and non-breastfeeding, felt that they were not supported.

When participants in this study were asked about their experience garnering breastfeeding support at 3 and 12 months, several reported difficulties. P1 stated that "they weren't very supportive. And, in fact, they kind of made me feel inadequate because she wasn't gaining at the rate that they wanted her to." P2 shared that "it was more of a mental barrier. It's very draining. For me, it was a very draining experience." According to P6, "I would say it's moderately difficult. It's just a lot to get the support because it's like either the baby latches on or they don't." The findings show that support for breastfeeding decreases over time. This confirms evidence-based research that African American women are less likely to receive breastfeeding support, and these healthcare practices contribute to racial disparities in infant feeding (Beauregard et al., 2019). Increasing support for breastfeeding might help increase breastfeeding initiation and duration among African American women, especially when that support comes from a health services provider.

Provider Influence

Findings from this study also indicate that health service providers play a pivotal role in breastfeeding initiation and duration, in support of Rosen-Carole et al. (2020) findings on obstetrician support and the central role of providers in breastfeeding outcomes. However, Rosen-Carole et al. found that breastfeeding support increased over time even when breastfeeding education did not improve in quality or quantity. The findings in this study show that support decreases over time disconfirming Rosen-Carole et al.'s findings. The patient/provider relationship is one that is particularly important, as this study reiterates this knowledge. Forty percent of breastfeeding mothers, and 40% of

non-breastfeeding mothers in this study said that their provider had an influence on their decision to breastfeed. Participants of the study recalled both positive and negative experiences of support which influenced their decision to breastfeed. This affirms previous research that determined there are provider behaviors that support breastfeeding such as assessing intention, discussing breastfeeding during prenatal care, providing education on the benefits, and supporting mothers during the decision-making process (Rosen-Carole et al., 2020). There are also provider behaviors that diminish breastfeeding intent such as marketing formula and non-breastfeeding promotional gifts (Rosen-Carole et al., 2020). Providers must ensure that they are doing everything possible to minimize negative impacts on breastfeeding and do no harm. Inequities in maternal health may have lifelong implications, and health service providers can positively influence maternal decisions through education and support.

The contextual framework inference is related to this research study findings as the SEM and its incorporation of spheres of influence. Bronfenbrenner's ecological model pertains to how there are spheres of influence around an individual's decision-making process. The SEM allows for simultaneous emphasis on individual and contextual systems and the interdependence between them (Eriksson et al, 2018). Perceived social support for breastfeeding on the community-level sphere of influence was conceptualized in this study as an element of the SEM. The findings of this study suggest that provider support does have an influence on the African American woman's decision to breastfeed or not breastfeed. It is critical that health service providers

understand their unique role to provide education, promote and support African American women on their decision to breastfeed.

Limitations of the Study

This study has provided rich and detailed experiences of African American mothers and support from community-level health services supports for breastfeeding, although there are limitations to note. Some expected initial limitations were initially discussed in Chapter 1, while new limitations were identified. It is imperative that qualitive research ensure trustworthiness, as this is an important component of rigor. Trustworthiness criteria or strategies include credibility, transferability, dependability, and confirmability. Credibility of the study was affirmed using member checking, data triangulation, and reflexivity. Member checking was used to validate participant responses and check for accuracy. Triangulation was used for reflexive journaling, consistent review of the raw data, and by triangulating data sources from Chapter 2. Reflections were written throughout the study to support the collection, analyzing, and interpretation of the data, including any feelings or thoughts of the researcher to address bias. Reflexivity was also used to provide dependability and confirmability of the study.

Participants in the study come from a diverse variety of backgrounds including marital status, income, number of children, education status and more; therefore, their experiences are not necessarily representative of all African American mothers in the Atlanta, GA area. To ensure trustworthiness in transferability with this study's findings purposeful sampling was used. Prior to the study being conducted, limitations on the generalizability of the results were expected. This limitation was due to the small sample

size of experts with just ten participants which created detail-rich responses, but limited, nonetheless. This study was also limited as it did not include marital status, nor education status, which are factors that may increase breastfeeding rates by way of support and general knowledge (Clark et al., 2018). This information was limited to support the SEM framework of this study to focus on the support provided by healthcare providers at the community level of influence and the impact to breastfeeding decisions.

An unexpected limitation was the level of difficulty recruiting non-breastfeeding mothers. While the flyer included inclusive language for all mothers to participate, non-breastfeeding mothers took longer to recruit. Mothers that did not breastfeed may be uncomfortable sharing their barriers to breastfeeding and how that may be perceived by others. This was also expressed by a study participant who shared "a lot of times it's an uncomfortable conversation. So, I guess overcoming that, not being uncomfortable, it might be easier to get that support." This suggests that women have varying levels of comfortability sharing their maternal experiences with others, whether it be researchers, or health service providers.

Recommendations

There has been a deep and complicated relationship between African Americans and healthcare support and breastfeeding, stemming from racism, slavery, and cultural distrust of medical professionals by many in the African American community. Racial bias and prejudice has an impact on the SDOH (Standish & Parker, 2021). The findings of this study show when support is provided and trust has been established, provider education can positively influence breastfeeding behaviors, in support of Smith (2018)

who found that we must recognize unequal access to conditions and resources that support health, and the social systems which exacerbate disparities. The findings of this study show that African American mothers in the Atlanta area received a wide range of support for breastfeeding initiation and duration from community-level providers. While 100% of the participating breastfeeding mothers experienced information shared with them on the benefits of breastfeeding from community-level health service providers, there were non-breastfeeding mothers that did not experience information shared with them on the benefits of breastfeeding. Understanding the benefits of breastfeeding helps to educate mothers, support infant feeding intentions, initiation, and support duration. Breastfeeding continues to benefit mom and baby well beyond the first year and breastfeeding support and education should continue further as well. With significant inequities in maternal health, it is critical to close these gaps for both mother and baby. Georgia has lower breastfeeding rates comparted to many other states in the country. This study focused on mothers living near the capital city, Atlanta. Analysis in a study from Beauregard et al. (2019) revealed making improvements to clinical care in health services in four southern states reduced racial disparities in breastfeeding initiation.

This study may provide data that can be used for further research. It is recommended that future researchers expand recruitment to include mothers outside of the Atlanta area, to be more representative of the entire state. Atlanta is a metropolitan area with lots of resources, while most of the state is made of rural cities with lower socioeconomic conditions. Future research may include experiences at the policy and organization levels. This may help to capture experiences of mothers in other regions of

the state and create a bigger picture of the issue. The study also recommends more collaboration with community-based health services after mom and baby leave the hospital, as many mothers feel as though they lose provider support once they have returned home, and the months go on. This study's findings confirm additional research is recommended into the design of programs and interventions aimed to support African American mothers. Programs and interventions need to ensure that they are culturally inclusive and have the reach intended. This support previous research which determined cultural may impact breastfeeding behaviors and maternal and child health outcomes (Segura-Perez et al., 2021). The continuation of breastfeeding support throughout the first year can nurture the patient and practitioner relationship to help change health behaviors.

Implications of Positive Social Change

This study has several implications for health service providers who seek to address African American breastfeeding disparities and breastfeeding support from healthcare providers. This study adds knowledge to an existing gap in literature pertaining to experiences of African American mothers breastfeeding rates and health service support. The purpose of this qualitative research study was to explore the participants' perspectives, opinions, beliefs, and experiences around breastfeeding support provided to them in healthcare settings and explore how that level of influence impacts breastfeeding decisions. The implications and results of this study highlight the importance of health service provider support for breastfeeding in the African American community. Through the incorporation of the SEM, this research took a comprehensive approach of improving health services by addressing the physical, behavioral and social

drivers that impact health in vulnerable populations. By addressing the research questions, participants help to determine that there are implications to positive social change through this study.

The findings of this study contribute positively to data on the impact of interventions to support breastfeeding for minority women within the SEM, as recommended from Ma et al. (2018). Healthcare costs increase for mother and child when breastfeeding is low or refused (AAFP, 2018). Therefore, it is important to society and to public health that breastfeeding research and interventions be targeted to the most at-risk populations. Breastfeeding is environmentally friendly, and has broad social and economic benefits (AAFP, 2018). The findings of this study contribute positively to broader academic research by exploring similarities and differences in African American women that chose to breastfeed and who refused breastfeeding. Racial representation in research is vital, builds awareness and sensitivity. Prior studies indicated the need to increase diversity in of racial groups represented in breastfeeding studies, and to study a single ethnic/racial group at a time, supporting a methodological framework to focus on the lived experiences of this group uniquely (Segura-Perez et al., 2021). The findings in this study may have a community-level impact on maternal health equity in Atlanta, GA, as it may increase from the continued knowledge that support for breastfeeding initiation and duration is still warranted and support is vital.

This study also implicates the need for stronger health services provider support relationships, as infant feeding decisions are not solely based on the mothers' intentions, as supported in this study. Implications for professional practice should focus on early

breastfeeding education and support. Provider support can be offered though free breastfeeding education, scheduled calls, or communication for continued care for the duration of the breastfeeding experience. According to study participants, mothers found it more difficult to access care to support breastfeeding as time went on. Finally, this study positively contributes to the implication of extended breastfeeding support and follow-up services for mothers for at least one year and as mothers being to wean because provider influence can help mothers with initiation and duration (Bueno-Gutiérrez et al., 2021; Schindler-Ruwisch et al., 2019). Increased provider support may drive positive social change by increasing breastfeeding rates in the African American community, thereby eliminating racial and ethnic disparities, reducing maternal and infant morbidity and mortality. As mentioned previously, there is a growing body of evidence on the health risks of not breastfeeding (AAFP, 2018). Increased community-level breastfeeding support is one way to prevent chronic disease and increase health services to this vulnerable population.

Conclusion

This was a unique study in that it focused solely on the African American mothers, comparing the experiences of both breastfeeding and nonbreastfeeding mothers with health service providers to learn more about provider effect on the decision to breastfeed, initiation, and duration. The study is essential to improving maternal healthcare support to increase breastfeeding rates in at risk groups. Community-level health services can help mothers to navigate barriers to a healthy maternal experience and healthy infant. African American mothers and babies deserve the same education,

support, and bias free experience as other groups, yet as this study reflects, disparities continue. The six themes identified in this study were knowledge of benefits, knowledge of barriers, accessibility to additional support, infant feeding intentions, feeling supported, and practitioner influence on decisions. There are barriers to breastfeeding throughout the entire experience, as demonstrated by the findings of this study, and it is critical that African American mothers be equipped to breastfeed from pregnancy to weaning. This model and the findings of this study may support the practices of doulas, lactation consultants, peer-counselors, nurses, doctors and other practitioners who support breastfeeding, better understand how support is linked to breastfeeding decisions, breastfeeding initiation and duration.

References

American Academy of Family Physicians. (2018). *Breastfeeding, family physicians supporting (position paper)*. https://www.aafp.org/about/policies/all/breastfeeding-position-paper.html

American Academy of Pediatrics. (2019). *Benefits of breastfeeding.* https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/Benefits-of-Breastfeeding.aspx

American College Health Association. (2018). *Ecological model.* https://www.acha.org/HealthyCampus/HealthyCampus/Ecological_Model.aspx

Anstey, E. H., Chen, J., Elam-Evans, L. D., & Perrine, C. G. (2017). Racial and geographic differences in breastfeeding – United States, 2011-2015. *MMWR. Morbidity and mortality weekly report*, *66*(27), 723–727. https://doi.org/10.15585/mmwr.mm6627a3

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. I*nternational Journal of Qualitative Methods, 18*. https://doi.org/10.1177/1609406919874596

Arts, M., Taqi, I., & Begin, F. (2017). Improving the early initiation of breastfeeding: The WHO-UNICEF Breastfeeding Advocacy Initiative. *Breastfeeding Medicine*, *12*(6), 326–327. https://doi.org/10.1089/bfm.2017.0047

Asiodu, I., Waters, C., Dailey, D., & Lyndon, A. (2017). Infant feeding decision-making and the influences of social support persons among first-time African American

mothers. *Maternal & Child Health Journal*, *21*(4), 863–872. https://doi.org/10.1007/s10995-016-2167-x

Azungah, T. (2018). Qualitative research: Deductive and inductive approaches to data analysis. *Qualitative Research Journal*, *18*(4), 383–400. http://dx.doi.org.ezp.waldenulibrary.org/10.1108/QRJ-D-18-00035

Barnwell, A. (2018). Durkheim as affect theorist. *Journal of Classical Sociology*, *18*(1), 21–35. https://doi.org/10.1177/1468795X17702917

Beauregard, J. L., Hamner, H. C., Chen, J., Avila-Rodriguez, W., Elam-Evans, L. D., & Perrine, C. G. (2019). Racial disparities in breastfeeding initiation and duration among US infants born in 2015. *Morbidity and Mortality Weekly Report*, *68*(34), 745–748. https://doi.org/10.15585/mmwr.mm6834a3

Becker, F., Anokye, N., de Bekker-Grob, E. W., Higgins, A., Relton, C., Strong, M., & Fox-Rushby, J. (2018). Women's preferences for alternative financial incentive schemes for breastfeeding: A discrete choice experiment. *PloS ONE*, *13*(4), 1–19. https://doi.org/10.1371/journal.pone.0194231

Black Maternal Health Caucus. (2021). *Momnibus*. U.S. House of Representatives. https://blackmaternalhealthcaucus-underwood.house.gov/Momnibus

Bloomberg, L. D., & Volpe, M. (2018). *Completing your qualitative dissertation: A road map from beginning to end*. Sage Publications.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative research in sport, exercise and health*, *13*(2), 201–216.

https://doi.org/10.1080/2159676X.2019.1704846

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531. https://doi.org/10.1037/0003-066x.32.7.513

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, *22*(6), 723–742. https://doi.org/10.1037/0012-1649.22.6.723

Bronfenbrenner, U. (1994). Ecological models of human development. In T. Husen & T. N. Postlethwaite (Eds.), *International encyclopedia of education* (2nd ed., Vol. 3, pp. 1643–1647). Pergamon.

Bronfenbrenner, U., & Evans, G. W. (2000). Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development*, *9*(1), 115–125. https://doi.org/10.1111/1467-9507.00114

Bueno-Gutiérrez, D., Castillo, E. U. R., & Mondragón, A. E. H. (2021). Breastfeeding counseling based on formative research at primary healthcare Services in Mexico. *International journal for equity in health*, *20*(1), 1-11. https://doi.org/10.1186/s12939-021-01491-6

Carlin, R. F., Mathews, A., Oden, R., & Moon, R. Y. (2019). The influence of social networks and norms on breastfeeding in African American and Caucasian mothers: A qualitative study. *Breastfeeding Medicine*, *14*(9), 640–647. https://doi.org/10.1089/bfm.2019.0044

Carroll, G. J., Buccini, G. S., & Pérez-Escamilla, R. (2018). Perspective: What will it cost

to scale-up breastfeeding programs? A comparison of current global costing methodologies. *Advances in Nutrition*, *9*(5), 572–580. https://doi.org/10.1093/advances/nmy041

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds? *Currents in Pharmacy Teaching and Learning*, *10*(6), 807–815. https://doi.org/10.1016/j.cptl.2018.03.019

Centers for Disease Control and Prevention. (n.d.-a). *Breastfeeding.* https://www.cdc.gov/breastfeeding/data/facts.html

Centers for Disease Control and Prevention. (n.d.-b). *The social-ecological model.* https://www.cdc.gov/violenceprevention/publichealthissue/social-ecologicalmodel.html

Centers for Disease Control and Prevention. (2011). *Hospital Support for Breastfeeding.* https://www.cdc.gov/vitalsigns/breastfeeding/index.html

Centers for Disease Control and Prevention. (2017). *U.S. breastfeeding rates are up!* More work is needed. https://www.cdc.gov/breastfeeding/resources/us-breastfeeding-rates.html

Centers for Disease Control and Prevention. (2018a). *Breastfeeding report card.* https://www.cdc.gov/breastfeeding/data/reportcard.htm

Centers for Disease Control and Prevention. (2018b). *Contraindications to breastfeeding or feeding expressed breast milk to infants.* https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/contraindications-to-breastfeeding.html

Centers for Disease Control and Prevention. (2021a). *Social Determinants of Health.* https://www.cdc.gov/socialdeterminants/about.html

Centers for Disease Control and Prevention. (2021b). *Surgeon general's call to action to support breastfeeding.* https://www.cdc.gov/breastfeeding/resources/calltoaction.htm

Clark, A., Baker, S. S., McGirr, K., & Harris, M. (2018). Breastfeeding peer support program increases breastfeeding duration rates among middle-to high-income women. *Breastfeeding Medicine*, *13*(2), 112–115. https://doi.org/10.1089/bfm.2017.0021

Comess, J. E. (2017). Enhancing breastfeeding rates in African American women: A literature review. *Journal of the National Society of Allied Health*, *14*(1), 43–49.

Creswell, J. W., & Creswell, J. D. (2017). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage Publications.

DeVane-Johnson, S., Woods-Giscombé, C., Thoyre, S., Fogel, C., & Williams, R. (2017). Integrative literature review of factors related to breastfeeding in African American women: Evidence for a potential paradigm shift. *Journal of Human Lactation*, *33*(2), 435–447. https://doi.org/10.1177/0890334417693209

Dodgson, J. E. (2017). About research: Qualitative methodologies. *Journal of Human Lactation*, *33*(2), 355-358. https://doi.org/10.1177/0890334417698693

DuMonthier, A., Childers, C., & Milli, J. (2017). *The status of African American women in the United States*. Institute for Women's Policy Research. https://statusofwomendata.org/wp-

content/uploads/2017/06/SOBW_report2017_compressed.pdf

Duran, D. G., & Pérez-Stable, E. J. (2019). Novel approaches to advance minority health and health disparities research. *American Journal of Public Health*, *109*, S8–S10. https://doi.org/10.2105/AJPH.2018.304931

Edwards, M. E., Jepson, R. G., & McInnes, R. J. (2018). Breastfeeding initiation: An in-depth qualitative analysis of the perspectives of women and midwives using social cognitive theory. *Midwifery*, *57*, 8–17. https://doi.org/10.1016/j.midw.2017.10.013

Eriksson, M., Ghazinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner's ecological theory in public mental health research: what is their value for guiding public mental health policy and practice? *Social Theory & Health*, *16*(4), 414–433. https://doi.org/10.1057/s41285-018-0065-6

Eunice Kennedy Shriver National Institute of Child Health and Human Development (2017). *What are the recommendations for breastfeeding?* U.S. Department of Health and Human Services. https://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/recommendations

FitzPatrick, B. (2019). Validity in qualitative health education research. *Currents in Pharmacy Teaching and Learning*, *11*(2), 211-217. https://doi.org/10.1016/j.cptl.2018.11.014

Food and Nutrition Service. (2018). *WIC income eligibility guidelines (2018-2019)*. U.S. Department of Agriculture. https://www.fns.usda.gov/wic/wic-2018-2019-

income-eligibility-guidelines

Forde, A. T., Crookes, D. M., Suglia, S. F., & Demmer, R. T. (2019). The weathering hypothesis as an explanation for racial disparities in health: a systematic review. *Annals of epidemiology*, *33*, 1-18. https://doi.org/10.1016/j.annepidem.2019.02.011

Gallo, S., Kogan, K., & Kitsantas, P. (2019). Racial and ethnic differences in reasons for breastfeeding cessation among women participating in the Special Supplemental Nutrition Program for Women, Infants, and Children. *Journal of midwifery & women's health*, *64*(6), 725-733. https://doi.org/10.1111/jmwh.13031

Grant, A. (2021). Breasts and the city: an urban ethnography of infant feeding in public spaces within Cardiff, United Kingdom. *International Breastfeeding Journal*, *16*(1), 1-9. https://doi.org/10.1186/s13006-021-00384-2

Green, V. L., Killings, N. L., & Clare, C. A. (2021). The Historical, Psychosocial, and Cultural Context of Breastfeeding in the African American Community. *Breastfeeding Medicine*, *16*(2), 116-120. https://doi.org/10.1089/bfm.2020.0316

Griswold, M. K., Crawford, S. L., Perry, D. J., Person, S. D., Rosenberg, L., Cozier, Y. C., & Palmer, J. R. (2018). Experiences of racism and breastfeeding initiation and duration among first-time mothers of the Black Women's Health Study. *Journal of racial and ethnic health disparities*, *5*(6), 1180-1191. https://doi.org/10.1007/s40615-018-0465-2

Gross, M. S., Rosenblum, N., Bossano, C. M., & Milio, L. A. (2019). Breastfeeding and marijuana use: Medical and ethical policy analysis [10I]. *Obstetrics &*

Gynecology, *133*, 98S. https://doi.org/10.1097/01.aog.0000558789.95337.f7

Gross, T. T., Davis, M., Anderson, A. K., Hall, J., & Hilyard, K. (2017). Long-term breastfeeding in African American mothers: A positive deviance inquiry of WIC participants. *Journal of Human Lactation*, *33*(1), 128–139. https://doi.org/10.1177/0890334416680180

Hamner, H. C., Beauregard, J. L., Li, R., Nelson, J. M., & Perrine, C. G. (2021). Meeting breastfeeding intentions differ by race/ethnicity, infant and toddler feeding practices study-2. *Maternal & Child Nutrition*, *17*(2), 1–10. https://doi.org/10.1111/mcn.13093

Hawkins, S. S., Noble, A., & Baum, C. F. (2017). Effect of the Affordable Care Act on Disparities in Breastfeeding: The Case of Maine. *American Journal of Public Health*, *107*(7), 1119–1121. https://doi.org/10.2105/AJPH.2017.303763

Hemingway, S., Forson-Dare, Z., Ebeling, M., & Taylor, S. N. (2021). Racial disparities in sustaining breastfeeding in a baby-friendly designated southeastern United States hospital: An opportunity to investigate systemic racism. *Breastfeeding Medicine*, *16*(2), 150–155. https://doi.org/10.1089/bfm.2020.0306

Hinson, T. D., Skinner, A. C., Lich, K. H., & Spatz, D. L. (2018). Factors that influence breastfeeding initiation among African American women. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *47*(3), 290-300. https://doi.org/10.1016/j.jogn.2018.02.007

Hogan, V. K., Rowley, D. L., Brooks, P. E., Gonzalez-Nahm, S. N., Berthiaume, R., Thompson, Y., & Derige, D. (2018). Achieving breastfeeding equity: A study of a

national breastfeeding initiative. *Breastfeeding Medicine*, 13(2), 142-148. https://doi.org/10.1089/bfm.2017.0068

Hughes, M. M., Saiyed, N. S., Roesch, P. T., Masinter, L., & Sarup, A. (2019). Local Disparities in Breastfeeding Initiation and Duration: A Cross-Sectional Population-Based Survey in Ten Chicago Community Areas. *Journal of Community Health*, *44*(4), 629–635. https://doi.org/10.1007/s10900-018-00597-3

Hvatum, I., & Glavin, K. (2017). Mothers' experience of not breastfeeding in a breastfeeding culture. *Journal of clinical nursing*, *26*(19-20), 3144-3155. https://doi.org/10.1111/jocn.13663

James, R. S. (2017). *Breastfeeding disparities in African American women.* National Institute on Minority Health and Health Disparities. https://nimhd.blogs.govdelivery.com/2017/08/08/breastfeeding-disparities-in-african-american-women/

Kapinos, K. A., Bullinger, L., & Gurley-Calvez, T. (2018). The Affordable Care Act, breastfeeding, and breast pump health insurance coverage. *JAMA Pediatrics*, *172*(11), 1002-1004. https://doi.org/10.1001/jamapediatrics.2018.2003

Kilanowski, J. F. (2017). Breadth of the socio-ecological model. *Journal of Agromedicine*, *22*(4), 295–297. https://doi.org/10.1080/1059924X.2017.1358971

Kim, J. H., Fiese, B. H., & Donovan, S. M. (2017). Breastfeeding is natural but not the cultural norm: A mixed-methods study of first-time breastfeeding, African American mothers participating in WIC. *Journal of Nutrition Education and Behavior*, *49*(7), S151–S161.e1. https://doi.org/10.1016/j.jneb.2017.04.003

Krol, K. M., & Grossmann, T. (2018). Psychological effects of breastfeeding on children and mothers. *Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz*, *61*(8), 977-985. https://doi.org/10.1007/s00103-018-2769-0

Lau, C. Y. K., Lok, K. Y. W., & Tarrant, M. (2018). Breastfeeding duration and the theory of planned behavior and breastfeeding self-efficacy framework: A systematic review of observational studies. *Maternal & Child Health Journal*, *22*(3), 327–342. https://doi.org/10.1007/s10995-018-2453-x

Lawrence, R. M. (2022). Transmission of infectious diseases through breast milk and breastfeeding. In *Breastfeeding* (pp. 393-456). Elsevier. https://doi.org/10.1016/B978-0-323-68013-4.00012-2

Louis-Jacques, A., Deubel, T. F., Taylor, M., & Stuebe, A. M. (2017). Racial and ethnic disparities in U.S. breastfeeding and implications for maternal and child health outcomes. *Seminars in Perinatology*, *41*(5), 299–307. https://doi.org/10.1053/j.semperi.2017.04.007

Louis-Jacques, A. F., Marhefka, S. L., Brumley, J., Schafer, E. J., Taylor, T. I., Brown, A. J., ... & Miller, E. M. (2020). Historical antecedents of breastfeeding for African American Women: from the pre-colonial period to the mid-twentieth century. *Journal of racial and ethnic health disparities*, *7*(5), 1003-1012. https://doi.org/10.1007/s40615-020-00727-5

Ma, A., Merçon-Vargas, E. A., Chambers, B. D., Nyambe, M., & Williams, T. A. (2018). Context of breastfeeding among Latina mothers using a social-ecological approach: An exploratory study. *Journal of public health issues and practices*, *2*,

124. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6693519/

Martucci, J. (2017). Childbirth and breastfeeding in 20th-century America. In *Oxford Research Encyclopedia of American History*. https://doi.org/10.1093/acrefore/9780199329175.013.428

McClatchey, A. K., Shield, A., Cheong, L. H., Ferguson, S. L., Cooper, G. M., & Kyle, G. J. (2018). Why does the need for medication become a barrier to breastfeeding? A narrative review. *Women and Birth*, *31*(5), 362-366. https://doi.org/10.1016/j.wombi.2017.12.004

McCormack, L., Thomas, V., Lewis, M. A., & Rudd, R. (2017). Improving low health literacy and patient engagement: a social ecological approach. *Patient Education and Counseling*, *100*(1), 8–13. https://doi.org/10.1016/j.pec.2016.07.007

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly, 15*(4), 351–377. https://doi.org/10.1177/109019818801500401

Merriam, S. B., & Grenier, R. S. (Eds.). (2019). *Qualitative research in practice: Examples for discussion and analysis*. John Wiley & Sons.

Morris, C., Schofield, P., & Hirst, C. (2020). Exploration of the factors influencing attitudes to breastfeeding in public. *Journal of Human Lactation, 36*(4), 776–788. https://doi.org/10.1177/0890334419878119

Moon, R. Y., Mathews, A., Oden, R., & Carlin, R. (2019). A qualitative analysis of how mothers' social networks are established and used to make infant care decisions. *Clinical pediatrics*, *58*(9), 985-992. https://doi.org/10.1177/0009922819845332

National Institute of Child Health and Human Development. (n.d.). *What are the benefits of breastfeeding?* https://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/benefits

Office of Disease Prevention and Health Promotion. (2021). *Maternal, infant, and child health.* U.S. Department of Health and Human Services. https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health

Office of Minority Health. (2021a). *Infant mortality and African Americans*. U.S. Department of Health and Human Services. https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23

Office of Minority Health. (2021b). *Minority health and health equity resources.* U.S. Food and Drug Administration https://www.fda.gov/consumers/minority-health-and-health-equity/minority-health-and-health-equity-resources#HealthDisparities

Office of the Surgeon General. (2011). *The Surgeon General's call to action to support breastfeeding 2011*. U.S. Department of Health and Human Services. https://library.thaibf.com/bitstream/handle/023548404.11/244/calltoactiontosupportbreastfeeding.pdf?sequence=1

Office of the Surgeon General. (2019). *Breastfeeding reports and publications*. U.S. Department of Health and Human Services. https://www.hhs.gov/surgeongeneral/reports-and-publications/breastfeeding/index.html#

Parker, C., Scott, S., & Geddes, A. (2019). Snowball Sampling. *SAGE Research Methods*

Foundations. https://www.doi.org/10.4135/9781526421036831710

Patchen, L., Ellis, L., Harrington, C. B., Ma, T., Mohanraj, R., Andrews, V., & Evans, W. D. (2020). Engaging African American parents to develop a mobile health technology for breastfeeding: KULEA-NET. *Journal of Human Lactation*, *36*(3), 448–460. https://doi.org/10.1177/0890334420930208

Pierce, JP, & Kealey, S. (2021). Socio-ecological Model and Health Promotion in the Healthy People Initiative. In *Introduction to Health Promotion and Behavioral Science in Public Health*. *UC San Diego*. Report #: 10. Retrieved from https://escholarship.org/uc/item/883092ft

Preiser, R., Biggs, R., De Vos, A., & Folke, C. (2018). Social-ecological systems as complex adaptive systems. *Ecology and Society*, *23*(4). https://doi.org/10.5751/ES-10558-230446

Pyles, T. E. H., Umi, S. A., Madubuonwu, S., Stiles, A., Devane-Johnson, S., Scott, H., Rhoads, S. & Russell, J. H. (2021). Breastfeeding sisters that are receiving support: Community-based peer support program created for and by women of color. *Breastfeeding Medicine*, *16*(2), 165–170. https://doi.org/10.1089/bfm.2020.0313

Quinn, P., & Tanis, S. L. (2020). Attitudes, perceptions, and knowledge of breastfeeding among professional caregivers in a community hospital. *Nursing for women's health*, *24*(2), 77–83. https://doi.org/10.1016/j.nwh.2020.01.010

Reich, A. L., Milroy, J. J., Wyrick, D. L., & Hebard, S. P. (2021). A social ecological framework: Counselors' role in improving student athletes' help-seeking

behaviors. *Journal of College Counseling*, *24*(1), 81–96. https://doi.org/10.1002/jocc.12178

Reis-Reilly, H., Fuller-Sankofa, N., & Tibbs, C. (2018). Breastfeeding in the community: Addressing disparities through policy, systems, and environmental changes interventions. *Journal of Human Lactation*, *34*(2), 262–271. https://doi.org/10.1177/0890334418759055

Richard, L., Gauvin, L., & Raine, K. (2011). Ecological models revisited: their uses and evolution in health promotion over two decades. *Annual Review of Public Health*, *32(1)*, 307-326. https://doi.org/10.1146/annurev-publhealth-031210-101141

Richard, L., Potvin, L., Kishchuk, N., Prlic, H., & Green, L. W. (1996). Assessment of the integration of the ecological approach in health promotion programs. *American Journal of Health Promotion*, *10*(4), 318–328. https://doi.org/10.4278/0890-1171-10.4.318

Rosen-Carole, C., Allen, K., Thompson, J., Martin, H., Goldstein, N., & Lawrence, R. A. (2020). Prenatal provider support for breastfeeding: Changes in attitudes, practices and recommendations over 22 years. *Journal of Human Lactation*, *36*(1), 109–118. https://doi.org/10.1177/0890334419830996

Runjic Babic, A. (2020). The socio-cultural context of breastfeeding in the nineteenth and twentieth centuries. *Collegium antropologicum*, *44*(4), 245-253. https://doi.org/10.5671/ca.44.4.8

Santacruz-Salas, E., Aranda-Reneo, I., Hidalgo-Vega, Á., Blanco-Rodriguez, J. M., & Segura-Fragoso, A. (2019). The economic influence of breastfeeding on the

health cost of newborns. *Journal of Human Lactation, 35*(2), 340–348. https://doi.org/10.1177/0890334418812026

Schindler-Ruwisch, J., Roess, A., Robert, R. C., Napolitano, M., Woody, E., Thompson, P., & Ilakkuvan, V. (2019). Determinants of breastfeeding initiation and duration among African American DC WIC recipients: Perspectives of recent mothers. *Women's Health Issues*, *29*(6), 513–521. https://doi.org/10.1016/j.whi.2019.07.003

Segura-Pérez, S., Hromi-Fiedler, A., Adnew, M., Nyhan, K., & Pérez-Escamilla, R. (2021). Impact of breastfeeding interventions among United States minority women on breastfeeding outcomes: a systematic review. *International Journal for Equity in Health*, *20*(1), 1–25. https://doi.org/10.1186/s12939-021-01388-4

Smith, P. H. (2018). Social justice at the core of breastfeeding protection, promotion and support: a conceptualization. *Journal of Human Lactation, 34*(2), 220-225. https://doi.org/10.1177/0890334418758660

Standish, K. R., & Parker, M. G. (2021). Social Determinants of Breastfeeding in the United States. *Clinical therapeutics*. https://doi.org/10.1016/j.clinthera.2021.11.010

Stuebe, A. (2020). Putting the "M" in Breastfeeding Medicine. *Breastfeeding Medicine*, *15*(1), 63-64. https://doi.org/10.1089/bfm.2019.29143.ajs

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, *10*(4), 282–298. https://doi.org/10.4278/0890-1171-10.4.282

Theobald, S., Brandes, N., Gyapong, M., El-Saharty, S., Proctor, E., Diaz, T., Wanji, S., Elloker, S., Raven, J., Elsey, H., Bharal, S., Pelletier, D., & Peters, D. H. (2018). Implementation research: new imperatives and opportunities in global health. *The Lancet*, *392*(10160), 2214-2228. https://doi.org/10.1016/S0140-6736(18)32205-0

Thorpe, R., Hawkes, G., Dune, T., Fileborn, B., Pitts, M., & Minichiello, V. (2018). Hidden boundaries and shared meanings: The roles of researcher characteristics and cultural norms in shaping understandings of sexuality in the unstructured interview setting. *International Journal of Social Research Methodology*, *21*(2), 205–217. https://doi.org/10.1080/13645579.2017.1350016

Tran, V. (2021). *A qualitative analysis of facilitators and barriers to breastfeeding among Black mothers in the Greater New Haven area* (Publication No. 28494179) [Master's thesis, Yale University]. ProQuest Dissertations and Theses Global. https://www.proquest.com/dissertations-theses/qualitative-analysis-facilitators-barriers/docview/2552872575/se-2?accountid=14872

UNICEF. (2018). *Breastfeeding: A mother's gift, for every child.* https://www.unicef.org/publications/files/UNICEF_Breastfeeding_A_Mothers_Gift_for_Every_Child.pdf

Voutsina, C. (2018). A practical introduction to in-depth interviewing. *International Journal of Research and Method in Education*, *41*(1), 123–124. https://doi.org/10.1080/1743727X.2017.1419693

Wasserman, J., Palmer, R. C., Gomez, M. M., Berzon, R., Ibrahim, S. A., & Ayanian, J. Z. (2019). Advancing health services research to eliminate health care disparities.

American Journal of Public Health, *109*, S64–S69. https://doi.org/10.2105/AJPH.2018.304922

Wolf, J. H. (2018). "They Lacked the Right Food": A brief history of breastfeeding and the quest for social justice. *Journal of Human Lactation*, *34*(2), 226-231. https://doi.org/10.1177/0890334418757449

Wold, B., & Mittelmark, M. B. (2018). Health-promotion research over three decades: The social-ecological model and challenges in implementation of interventions. *Scandinavian Journal of Public Health*, *46*(20_suppl), 20-26. https://doi.org/10.1177/1403494817743893

World Health Organization. (n.d.). *The ecological framework.* https://www.who.int/violenceprevention/approach/ecology/en/

World Health Organization. (2017). *Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services.* http://www.who.int/nutrition/publications/guidelines/breastfeeding-facilities-maternity-newborn/en/

World Health Organization. (2018). *Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised baby-friendly hospital initiative.* https://apps.who.int/iris/bitstream/handle/10665/272943/9789241513807-eng.pdf

World Health Organization. (2021). *Breastfeeding.* https://www.who.int/health-topics/breastfeeding#tab=tab_1

Wu, Y. H., Ho, Y. J., Han, J. P., & Chen, S. Y. (2018). The influence of breastfeeding

self-efficacy and breastfeeding intention on breastfeeding behavior in postpartum women. *Hu li za zhi The Journal of Nursing*, *65*(1), 42-50.

Yin, R. K. (2017). *Case study research and applications: design and methods*. Sage Publications.

Zhang, Q., Lamichhane, R., Wouk, K., Guthrie, J., & Li, K. (2021). Prenatal perception of breastfeeding recommendation predicts early breastfeeding outcomes of participants in the Supplemental Nutrition Program for Women, Infants, and Children (WIC). *The American Journal of Clinical Nutrition*. https://doi.org/10.1093/ajcn/nqab268

Appendix A: Semistructured Interview Questions

1. Do you have any questions for me before we begin?
2. Can you tell me about a conversation that you had with a health service practitioner within a community level breastfeeding support system (such as a lactation counselor, doula, nurse, midwife, doctor etc.) regarding infant feeding methods?
3. Can you tell me about information shared with you on the benefits of breastfeeding during your experience with your health services provider?
4. Can you tell me about any information shared with you regarding barriers to breastfeeding during your experience with your health services provider?
5. How difficult would it be to get the support needed to give only breast milk to your baby for the first 3 months?
6. How difficult would it be to get the support needed continue providing breast milk to your baby for 12 months?
7. Please tell me about your decision to breastfeed or not breastfeed.
8. Can you tell me about a time when you reached out to your health service provider for breastfeeding support on initiation or duration?
9. Do you feel that you were well supported by your health service practitioner?
10. Did your experience with the provider have any influence on your decision to breastfeed or not breastfeed?

Appendix B: Demographic Form

1. Please state your gender. _____

2. Please state your ethnicity. _____

3. What is your age? _____

4. What year was your child born? _____

Appendix C: Prescreening Questions

1. Are you at least 18 years old?
2. Do you self-identify as African American or Black?
3. Have you given birth to a living child born from 2015 through 2020?
4. Did you breastfeed?
5. Did you seek support from breastfeeding support systems provided in healthcare settings by healthcare professionals?
6. Do you live in Atlanta, GA or surrounding cities?