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Primary Factors Affecting Breastfeeding in African American Communities

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Walden University
2015

Abstract

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MS, Jackson State University, 1978

BS, Jackson State University, 1977

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

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Abstract

Prior research has shown that African Americans are less likely than are Hispanics and Whites to breastfeed their children. Compounding this problem is the scarcity of research that examines African American's culture, perceptions, and beliefs about breastfeeding. This study was conducted to gain a greater understanding of the phenomenon of breastfeeding through the perspectives of African American mothers. Guided by the theories of reasoned action and planned behavior, this ethnographic study elicited African American mothers' perspectives on breastfeeding by examining what influenced their decision to breastfeed or not. This study took place in Washington State. Ten women recruited through purposeful sampling took part in the study. Data were largely collected through interviews utilizing open-ended semi-structured questions, which were used as the level-1 priori codes for data analysis. Inductive codes were developed from additional information provided by subjects during interviews. Sublevels were developed as needed. Codes with 2 or more responses from subjects were utilized in the analysis. Findings were based on the data and solely on the experiences and information shared by the subjects. The findings revealed that, among this sample of women, breastfeeding figured prominently in the African American culture. Most participants indicated they would breastfeed regardless of any support. Barriers to breastfeeding included the stigma that only the poor breastfeed, perceived inconsistency in information and assistance provided by health care personnel to African Americans as compared to other groups, and mothers not being aware of available resources. These results can be used to enhance social change initiatives, laws, and policies on breastfeeding for African Americans.

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Dedication

I wish that I could name everyone who has had a hand in my reaching this milestone, but this is impossible because there have been so many wonderful people who have touched and inspired me along the way. My parents, LD and Curley Taylor-Jones; my paternal grandparents, Lewis and Enis Deberry-Jones; and my maternal grandparents, Bishop and Emma Pointer-Taylor are but a few of these people. The wonderful and exemplary way they lived their lives has profoundly impacted me and helped me to reach this milestone. My parents and grandparents are all deceased, but their words of wisdom and their belief in me has been a constant motivator and companion through this process, and throughout my life. Special dedications go to my sister, Edna Jones-West; my brothers, Howard and LD Jones, Jr., and Eddie, Leon, James, and Alfornia Parker, Jr; Godmother Evelyn Ward; Stepmother Wilmer Jones; my aunts, Carnell Jones-Brown, Noble Jones-Muse, Ivory Jones-Bell, Gertha Jones-Payne, Helen Jones-Young, Idise Jones-Crockett, Delma Taylor-Richmond; Myrtle Taylor-Richmond, Nancy Taylor-Richmond, Maggie Taylor-Rankins, Minerva Taylor-White, Lula Mae Taylor-Houston, Fannie Taylor-Malone, and Sallister Taylor; my uncles, Jesse Willard Jones, Joe Lewis Jones, Peter Flynn Jones, and Bishop Miles Taylor, Jr.; and all of my nieces, nephews, and cousins. You all have been there for me either through laying the foundation or in spirit, and actions. You have given me strength, love and support. I am eternally grateful to all of you for encouraging me to continue to grow and follow my dream. This achievement is dedicated to all of you and to others who were not mentioned by name, but motivated and encouraged me along to way.

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Chapter 1: Introduction to the Study

Introduction

Breastfeeding for the first 6 months of an infant's life significantly improves their wellbeing. Studies have shown improved infant morbidity and mortality rates, improved bonding between mother and child, fewer behavioral problems in children, and improvements in health outcomes of the mother and child when the mother chooses to breastfeed (Centers for Disease Control and Prevention [CDC], 2013d; Meyers & Camp, 2010; Phillips, 2011; Heikkila, Sacker, Kelly, Renfrew, & Quigley, 2011). Overall breastfeeding rates in the United States have improved over time, but African Americans' breastfeeding rates have historically lagged behind other ethnic groups (CDC, 2012; 2013e, f).

The CDC stated, the consistently low prevalence of breastfeeding in African American communities (58.9%) compared to white (75.2%) and Hispanic (80%) mothers deserved increased attention and action (CDC, 2013). Breastfeeding becomes even more important when examining the impact of young children's deaths on life expectancy of a population, when the deaths may have been prevented through breastfeeding (Friedman, 2012). Jones, Steketee, Black, Bhutta, and Morris (2003) postulated that promotion of proper breastfeeding could cut the infant and child (5 and under) mortality rate by 13%.

In this study, I examined breastfeeding in the context of the African American culture while searching for the reasons African Americans lag behind others in bridging the breastfeeding gap. Breastfeeding is a cost-effective intervention that can help improve

life expectancy in the African American community (Ulak, Chandyo, Mellander, Shrestha, & Strand, 2012). This study was designed to identify the root cause of low breastfeeding in the African American community, with the hope and intent that the results lead to improved breastfeeding rates immediately after birth and up to one year of age for this population.

Background of the Problem

Breastfeeding is considered to be an important method of keeping a newborn and mother healthy. The NRDC (2003) found that 71% of U.S. mothers started breastfeeding their newborns, but only 36% continued to breastfeed when infants reached 6 months of age. Rates in the African American community were significantly lower than the national average, with only 55% of women initiating breastfeeding and only 24% continuing to breastfeed at six months. CDC (2013f) found that data collected in 2009, 2010, and 2011 for infants born in 2008 revealed some improvements in breastfeeding initiation and continued breastfeeding at 6 months overall, but African Americans were still behind other races in breastfeeding. The CDC (2010a) found that in 2007, formula supplementation typically occurred with African American infants' diets before 3 months of age at a rate of 46.2%, in Hispanic or Latino infants at 43.4%, and in whites at 35.5%. This high prevalence is an important indicator and runs contrary to current recommendations from the American Academy of Pediatrics and the World Health Organization (WHO) to exclusively breastfeed infants until they are 6 months of age (AAP, 2012a; WHO, 2013a).

Flower et al.'s (2008) ethnographic interviews showed that many women in their study population had never considered breastfeeding. Flower et al. further found that if these women actually started breastfeeding, they stopped because it was uncomfortable or caused embarrassment, and because of a lack of assistance. This raises the issues of support mechanisms, appropriate health education, body image, cultural norms, and other issues that may serve as barriers to breastfeeding.

Some evidence suggests that differences in breastfeeding rates among the different groups can be strongly influenced by cultural patterns. For example, Kelly, Watt, and Nazroo (2006) compared patterns of variation in breastfeeding across different racial and ethnic groups in the United Kingdom versus the United States. The trend in breastfeeding for blacks in the United Kingdom was the exact opposite of that of African Americans in the United States. Black or mothers of African descent in the United Kingdom breastfed at a rate of 95%, and white mothers at 67% (Kelly et al., 2006). These researchers concluded that further research was needed that focused on the culture, economics, and social profiles of groups and communities in reducing breastfeeding disparities in the United Kingdom (Kelly et al., 2006).

There are various reasons why breastfeeding should be embraced by all communities. For example, Chen and Rogan (2004) found there was less chance of postneonatal infants dying when they were breastfed. It is unclear why the African American community has not embraced breastfeeding as much as Hispanic and white communities (CDC, 2010b). For these reasons, it is imperative to conduct studies focused

on cultural beliefs, economic, and social support around breastfeeding to determine why breastfeeding rates are low in any particular population. There is a gap in the current literature as to the reasons why African American mothers do not breastfeed their infants at the same rate as other ethnic groups in the United States.

This study helps to fill the gap in the literature and demonstrate positive social change. This is done by the study being used to support or improve current interventions, and to develop new ones aimed at improving breastfeeding in the African American community. Moreover, the results can be used to effect change in policies and laws, and target grant opportunities centered on improving breastfeeding in this community. This study can serve as a model for others to follow in conducting studies related to minority populations and thus serve as a driver of positive social change.

Statement of the Problem

African Americans breastfeed at a consistently lower rate than whites and Hispanics in the United States, even though studies show increased benefits of breastfeeding versus formula feeding of infants (AAP, 2012a, 2012b; CDC, 2010b). The national prevalence of breastfeeding initiation and continuation through 12 months increased by 2.3 percentage points from 74.6% in 2008 to 76.9% in 2009 (CDC, 2012). In 2011, data collected through the Pediatric and Pregnancy Nutrition Surveillance System showed nationwide breastfeeding rates for women who had ever breastfed their children was 77.9% for Hispanics; 63.7% for whites; and 54.1% for African Americans. Breastfeeding continuation rates for six months were 36.0% for Hispanics; 21.5% for

whites; and 18.8% for African Americans (CDC, n.d). Breastfeeding continuation at 12 months was at a rate of 26.8% for Hispanics; 13.3% for whites; and 11.4% for African Americans (CDC, n.d.). These statistics show the large disparity between African American mothers breastfeeding in comparison to other ethnic groups, and in these groups continuing to breastfeed at 12 months.

African Americans represent the most at-risk group for not breastfeeding, leaving African American children most at risk for the poor outcomes associated with a lack of breastfeeding (CDC, 2011; Phillips, Brett, & Mendola, 201l; Stuebe, 2009; Department of Health and Human Services – Office of the Surgeon General [DHHS-OSG], 2011). Even though the disparity rates of breastfeeding among African Americans in comparison to other groups is well documented, there is limited extant research on variables such as cultural beliefs, norms, support, housing, and trust issues as potential barriers to breastfeeding in this population (CDC, 2010b; Kaufman, Deenadayalan, & Karpati, 2010; MacGregor & Hughes, 2010; MBC, 2007; Meyers & Camp, 2010; NRDC, 2005; National Sudden and Unexpected Infant/Child Death & Pregnancy Loss Resource Center, 2009; Watkins & Dodgson, 2010). Few extant studies have explicitly asked women why (or why not) they choose to breastfeed or continue to breastfeed. This study was designed to bridge this gap in the literature by examining these variables to gain a further understanding of the impact they may have on breastfeeding by African American mothers.

Purpose Statement

The purpose of this qualitative study was to explore and gain insight into why African Americans initiate and continue breastfeeding at much lower rates than other populations in the United States. This study was further designed to gain insight into what impacts the behavior of African Americans that cause the low rates of breastfeeding. The findings are intended to be used to reduced infant mortality and healthier outcomes for mother and baby. The study was conducted in Washington State. Most participants were recruited from Washignton's Pierce County, with one participant from the adjacent county of Thruston and one from Spokane County. The findings from this study contribute to knowledge about breastfeeding in the African American community and how to improve breastfeeding rates.

Nature of the Study

This study was of a qualitative ethnographic design to gain a deeper understanding of issues surrounding breastfeeding in the African American population. The study focused on the primary factors affecting breastfeeding rates and the factors that influence how decisions to breastfeed or not breastfeed were made. Interview questions were designed to investigate the impact of spousal and partner support on the decision to breastfeed or not breastfeed; other breastfeeding support issues; the impact of beliefs about the image of breastfeeding in relation to economic status; cultural implications; and barriers such as beliefs about body image, and self-efficacy.

There are numerous extant quantitative studies on breastfeeding that outlined rates and population characteristics, but a much more limited number of qualitative studies that examined the phenomena of low breastfeeding rates in the United States, and specifically African Americans. The disparities continue for breastfeeding between Hispanics, whites and African Americans.

Qualitative research is used to gain a deeper understanding of the phenomena being studied (Trochim, 2005). It is commonly used by researchers who are seeking to understand the reasons behind decisions that have been made. In qualitative studies, rich details are gained about personal experiences of the subjects that help explain the phenomena that would not be gained in a quantitative study (USA, n.d.). Mora (2010) found that qualitative studies were used to get deeper into issues while exploring nuances related to the problem. Whereas quantitative research quantifies issues by looking at prevalence, rates and incidence (Mora, 2010), surface statistics such as these were not the aim of this study.

Trochim and MDHS (n.d.) found value in a mixed methods design to summarize large amounts of data generated through the qualitative part of a study. In contrast, MDHS (n.d.) also found that knowing how populations understand and act on health related issues helps health policy makers and planners make informed decisions on treatment, policies, and programs. MDHS further found that qualitative studies were useful in designing training, health education, dissemination of material, and revising standards. The small sample size used, coupled with the aim of this study, supported the

selection of a qualitative ethnographic design as the best fit for answering the research question, and for gaining a deeper understanding of the phenomena of low breastfeeding in the African American community. The ethnographic design was further supported with this study largely examining the culture of African Americans around breastfeeding.

Research Question

The overarching research question for this study was: What are the perspectives of African American mothers regarding breastfeeding?

The following secondary research questions were used to assist with answering the primary research question:

- How do African American women describe what influenced their decision to breastfeed or not?
- What are factors that African American mothers think encourage or discourage breastfeeding?

Theoretical or Conceptual Framework

The theory of reasoned action (TRA) and the subsequent theory of planned behavior (TPB) were the two social cognitive models that were used as a theoretical framework for this study on breastfeeding in African Americans (Benoit, n.d.). This theory was developed by Fishbein and Ajzen in 1975. The TRA was used in this study to predict and help to understand motivational influences on behavior to improve breastfeeding. It had been previously used in some successful models for predicting health behaviors (Benoit). According to the TRA, social behavior such as decision-

making is at the individual level. The intent to adopt a behavioral change towards breastfeeding depends on the individual's attitude towards breastfeeding and social influences towards performance of breastfeeding (Godin, 1994). In this model, subjective norms and attitude about the behavior drives the intention. The intention was the antecedent to actual breastfeeding initiation and continuation. Subjective norms and attitude were formed from beliefs. Beliefs were foundational and were formed as a result of culture, how an individual was raised, and overall life experiences. A change in belief may change subjective norms, attitude, and ultimately, intention (Bleakley, Hennessy, Fishbein, & Jordan, 2011; Fishbein & Ajzen, 2010; Orr, Thrush, & Plaut, 2013).

The TPB was developed by Ajzen in 1985 after the TRA to help explain human behavior versus just predicting it (Rhoades, Kridli, & Penprase, 2011). In this doctoral study, the theory was used to examine attitudes, behavior and perceive behavioral control. The TPB and the TRA are very similar theories, except for the addition of the construct of perceived control to the TPB (Ajzen, 1991). If perceived control is low or missing, an individual will fail to make behavioral change. This theory has been a useful tool in studying breastfeeding (Lamontagne, Hamelin, & St-Pierre, 2008). Giles et al. (2007) utilized a theoretical framework centered on the TPB to examine attitudes towards breastfeeding intentions. Giles found that the framework strongly supported the predictive power of TPB.

Intention is a central part of the TRA and the TPB. Rhoades, Kridli, and Penprase (2011) defined intention as "the person's motivation to engage in a specific behaviour"

(p. 563). The TPB assumed behavior to be a function of the strongest beliefs a person holds about a specific behavior and therefore determined a person's intentions and actions (Ajzen, 2002; Rhoades, et al., 2011). The key constructs for the TRA and the TPB are subjective norms and normative beliefs, attitude towards the behavior and behavioral belief, control belief and perceived behavioral control, and self-efficacy (Ajzen, 2011a, b; Giles et al., 2007; Rhoades et al., 2011). The constructs influence intention and, ultimately, breastfeeding behavior because breastfeeding behavior must be a conscious decision. These theories are suitable for this study because it examined the foundational beliefs and culture of African Americans in relation to breastfeeding. The conceptual framework included examining what influenced the decision to breastfeed or not to breastfeed. These influences included culture, economic status, housing, and age. The framework further included factors that encourage or discourage breastfeeding. These factors included barriers to breastfeeding such as a lack of support from spouse, partner, or others, including health care providers; education; self-efficacy; and ambivalence.

Definition of Terms

African American: Americans who are descendants of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify as African American and with a common ethnicity, or persons who identify as African American, have spouses that are descendants of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify as African

American and with a common ethnicity (Cambridge Dictionaries Online, 2013; Merriam-Webster, n.d.; Berlin, 2010, p. 1).

Exclusive breastfeeding: A practice in which an infant receives only breast milk (WHO, 2013a, p. 1).

Intention: A person's motivation to engage in a specific behavior (Rhoades et al., 2011, p. 563).

Nursing: The practice of suckling an infant (Kipfer & Chapman, 2007, p. 1).

Self-efficacy: A belief in one's capabilities to achieve a goal or an outcome (Kirk, 2013, p. 1).

Subjective or perceived norms: Beliefs about how people that an individual cares about will view their behavior. The perceived social pressure to perform or not to perform the behavior (Ajzen, 1991, p. 188).

Assumptions

A single culture and ethnicity was reflected in the study of only participants who met the definition of African American as outlined in this study, which means participants were decedents of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify as African American and with a common ethnicity. For this study, an African American may also be a person who identify as African American, have spouses that are descendants of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify as African American and with a common ethnicity. These assumptions were

made because of the varying ethnicities and cultures that identify as African American. Participants provided nonbiased participation in this study. In relation to the theory of reason action, an assumption was made that the determinant of breastfeeding behavior was the intention to perform the behavior or not perform it by the individual in question. The findings will be useful in the advancement of breastfeeding for policy makers, designers of interventions aimed at the African American community, and the medical community.

Limitations

All studies have limitations and delimitations. A limitation is the sampling methodology. Convenience and criterion sampling was used in selecting participants. Washington State and especially Pierce, Thurston and Spokane counties are largely inhabited by military families. Because of this, subjects may have grown up in various areas of the country before relocating to Washington. This may have caused some cultural differences in the study participants who fit the definition of African Americans. This was beyond the scope of this study. In 2012, the United States Census Bureau (USCB) showed that 4.3% of Washington's households were of two or more races (USCB, 2013). Overall, 2.4% of the United States households for this same period had more than one race (USCB, 2013). Households with more than one race may impact how members of the household identify themselves both racially and ethnically. This will further impact culture beyond the scope of this study.

The theoretical basis for this study had limitations that were mentioned herein. The theory of planned behavior assumes that an individual has opportunities and resources to be successful at breastfeeding, but that is not always true. Additionally, how variables such as past experiences, economic and environmental factors, fear, threat, mental health, and mood relate to behavioral intention and motivation were not taken into account (Boston University School of Public Health, 2013).

Delimitations

The population chosen as the subject of the study was limited to African American mothers as defined in this study. The overarching research question examined perspectives of African American mothers in relation to breastfeeding while addressing the questions of how African American women described what influenced their breastfeeding decisions. Establishing causation, correlation, or association for the lack of breastfeeding in this community is not within the scope of this study. This study is generalizable in other African American communities.

Significance of the Study – Social Change Implications

The problem of reducing the high infant death rates in the African American community has evaded the medical community, and federal and state governments for many years. This study is of particular significance because it focused on important factors that may improve rates of breastfeeding at the individual and community levels, and help reduce infant deaths in this community. Increased breastfeeding rates will lead to a decrease in infant mortality and morbidity (Philipp & Jean-Marie, 2007).

The results of this study added to existing breastfeeding information and conversation, and helped fill gaps on cultural issues around breastfeeding in the African American community. For example, the study looked at cultural beliefs that create barriers to breastfeeding. Such barriers included equating societal status and economics with the ability to purchase formula versus breastfeeding. The results of this study may be used to develop interventions that promote breastfeeding at the community level; in medical practices; in the federal Women, Infants and Children's (WIC) program; and county health departments. The results of this study can also be a teaching tool for educators and nurses. Such interventions can impact cultural norms, and may change societal beliefs about cultural norms around breastfeeding in the African American community (Philipp et al., 2007).

Transition and Summary

This chapter provided an overview of the study addressing primary factors affecting low breastfeeding in the African American community. African Americans have been found to breastfeed at a much lower rate than the Hispanic and white population (American Academy of Pediatrics [AAP], 2012a, b; CDC, 2010b). This study aimed to gain an in-depth insight as to why. The study's central focus was on cultural beliefs and those things that impact breastfeeding in the African American Community. This was a qualitative ethnographic study that took place largely in Washington State's, Pierce County. The TRA and TPB were the theoretical basis for this study.

In Chapter 2, a review of the literature on breastfeeding issues in the African American community is presented. Barriers to breastfeeding, breastfeeding rates, actions health care providers could take to improve rates, methodologies, and theoretical framework are further discussed. The literature review consists of both qualitative and quantitative studies with many of the studies being quantitative.

In Chapter 3, the methodology, study design, data collection and analysis of data are discussed. Protection of data and human subjects along with dissemination of the research is addressed.

Chapter 2: Literature Review

Introduction

This literature review explores peer-reviewed literature related to breastfeeding in the African American Community. Chapter 2 is divided into 7 sections. The first section provides the search strategy. The second section explores the underpinnings of the research question, including previous findings on influences on decisions to breastfeed such as culture, age and economic status. This section also examines factors that encourage or discourage breastfeeding, such as a lack of support, education, and self-efficacy. The third section examines perspectives from a debate in the literature over the relative superiority of breastfeeding or formula feeding, in addition to exploring issues related to the health and wellbeing of newborns and mothers. The fourth section examines current breastfeeding rates. The fifth section covers the theoretical framework, the theory of reasoned action/theory of planned behavior (TRA/TPB), used in this study and examines intention, attitudes, subjective norms, and perceived behavioral control. The sixth section reviews the methodologies used in various studies related to breastfeeding. The seventh section summarizes the entire chapter.

Breastfeeding is an effective preventive health measure for infants. The American Academy of Pediatrics (AAP) (2012) recommends that infants only consume breast milk for the first 6 months of life. For the remaining first year of life, the AAP recommends that breastfeeding be continued with the introduction of complementary foods to the infant's diet (AAP, 2012). Exclusive breastfeeding has been associated with

improvements in mortality and morbidity (Edmonds et al., 2006; Jones et al., 2003). This study seeks to identify factors related to African Americans breastfeeding at much lower rates than Hispanic and whites, as suggested by the Centers for Disease Control and Prevention (CDC, 2012).

Search Strategy

The following databases were accessed through the Walden University Library, Google, Google Scholar, and Dogpile search engines to search for and retrieve articles: Academic Search Premier, Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLine, EBSCOhost, ProQuest, Pubmed, and Sage Full-text Collection. Boolean operators and search terms were used to conduct the search. The primary terms and keywords used were: blacks and breastfeeding, breastfeeding in blacks, breastfeeding in African American women, breastfeeding, barriers to breastfeeding, breastfeeding data, breastfeeding statistics, lack of breastfeeding support, formula or breastfed, partner support for breastfeeding, benefits of breastfeeding, breastfeeding and economics, baby friendly hospital, theory of reasoned action, theory of planned behavior, disparities in breastfeeding, culture and breastfeeding, breastfeeding health, formula versus breastfeeding, and roots of breastfeeding.

Impacts on Breastfeeding

Influence on Decision to Breastfeed

Currently, more women in the United States breastfeed than ever before. The CDC (2013e) found that initial breastfeeding of infants in the United States was at 77%.

Breastfeeding increased for all populations of women between 2000 and 2010 (CDC, 2013e). Data from the National Immunization Survey (CDC, 2013c) show that 49% of infants born in 2010 were breastfed for 6 months as compared to 35% being breastfed in 2000 for 6 months. The 2010 rates for breastfeeding at 12 months increased to 27% as compared to 16% for 2000 for this same period (CDC, 2013c). The breastfeeding disparity between African Americans and white communities decreased between 2000 and 2010 from 24% to 16% (CDC, 2013c). These statistics show an overall improvement in breastfeeding in the United States, but do not indicate why the disparity of 16% still exists between white and African American communities.

There are several factors that have been documented as affecting a woman's decisions to breastfeed. For example, smoking plays a role. Women who smoke are more than 2 times as likely to quit breastfeeding by 10 weeks postpartum than women who do not smoke (Phillips, Merritt, Goldstein, Deming, Jayakaran et al., 2010). Many tobacco-smoking women quit smoking during pregnancy (Kendzor, Businelle, Costello, Castro, Reitzel et al., 2010). A few weeks after giving birth, however, the smoking relapse rate for these women is over 50% (Phillips et al., 2010). Phillips et al. (2010) examined prolonged breastfeeding in postpartum women who quit smoking during pregnancy. The results of this study showed that mothers who participated in the Relapse Prevention group were significantly more likely than the control group to continue breastfeeding through 8 weeks postpartum (Standard Care group).

Pannu, Giglia, Binns, Scott, and Oddy (2010) examined the effects that health promotion material and education had on breastfeeding antenatally, postnatally, or both. A positive association was found when women received individualized information about breastfeeding. Phillips (2011) supported Pannu et al.'s (2010) findings that realistic information improved breastfeeding preparation, attributing this difference to mothers receiving information that outlined breastfeeding as the healthy thing to do. Participants in another study of African American mothers identified bonding and making healthy choices as reasons to breastfed (Lewallen & Street, 2010). The literature did not identify a single reason to breastfeed, but a multitude of reasons some of which were abandoned because of barriers as discussed further into this chapter (Kendzor et al., 2010; Lewellen & Street, 2010; Pannu et al., 2010; Phillips, 2011).

Culture. Culture is a variable that plays an important role in breastfeeding. For example, Morse, Jehle, and Gamble (1990) examined 120 cultures and found that 50 delayed breastfeeding for two days because of a belief that colostrum (a form of breast milk produced only in late pregnancy and a few days after delivery) was dirty. Colostrum is rich with antibodies, protein, and carbohydrates to protect the infant and keep it healthy (La Leche League International, 2006). The literature review revealed that culture and the effects of culture on breastfeeding have not been well studied in the African American community. Lewellen and Street (2010), found that it was difficult to isolate cultural influences on breastfeeding with the studies that have been done thus far.

This difficulty isolating cultural influences is due in part to data coding and collection practices. Lewallen and Street (2010) found that most studies on this topic combined race samples without regard to ethnicity when examining issues associated with initiation and duration of breastfeeding. For example, most studies used the U.S. Census Bureau's racial categories (McCarter-Spaulding, 2007). Such categories include black or African American, white, and Hispanic, yet the people making up these races may come from all over the world and not share a common culture, and therefore have different beliefs (Lewallen & Street, 2010; McCarter-Spaulding, 2007). This poses a particular problem for isolating cultural issues for the African American population who consist of people born in the United States, descendants of institutionalized slaves, and many others with varying ethnicities, including those who have immigrated from Africa and the Caribbean Islands.

Africa alone has hundreds of ethnic groups (University of Pennsylvania – African Studies Center [UP-ASC], n.d.). For example, Tanzania has over 120 different ethnicities, and these ethnic groups differ in social organization, culture and language (UP-ASC). There are also Black Cubans and others who may or may not identify ethnically as Hispanics, but as black or African Americans. There are many biracial individuals who choose their own ethnic identity (McCarter-Spaulding, 2007). The identity they choose may be due to the custodial parent's racial identity, friends or peers, skin complexion, or other reasons. Between 2000 and 2010, over 1.6 million African foreign-born people immigrated to the United States, bringing different ethnicities and

cultures with them (American Immigration Council-Immigration Policy Center, 2012). These dynamics made it difficult to isolate cultural issues for African Americans. More research needs to focus on the impact of culture on breastfeeding initiation and duration in the African American community to improve rates and decrease disparities (Lewallen & Street, 2010). For this study the following persons were interviewed:

- Americans who are descendants of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify with a common ethnicity or race of black or African American.
- Persons who identify as African American with spouses that are descendants of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify with a common ethnicity or race of black or African American.

Kaufman, Deenadayalan, and Karpati (2010) found that race was a significant factor in breastfeeding and that many African American women who do not breastfeed place a higher value on formula than breast milk. Kaufman et al. additionally found that African American and Puerto Rican women believed formula to be good and safe and that the formula had added nutrients. Bunik et al. (2010) found that mothers perceived that formula was a good alternative to breastfeeding. Kaufman et al. (2010) also found that the value of formula was generational, and this belief was "further bolstered by WIC's formula subsidies and hospitals distributing formula" (p. 699). The women in this study help their own mothers with their siblings and became mothers at an early age

themselves (Kaufman et al., 2010). In contrast, McCarter-Spaulding (2007) found that race was not significant in breastfeeding of women with similar experiences, backgrounds and lifestyles. Culture appeared to be a dominant factor in breastfeeding. Rather than grouping many ethnicities under one umbrella when doing research, each ethnicity needs to be viewed under its own cultural lens as it relates to breastfeeding. More research needs to be done around culture.

Age. Age was another variable related to breastfeeding. The CDC (2010b) analyzed data from the National Immunization Survey (NIS) for 2004 – 2008 for children born between 2003 and 2006. Data analyzed in the NIS included races and ethnic groups that were Hispanic, white non-Hispanic, African American non-Hispanic, American Indian/Alaska Native, and Asian or Pacific Islander. The CDC (2010b) found that mothers less than 20 years old initiated breastfeeding 53.3% of the time for all groups studied, and mothers who were less than 20 continued to breastfeed at 19.3% for 6 months. For mothers between the age of 20-29, breastfeeding initiation was at 69% and for mothers older than 30, the initiation rate was 77.5% (CDC, 2010b; 2011). For poor mothers in Scotland who gave birth between 2009-2010, age had a less effect on breastfeeding rates, but other findings were similar to that of the United States (Child Health, 2010).

Much of the data and research showing breastfeeding by age of mother did not address race or ethnicity separately. The National Nutrition Survey for 1999 – 2006 data showed Mexican-American mothers younger than age 20 breastfed at significantly higher

rates (66%) than non-Hispanic whites (40%) and African Americans (30%). African Americans women over 20 years were significantly less likely to breastfed their infants than whites and Mexican Americans (CDC, 2010c). The literature was clear that the younger the mothers of infants are, the less likely breastfeeding will occur.

Economic status. Economic status was another variable that impacted breastfeeding. Pugh, Serwint, Frick, Nanda, Sharps et al. (2010) conducted a study on community nurse peer counselor intervention in low-income mothers, and found that the mothers shared information that revealed complexities in their lives. Such complexities included increased stress related to housing, returning to work and school, helper support, and being in settings that were not supportive of pumping and storage of milk (Pugh et al., 2010).

The CDC (2010b) found when analyzing the National Immunization Survey data for WIC recipients that 66.1% of these mothers initiated breastfeeding and that by 6 months, 32.7% continued to breastfeed. Rates were significantly lower among WIC and Medicaid recipients. Petry (2013) had similar findings as the CDC (2010b). Petry further noted that the United States had the lowest breastfeeding rates of developed countries, and that breastfeeding correlated with higher socioeconomic status for every race and ethnicity except Mexican Americans. African Americans women have the lowest breastfeeding rates for race and ethnicity (CDC, 2011; Petry, 2013). Even when WIC participation was considered, breastfeeding disparities still existed (CDC, 2010b). Breastfeeding initiation rates are higher in the western states versus the southeastern

states (CDC, 2011). These findings imply that more attention needs to be paid to cultural issues around breastfeeding that are unique to African Americans.

Housing. Housing or living conditions was another variable that played a role in breastfeeding for low-income individuals. For example, Kaufman et al. (2009) found in their study that many apartments in north and central Brooklyn did not have doors for privacy; many women shared bedrooms with both male and female family members; and many women were shamed by their family members for breastfeeding in their presence. Many of the women saw breastfeeding in front of their children to be a corruptive influence and that only bad mothers would do this as compared to good mothers who would not (Kaufman et al., 2009). Kaufman clearly demonstrated the role adequate housing play in supporting breastfeeding.

Geographical location. Kogan, Singh, Dee, Belanoff, and Grummer-Strawn (2007) found that breastfeeding was higher in the western and northwestern states as compared to other geographical locations in the United States. For example, the ever breastfed rates for Louisiana (45.05%), Mississippi (51.87%), Kentucky (54.95%), and Florida (72.75%) were lower than Montana (81.73%), Idaho (84.66%), Colorado (85.17%), California (86.48%), Oregon (87.69%), and Washington (87.93%). The odds of children being breastfed were 2.5 to 5.15 times higher in western and northwestern states such as Washington and Oregon as compared to southern states. Kogan et al. concluded that in states with breastfeeding legislation, children had a greater chance of being breastfed; that sociodemographic and maternal factors did not account for most

variations in breastfeeding; and that further studies should explore the association with breastfeeding legislation which may be reflective of cultural norms. Kogan et al. demonstrated that geography has a bearing on whether a person breastfeeds or not.

Factors that Encourage or Discourage Breastfeeding

In the United States, 75-80% of mothers start out breastfeeding their newborns regardless of socioeconomic status, race and ethnicity (CDC, 2013b). By the time babies are 6 months of age, less than 55% or about one in four African American babies are breastfed. In comparison to other races, this was low. Yet, it was an increase from the 1970s' rate of 35% for African Americans (CDC, 2013b). There were many barriers to breastfeeding, which were addressed as a separate issue from age, education, housing, spousal or partner support, and health care support. The following section addressed these barriers, and other factors.

Barriers to breastfeeding. Barriers to breastfeeding are variables that affected breastfeeding rates. The United States Department of Health and Human Services, Office of Women's Health [DHHS-OWH] (2013b) reported the lack of information on how to breastfeed, stigmas, myths, and the lack of public venues to breastfeed are barriers to breastfeeding. Myths include: everybody used formula; formula had more vitamins; formula feeding was easier; formula was cheaper; breastfeeding caused breast to sag; some women's breasts were too small or large to breastfeed; breast milk would sour; breastfeeding was painful; and breastfeeding spoiled the baby (DHHS-OWH, 2013a).

Hurley, Black, Papas, and Quigg (2008) conducted a cross-sectional study of Maryland's participants in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Hurley et al. (2008) found that the most common reason (35.6%) for not initiating breastfeeding among African American and white mothers was a belief or fear that breastfeeding would be painful. Additionally, Hurley et al. found that African American mothers reported a need to return to work more often than others; and that younger mothers and mothers without high school education showed greater breastfeeding cessation than others. Hurley et al. found that for low income populations, there was little difference in the breastfeeding rate for African Americans and whites. Suggested explanations for this included both population being exposed to WIC breastfeeding education material or minimal economic confounders were present (Hurley et al.).

Palaniappan, Feldman-Winter, and Knapp (2010) found that pain, latching problems, milk supply and misinformation were some easy to fix problems associated with breastfeeding. Palaniappan et al. found barriers not easy to fix included a lack of self-efficacy, lack of desire, return to work issues and others. Additionally, Palaniappan et al. found that 42% of the barriers reported by non-African Americans could easily be fixed or modified as compared to 23% of barriers reported by African American women. African Americans reported a lack of desire 55% of the time as the reason for not breastfeeding as compared to non-African Americans (Palaniappan et al., 2010).

Nommsen-Rivers, Chantry, Cohen, and Dewey (2010) found that comfort with formula feeding was higher in African Americans than with white, Asian and Hispanic mothers. Breastfeeding comfort, self-efficacy and breastfeeding exposure were similar in white, Asian, Hispanic and African Americans. Comfort was a good predictor of disparities in breastfeeding intention. Comfort with formula needs to be further explored when conducting breastfeeding campaigns (Nommsen-Rivers et al., 2010). Barriers to breastfeeding examined in this section were multifaceted with myths about breastfeeding and mothers comfort with formula feeding versus breastfeeding standing out as issues that need further examination.

Breastfeeding support from healthcare professionals. Breastfeeding support from healthcare professionals was another variable. Phillips (2011) found that knowledgeable professionals were needed to provide initial breastfeeding support and that first time breastfeeding mothers reported they did not know what questions to ask of health care providers. A deeper understanding of the breastfeeding experience of women was needed to improve breastfeeding rates for continuation and duration. Consistent information was reassuring and needed. Saunders-Goldson and Edwards (2004) had similar results in a study focused on breastfeeding intentions in African Americans in military health programs. Keister, Roberts, and Werner (2008) found that multiple strategies should be engaged to promote, protect and support breastfeeding. Family physicians should ensure that all families receive structured prenatal breastfeeding education and have access to breastfeeding support from knowledgeable peers and

professionals (Keister et al., 2008). Nyqvist et al. (2013) found that when infants were preterm, and either the mother or the infant were not healthy, that specific breastfeeding policies such as those in Baby Friendly Hospitals needed to be in place. Under such circumstances, health care providers need to be well informed and have skills in lactation and breastfeeding support that are specific to neonatal care. Watkins and Dodgson (2010) had similar findings as Nyqvist et al. (2013), and found that many healthcare providers lacked the education to provide current, reliable and consistent information to pregnant women and new mothers. Yet it was their responsibility to do so.

Watkins and Dodgson (2010) found that little research had been done in examining the efficacy of breastfeeding educational interventions for health professional. Health professionals needed to be equipped with the skills and knowledge to provide effective breastfeeding education interventions and support. Flower et al. (2008), McInnes and Chambers (2008), and Saunders-Goldson and Edwards (2004) found that knowledge of the benefits of breastfeeding affected initiation and duration of breastfeeding for all races.

Lewellen and Street (2010) found that health care providers did not routinely discuss in detail breastfeeding during pregnancy. When breastfeeding was discussed, it was often late in the pregnancy and after the mother went into labor when questions about which method of feeding the mother would use were asked. Cricco-Lizza (2006); Miracle, Meier, and Bennett (2004); and Sarasua, Clausen, and Frunchak (2009) found similar results with their studies. Lewellan and Street found that participants in their

study perceived a lack of information about benefits and management of breastfeeding in African American women. Shinwell, Churgin, Shlomo, Shani, and Flidel-Rimon (2006) found a significant increase (84% to 93%) in breastfeeding initiation and duration after healthcare providers went through an intensive breastfeeding course at one hospital. Labarere et al. (2005) found that mothers more often reported exclusive breastfeeding at 4 weeks and longer overall duration of breastfeeding in their intervention groups.

The CDC (2013a) found that hospitals could help improve breastfeeding initiation by becoming baby friendly. Hospitals and birthing centers with the designation "Baby-Friendly" have programs that include written policies around breastfeeding that all health care staff are aware of. Such programs have trained staff to implement the policies. These programs inform pregnant women of breastfeeding benefits; assist new moms to begin breastfeeding within an hour of birth; and show mothers techniques for breastfeeding and maintaining lactation. In these programs, infants were only given breast milk, unless medically necessary; infant and mother were placed together while in care; mothers were encouraged to breastfeed on demand; and infants were not given pacifiers or false nipples. The programs lead the way in establishing breastfeeding support groups, and referral of new mothers to these groups (CDC, 2013a). Since the inception of Baby-Friendly Hospitals initiatives in 1991, over 20,000 medical facilities have been designated baby friendly. The policies and practices of baby friendly facilities have increased breastfeeding initiation and duration, and have been associated with an increase in exclusive breastfeeding in 14 countries (Abrahams & Labbok, 2009).

In a randomized study of 34 maternity hospitals, infants born in Baby-Friendly Hospitals were significantly more likely to be breastfed at 3 months postnatal than infants who were not (Meyers & Turner-Maffei, 2008). Another study showed that breastfeeding for children born in a baby friendly hospital coupled with home visiting remained higher (45%) at 3 months as compared to those who did not receive home visits where rates of breastfeeding dropped by 10% (Meyers & Turner-Maffei, 2008). Duyan et al. (2007) found when evaluating the effects of Baby-Friendly Hospitals on breastfeeding that exclusive breastfeeding rates were higher for the first 6 months in babies born in Baby-Friendly Hospitals. Abrahams and Labbok (2009) found similar results as Duyan et al. (2007) for infants exclusively breastfed. Samuel, Thomas, Bhat, and Kurpad (2012) measured breastfeeding rates in babies born in Baby-Friendly Hospital in India and found that complimentary feeding was introduced as early as one month among 44% of the infants. This was done to help reduce infant crying. Samuel et al. (2012) also found that 14.2% of the infants were exclusively breastfed at 6 months. Home and community approaches need to address such barriers to exclusively breastfeeding. In the United States, as few as 5% of infants were born in Baby-Friendly Hospitals (CDC, 2013a).

Spousal or partner and other support. Spousal or partner support was another variable that affected breastfeeding. Meier, Olson, Benton, Eghtedary, and Song (2007); and Wambach and Koehn (2004) found that support from the infant's father was associated with breastfeeding and initiation. Pugh et al. (2010) found in their study of

low-income women nurse peer counselor intervention that not having helper support posed a problem for breastfeeding that resulted in less breastfeeding.

Lewallen and Street (2010) found that a lack of support system was a major problem for continued breastfeeding in African American women. Meier et al. (2007) and Wambach and Koehn (2004) found that support from family and friends was associated with breastfeeding and initiation. This is supported in the findings of McInnes and Chambers (2008) that mothers rate social support for breastfeeding higher than support from their health care providers. Kaufman, Deenadayalan, and Karpati (2009) found that women who routinely breastfed had more support from their mothers, siblings, friends and partners than women who did not. Having role models who breastfeed their children is important. Bunik et al. (2010) found that women breastfed longer when they had a friend or other family member who breastfed. Manstead (2011) reflected on the significance of social forces in changing behavior while noting that many behaviors rely on others. For example, barriers exist if a new mother's spouse, partner, or support system is unfavorable towards breastfeeding. The role that spousal or partner, family and others play in breastfeeding is important, and may determine whether a mom successfully breastfeeds her baby for 6 months or more.

Education factors. Education was another variable related to breastfeeding. Ludington-Hoe, McDonald, and Satyshur (2002) found that when education and income were equal in African Americans, Hispanics, and whites, the disparities for breastfeeding were considerably minimized. Ludginton-Hoe et al. recommended that until disparities in

education and incomes are considerably reduced, focusing on culture to promote breastfeeding in African-American women should be done. The CDC (2010b) found when analyzing mother's education, initiation rates for breastfeeding for all races and ethnic groups analyzed was 66.2% and at 6 months breastfeeding rates had dropped to 35.9% for mothers with less than a high school diploma. For mothers with a high school diploma or GED, breastfeeding initiation was at 65.2% and at 6 months, breastfeeding continued at a rate of 31.7%. For mothers with some college, breastfeeding initiation was at 74.8% and continued at 40.5% at 6 months. For mothers with a college degree, breastfeeding initiation was at 85.4% and continued at 56.5% at 6 months (CDC, 2010b). The role that education plays in breastfeeding has been demonstrated. Interventions needs to be developed that offset the lack of education in order to improve breastfeeding in the less educated group.

Self-efficacy. Self-efficacy was another variable that affected breastfeeding. Self-efficacy reflects the extent people believe they have control and ability over stopping, starting or performing a behavior to get the desired outcome (Manstead, 2011). Mothers with the highest self-efficacy for breastfeeding tended to have longer breastfeeding rates (Britton & Britton, 2008; Kington et. al., 2007). Palaniappan et al. (2010) had similar findings about mothers with high self-efficacy. When mothers were concerned with their ability to meet their infants' nutritional needs, self-efficacy was lowest (Phillips, 2011). Kingston et al. (2007) found that mothers who needed assistance from a professional to breastfeed and those who experienced pain had low breastfeeding efficacy. On the

contrary, McQueen, Dennis, Stemler, & Norman (2011) found that nursing intervention improved self-efficacy in a study of 150 primiparous women. Breastfeeding role models play an important role in self-efficacy. Kingston et al. found that mothers who had breastfeeding role models or received praised for how well they were doing with breastfeeding had the highest level of self-efficacy.

Nommsen-Rivers et al. (2010) found that formula and breastfeeding comfort, and self-efficacy were independent predictors of breastfeeding intentions. African Americans had similar breastfeeding comfort levels and self-efficacy as non-African American. The distinguishing factor for African Americans was that they had the highest comfort for formula, which is consistent with low breastfeeding rates (Nommsen-Rivers et al.). More research needs to be done on self-efficacy.

Ambivalence. Ambivalence was another variable related to breastfeeding. Kaufman et al. (2009) examined low-income African American and Puerto Rican women breastfeeding practices and found that ambivalence about breastfeeding caused various feeding patterns that included both breast milk and formula. Many of the women had competing ideas about which way to feed their babies. Kaufman et al. found that even when the women knew the benefits of breastfeeding they expressed bottle feeding was easier. All of the women in Kaufman et al. study believed that their children could absorb their health conditions through breastfeeding. These conditions included colds, bronchitis, toxins, and conditions arising from poor eating habits and personal practices. Because of this, the women believed breast milk could be dangerous as compared to

formula. Kaufman et al. (2009) found that "the ambivalence women experience around breastfeeding served to erode their establishment of intention, making their breastfeeding perceptions and practices provisional" (p. 703). Conflicting and mixed feelings about breastfeeding can hinder successful breastfeeding.

Breastfeeding is Best

Multiple studies related to maternal and child health outcomes show an association between breastfeeding and a decrease in mortality and morbidity in infants and children. For example, when infants are not breastfed there is an increased risk of obesity, ear infections, asthma, gastrointestinal infections, respiratory tract infections and other infantile illnesses (Meyers & Camp, 2010). Ehlayel et al. (2009) found that exclusive breastfeeding was protective against infantile diarrhea. Ehlayel et al. studied 1,278 infants with more than half exclusively breastfed. For those infant that were partially breastfed and nonbreastfed, a statistically significant higher risk for diarrhea was found (Ehlayel et al.).

Edmond et al. (2006) conducted a study in rural Ghana to examine impact based on when initiation of breastfeeding occurred. The researchers found that 22% of neonatal deaths were preventable if breastfeeding initiation occurred within an hour of birth, and 16% if breastfeeding occurred on the same day of birth. This was a large study of 10,947 healthy infants who were breastfed, and lived at least two days (Edmond et al., 2006).

Health and Wellbeing

Breastfeeding improves bonding of mother and child. It has been deemed one of the highest effective measures parents can take to ensure the health of their infants (CDC, 2013a; Phillips, 2011). Several studies found that obesity rates were significantly lower in people who were breastfed as infants (Gillman, Rifas-Shiman, & Camargo, 2001; Arenz, Ruckerl, Koletzk, & von Kries, 2004; Li, Kaur, Choi, Huang, & Lee, 2005; Toschke, Vignerova, Lhotska, Osancova, Koletzko et al., 2002; Woo, Dolan, Morrow, Geraghty, & Goodman, 2008). Woo et al. (2008) found that teens who were breastfed at least 4 months as infants had a lower body mass index than those who were not breastfed. These findings were not dependent on race and parent education. Not everyone supports these findings. Jiang and Foster (2013); Michels et al. (2007); and Burdette, Whitaker, Hall, and Daniels (2006) did not find an association between weight and breastfeeding.

Infants and children were not along in beneficial gains from breastfeeding. Liu, Jorm, and Banks (2010) found a 50% increase in risk for type 2 diabetes later in life in women who had children, but did not breastfeed as compared to women who have never had children. Labayen, Rutz, Vicente-Rodriguez, Turck, Rodriguez et al. (2009) found in their study of abdominal adiposity in teenagers that "fetal nutrition may have a programming effect on abdominal adiposity" (p. 2120). Another benefit was explored by Ebina and Kashwakura (2012), and Lupton et al. (2012) who found that breastfeeding had a beneficial effect of keeping blood pressure normal in mothers who breastfeed. Owens, Whincup, Gilg, and Cook (2003) found that had earlier investigated such claims

and concluded that such claims may have been exaggerated and did not have public health significance. Kwok, Leung, and Schooling (2013) found that the observations varied with settings and did not find evidence that breastfeeding reduced blood pressure. A recent study by Gonzalez-Jimenez et al. (2013) found that nonsmoking Spanish women who did not breastfed for 6 months got cancer earlier in life than those who were nonsmokers and breastfed for 6 months. Mother and child reap excellent benefits from breastfeeding.

Current Breastfeeding Rates

The CDC (2012) found that overall breastfeeding initiation increased from 74.6% in 2008 to 76.9% in 2009. Continued breastfeeding at 6 months continued to increase from 44.3% in 2008 to 47.2% in 2009. Continued breastfeeding at 12 months increased from 23.8% to 25.5% for this same period (CDC, 2012). In 2013, the CDC found that about 75% of all babies start out being breastfed, but only 15% were exclusively breastfed 6 months later. Rates were much lower for African Americans (CDC). The 2008 Pregnancy Risk Assessment Monitoring System (PRAMS) data showed that Hispanics initiated breastfeeding 86.8% of the time; whites followed with an initiation rate of 77.3%; and African Americans followed with an initiation rate of 61.8%. The PRAMS data also showed that the rate of breastfeeding at 4 weeks postpartum for Hispanics was 74.2%; for whites, 64.8%; and for African Americans, 46.6% (CDC, 2011). Success rates among mothers who want to breastfeed can be improved with

support from families, friends, communities, clinicians, health care leaders, employers, and policymakers (CDC, 2013a).

Theoretical Framework

The theory of reasoned action (TRA) and the theory of planned behavior (TPB) served as the theoretical framework for this study (Benoit, n.d.). The TRA was used to predict and understand motivational influences on behavior. The TPB was used to examine attitudes, behavior and perceive behavioral control (Ajzen, 2006, 2011a, b). The conceptual framework included support or lack of support from spouse or partner; general feelings about breastfeeding as related to economic beliefs; access to appropriate and culturally relevant health education material; and cultural beliefs (Ajzen, 2006, 2011a, b; Manstead, 2011; Orr et al., 2013; University of Twente, 2013).

Theory of Reasoned Action

TRA was developed in 1980 by Ajzen and Fishbein while estimating the discrepancy between attitude and behavior (University of Twente, 2013). The TRA related to voluntary behavior. It was not designed to address learning, the effect of social forces, and to capture changes in beliefs. There has been evidence that sometimes beliefs change systematically based on the desire or need for the outcome related to behavior (University of Twente). For example, women who smoke want healthy children; they associate healthy children with not smoking, so they stop smoking. This results in more healthy babies, and a change in maternal attitudes and intentions (Bleakley, Hennessy, Fishbein, & Jordan, 2011). The TRA can be used to predict a person's intention and

behavior. It can be used to identify the best methods to target consumers of products and actions or to target change in behavior (Ajzen, 2006, 2011a, b; Manstead, 2011; Orr et al., 2013; University of Twente, 2013).

Intention. Intention to feed is a variable that affects breastfeeding. A person's behavior is a result of intention to perform a behavior. Intention as described by Ajzen and Fishbein is a culmination of attitude towards the behavior and a person's subjective norms (University of Twente, 2013). Intention occurred just before the behavior was demonstrated, so a good predictor of behavior is intention. The latter indicated readiness to indulge in the behavior or a cognitive representation of readiness. Attitude, subjective norms, and perceived behavioral control determined intention (Ajzen, 2006, 2011a, b; Manstead, 2011; Orr et al., 2013).

Attitudes. Attitude towards breastfeeding is another variable that affects breastfeeding. The TPB suggested that specific attitudes such as a desire need to be in place to predict the likelihood of the desired outcome. For example, a woman needs to desire to breastfeed in order for the likelihood of breastfeeding to occur (Ajzen, 2006, 2011a, b; Manstead, 2011; Orr et al., 2013).

Subjective norms. A person's subjective norm was another variable that affected breastfeeding. Subjective norms are beliefs about how people an individual cares about will view their behavior. In breastfeeding for example, family members do not always show support of new moms. Family members made unpleasant remarks at seeing breastfeeding taking place. In one study, moms felt embarrassed and ashamed to

breastfeed in front of their family members (Kaufman et al., 2009). Kashima et al (1993) found that it was not enough to have intentions to perform a behavior, but that the behavioral change needs to be a cooperative one between the new mom and her support.

Perceived behavioral control. Perceived control was another variable that affects breastfeeding. Intentions are influenced by a perception of control over the immediate situation and individuals believing that they can perform the task, or self-efficacy. Women who breastfeed the longest tend to have the strongest degree of self-efficacy (Kaufman et al., 2009). Breastfeeding self-efficacy was a strong predictor for breastfeeding (Ajzen, 2006, 2011a; Manstead, 2011; Orr et al., 2013).

The Theory of Planned Behavior

The TRA was based on the premise that behavior was voluntary. Behavior is not 100% voluntary and under control of the individual. Because of this, perceived control of behavior was added, and the latter became the TPB, which predicts deliberate and planned behavior (University of Twente, 2013). The TPB helps to explain the relationship between beliefs, attitudes, subjective norms, and the resulting outcome when behavior changes. The TPB theorizes that individuals will perform a behavior if they feel the behavior will have desired consequence. The desired consequences are based on attitudes and beliefs of the individual and by others. For example, norms within a culture. Under TPB, the behavior is something that individuals can do or have perceived control over (Dowling, Madigan, Anthony, Elfettoh, & Graham, 2009).

Group norms should be considered when looking at planned behaviors. Terry, Hogg, and White (1999) reviewed the roles of personal and social identities in relation to planned behavior. They argued that people who belong to a group are more likely to engage in behavior that is considered the group norm. Terry et al. used the example of recycling and "found that personal and social identities shaped intention and behavior' (Manstead, p. 366). Terry et al. showed that normative factors shape intentions, if the individual identify with a behaviorally relevant social group (Manstead).

Review of Methodology

Numerous studies have been done to determine the rates of breastfeeding among all ethnic and racial groups. These studies were all based on quantitative data that looks at demographics such as age, socioeconomic, education, income and marital status (Abrahams & Labbok, 2009; CDC, 2010a, 2010b, 2011, 2012; Hetzner et al., 2009; Hurley et al., 2008; Pugh et al., 2010). Some quantitative studies examined which hospitals and medical clinics promote breastfeeding. A few studies were found that were qualitative and ethnographic in nature (Kaufman et al., 2010; Lewallen & Street, 2010; Meyers & Camp, 2010)

Pugh et al. (2010) conducted a randomized controlled trial of 328 breastfeeding mothers with healthy infants. These women were eligible for the Women, Infants and Children (WIC) food supplementation program. The intervention used consisted of a breastfeeding support team that did home visits and provided telephonic support to the mothers. The control group received standard care. The study was design to determine

the effect of the breastfeeding support teams on breastfeeding for women eligible for WIC. Study subjects were recruited from 2 hospitals within 24 hours for vaginal birth and 48 hours of Cesarean birth. Qualified participants for the study had a singleton pregnancy, was English speaking, intended to breastfeed, was WIC eligible, was accessible by phone, and resided no more than 25 miles from hospital where birth occurred. Unhealthy infants and mothers who tested positive for drugs were excluded. Sealed envelopes were used to randomly assign mothers to the study groups. Data were collected every two weeks for 12 weeks and once a month for 24 weeks. Data points were 6, 12, and 24 weeks. The dichotomous variable was breastfeeding. In this study, various categorical measures were compared; and analysis of variance was done; bivariate and covariate analyses were done; and multiple logistic regressions were done. Covariates were included in the regression calculations because of the significant association of covariate with breastfeeding.

The CDC (2011, 2012) utilized various national data sources to collect data and use in their studies. National sources include the Maternity Practices in Infant Nutrition and Care (mPINC) survey. This survey was used to assess and rate maternity care practices at health care facilities, nationally. A scale from 0 to 100 was used, and the higher the score, the better the practice. Scores in the last few years have shown an increase in Baby Friendly Hospitals (CDC).

The National Immunization Survey was used by the CDC for data and information (CDC, 2010a, b). It was intended to provide estimates. It was used to collect

data for immunizations and breastfeeding initiation and duration, and includes a telephonic survey of homes with children between 19 and 35 months of age. The survey was continuous with participants randomly dialed in all states and the District of Columbia. These surveys were cross-sectional, and included children born in 3 different calendar years. To increase sample size and allow for stratification of racial and ethnic groups, the 2004 through 2008 data were combined creating a cohort for 2003 through 2006 (CDC).

Kaufman et al. (2010) conducted an ethnographic study observing and interviewing 28 African Americans and Puerto Rican women and families' regarding their beliefs about breastfeeding and breastfeeding practices. The interviews were semistructured and conducted in groups. The intent was to engage people in their own environment where they were most comfortable and open. A topic-based interview instrument was used for interviews. It was designed to obtain family histories, feeding histories, feelings about breastfeeding, experiences of breastfeeding promotion, decision-making about breastfeeding, and overall infant feeding practices. The participants living conditions and social circumstances were also examined. Family members were interviewed, if available. Interviews lasted about 2 hours. They were audiotaped (Kaufman et al., 2010).

Hetzner, Razza, Malone, and Brooks-Gunn (2009) utilized data from the Early Child Longitudinal Study-Birth Cohort (ECLS-B), which was sponsored by the U.S. Department of Education - National Center for Education Statistics to examine children

feeding practices. The ECLS-B contains a national representative sample of children along with questions related to early feeding demographic characteristic of the families. Hetzner used a subsample of 7,900 children from the data set for the 9 months to 2 year group. These data were analyzed to determine occurrence of feeding practices for children up to 6 months of age. The independent variables used were infant feeding combinations that occurred in the first 6 months. Children's illnesses were the outcomes examined (Hetzner et al.).

Lewallen and Street (2010) conducted a qualitative study of 15 women breastfeeding in the African American community with a focus on initiating and sustaining breastfeeding. Focus groups were used to collect data. Women included in the study were 18 years of age or older, breastfeeding or had breastfed within the last year, and identified as African American. Audiotapes were used during the1.5 hour long focus groups. Open-ended questions were used. Data were organized and analyzed (Lewallen and Street).

Hurley et al. (2008) conducted a cross-sectional study of women's breastfeeding behaviors and perceptions by race and ethnicity in the United States for low-income WIC participants. From 33,804 WIC participants in Maryland a study sample of 10,376 was selected using a random number table based on a stratified population. From this sample, 3285 were contacted. The final number of participants was 767. A questionnaire was used for some question. Open-ended questions were posed to measure perceptions and experiences related to breastfeeding. Descriptive statistics were used to analyze

demographics. To look at variations across demographics, the chi-square test and analysis of variance were used. Cox proportional hazards regression model was used to analyze the association between different variables, and adjustment for co-founders were made (Hurley et al., 2008).

Hurley et al. (2008), Kaufman et al. (2010), Lewallen and Street (2010), Nommsen-Rivers et al. (2010), Palaniappan et al. (2010), and Street (2010) conducted qualitative studies focused on African Americans. These researchers and Meier et al. (2007), Wambach and Koehn (2004), and Manstead (2011) all found that a support system needed to be in place for breastfeeding success. Support systems were in various forms from family, health care provider and friends. Support from spouse or partner, health care and families were used as a construct in this study. Palaniappan et al., Street, and Nommsen-Rivers et al. all looked at some aspects of culture but did not go far enough in examining culture.

Quantitative studies on breastfeeding are numerous and widespread in the literature. However, there is a gap in the literature in qualitative studies. The existing research is limited and does not adequately address the low breastfeeding phenomena in the African American community. The breadth and depth of the phenomena has not been widely explored deeply enough from a qualitative perspective to get to the root of the issue. A qualitative study as opposed to a quantitative study will inform the results as patterns, themes and different perspectives emerge during the research process (Ulin, Robinson, & Trolley, 2005).

Summary and Transition

A review of the literature related to breastfeeding was conducted. Through the review, knowledge was gained about the history and current information on breastfeeding in the African American Community. The review revealed well documented disparity rates for breastfeeding among African Americans in comparison to other groups. Known barriers to breastfeeding, actions to improve breastfeeding, and recommendations to increase breastfeeding in the African American community were addressed. Despite the recommendations and revelations about what it takes to improve breastfeeding, African Americans still lag behind other populations for breastfeeding their infants (CDC, n.d.). This leaves African American children most at risk for poor outcomes associated with the lack of breastfeeding (CDC, 2011; Phillips, Brett & Mendola, 201l; Stuebe, 2009; DHHS-OSG, 2011). The review further revealed that little research on cultural beliefs, norms and support issues as potential barriers to breastfeeding in this population had been done (CDC, 2010b; MacGregor & Hughes, 2010; MBC, 2007; Meyers & Camp, 2010; NRDC, 2005; National Sudden and Unexpected Infant/Child Death & Pregnancy Loss Resource Center, 2009; Watkins & Dodgson, 2010). This study helped to bridge this gap. The review brought to light some difficulties in assessing and conducting research on the African American communities because there are so many ethnicities that have been categorized as African American.

Several quantitative studies addressed the disparities in breastfeeding between Hispanics, whites, and African Americans. These particular studies do not shed light on

the reason for the disparities. Four quantitative studies (Kaufman et al., 2009; Lewallen & Street, 2010; Nommsen-Rivers et al., 2010; Pugh et al., 2010) in particular were rich with information that gave some insight into why African American women are not breastfeeding at the same or nearly the same rate as other races. The literature list many barriers to breastfeeding such as lack of education, age of mother, support, mother needing to return to work, culture, and others. Economic beliefs as they relate to culture need to be examined more closely. These studies also suggested the health care community did not do enough to support and educate these women on how to breastfeed (Phillips, 2011). Pugh et al. (2010) for example, found that women reported breastfeeding to increase stress in their lives such as housing or living situation that was not ideal for breastfeeding and returning to work or school. Lewallen and Street (2010) concluded that women need to be taught about the benefits of breastfeeding early in their pregnancies as a means of influencing their intention to breastfeed. However, Bunik et al. (2010) found that failure to breastfed was not related to a lack of knowledge about breastfeeding and the importance of breastfeeding. This supported Kaufman et al. (2009) finding that women with the highest comfort with formula feeding were more apt to formula feed their infants. More work needs to be done on examining the role of culture in breastfeeding. This study helped to bridge this gap by focusing on culture, norms, support, and other issues.

In Chapter 3, the methodology will be discussed, including study design, sampling data collection and analytical strategies.

Chapter 3: Research Method

Introduction

This study was conducted to gain a greater understanding of issues related to breastfeeding in the African American community, including those issues that impede or discourage breastfeeding in this population. In Chapter 3, steps that were taken in conducting the study will be outlined. This includes the research question, the study design, the study participants, study eligibility, data collection tools, procedures, data collection and analysis, and the setting of the study.

Research Design and Approach

This study was designed to generate insight into why African Americans breastfeed at a lower rate than other populations. Data related to barriers and influences that may impact or cause women not to breastfeed were collected through one-on-one, open-ended interviews. Interview questions (see Appendix A) were adopted from Street (2011) and from the focus group guiding questions developed by Lewallen and Street (2010). A demographic questionnaire was adopted from Street's study (see Appendix B). These questions were used to document participants' feelings and perceptions about breastfeeding or not breastfeeding. One overarching research question and two secondary research questions informed and guided this study.

Research Questions

This study was designed to provide insight into factors that influenced the decision to breastfed. The overarching research question for this study was: What are the perspectives of African American mothers regarding breastfeeding?

The following secondary research questions were used to assist with answering the primary research question:

- How do African American women describe what influenced their decision to breastfeed or not?
- What are factors that African American mothers think encourage or discourage breastfeeding?

In my research, I found that few qualitative studies had previously explored breastfeeding in African American mothers to acquire insight into why breastfeeding was low in this community. This limited number of extant studies did not fully explore the cultural aspects of breastfeeding. The factors that this dissertation study examined included culture, age, economic status, and housing. This study also looked at factors that encourage or discourage breastfeeding, such as barriers. The barriers and factors examined included a lack of breastfeeding support from healthcare professionals, spousal or partner and other support, education, self-efficacy, and ambivalence. The interview questions related to these issues were used to provide a vivid picture of the issues and a path to understanding why this phenomenon occurred in the African American communities. All of the interview questions contributed to answering the overarching

question of what are the perspectives of African American mothers regarding breastfeeding.

Central Concept Phenomena

In this study, I sought to gain insight into what influenced mothers in the African American community to breastfeed or not breastfeed. The influences that I examined included culture and support from family, medical community, and spouse or partner. I also examined issues that are often economically related, such as housing and education.

Blum (1999) identified cultural differences as being a factor in breastfeeding differences. Blum found that there was little difference in white and African American middle class mothers' understanding of the benefits of breastfeeding, but in comparison to whites, African Americans rejected breastfeeding as a need for intensively mothering their children. African Americans, for the most part, felt more guilt-free when they did not breastfeed their children, as compared to whites. Blum also found that African Americans had a much broader definition than whites about what it took to be a good mother. For example, African Americans placed a greater emphasis on older children and extended families' importance in rearing children, which bottlefeeding helps to facilitate.

Blum (1999) also noted that African American mothers reported that breastfeeding reinforced racist stereotypes about their bodies as threatening or animalistic. Their rejection of medical advice about breastfeeding was seen as having control. By rejecting medical advice about breastfeeding, African American mothers asserted some control over their own bodies (Blum, 1999). The perception of control is

important. Control is one of the antecedents to an individual's intention to perform an activity or make a behavioral change as outlined in the TRA/TPA (Ajzen, 2006; University of Twente, 2013). This intention is determined by an individual's attitude toward the specific behavior, subjective norms, and perceived behavioral control. Britton and Britton (2008), (Kington et al. (2007), Palaniappan et al. (2010), and Phillips (2011) all theorized and found that mothers who had self-efficacy or the belief that they have control and ability over stopping, starting, or performing a behavior to get the desired outcome had higher breastfeeding rates. Ducket et al. (1998) theorized and found that the TPB was a model that was quite useful in understanding personal motivational behavior in breastfeeding. The current study benefits from the theorists and researchers work mentioned above by providing work that can be built upon.

Research Tradition

This study was ethnographic in nature in that it explored the social phenomena of breastfeeding in the African American community. It did not test a hypothesis about this population, but rather sought to understand previously documented behavior through interviews and observations (Robert Woods Johnson Foundation, 2008). The data were unstructured at collection and later categorized for analysis. The analysis of the data required interpretations and descriptions. Descriptive statistics will play a small role in the study analysis. A small number of subjects were utilized in the study.

Role of the Researcher

As the researcher, I conducted informal semi-structured interviews, documented observations, and interpreted the results of these observations and interviews. I connected with the population under study, and reported in a responsible manner on the culture and other variables that impacted breastfeeding in the African American community. Recognizing and appropriately dealing with biases and incentives were dealt with as discussed below.

Biases

I did not have any preexisting personal or professional relationships with the population under study that would have impacted my subjectivity and neutrality. I recognize that personal biases can impact subjectivity and neutrality. To deal with this, I kept a subjectivity log and documented when subjectivity and neutrality appeared to be an issue. The important thing is to be aware of researcher bias and have an effective plan for dealing with it. As the researcher, I remained as neutral as possible to help limit researcher bias and to keep the study focused on the subjects. I viewed each subject as an expert that gave valuable input into the study. To further minimize bias and enhance rigor, careful documentation of each encounter with participants was done at the time of the encounter or on the same day of the encounter (Mehra, 2002; Ulin, Robinson & Tolley, 2005).

Incentives

The research participants included people of all of income, and socio-economic status. Participants were married, divorced or single; in a relationship with a partner or significant other or not in a relationship; employed or unemployed; Medicaid recipients or had private insurance; and some were recipients of the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) (USDA-SNAP, n.d.). For this research, incentives that are designed to help facilitate the study process will be used. I provided small monetary incentives of five to ten dollars to participants at the time of their in-person interviews or sent it through United States mail soon after. Studies have shown that when giving incentives, money works better than gifts; the response rate increases with higher amounts; and incentives improve response rates (Singer, 1999, 2002; Singer & Cong, 2013; Singer & Couper, 2008; Singer, Van Hoewyk & Maher, 2000). Documentation of incentives given was kept.

Methodology

This ethnographic qualitative research study utilized a convenience and criterion sample of African Americans mothers to explore why African American mothers do not breastfeed at the rate of other mothers. The county and population description, setting, recruitment for the study, participant selection, inclusion and exclusion, and data collection and analysis will be addressed in this section.

Setting/Population

The location of the study was primarily in Pierce County in Washington State. One participant was interviewed from the neighboring county of Thurston and one from Spokane County. Pierce County is the home of Joint Base Lewis-McCord, a military base. Pierce County's population in 2012 was 811,681. About 93% of the population dwells in urban areas and 7% in rural areas of the county. White non-Hispanic individuals make up 70.3% of the population; Hispanics or Latinos makes up 9.2%; African Americans makes up 6.5%; Asians make up 5.8%; two or more races makes up 5.6%; Hawaiian and other Pacific Islanders makes up 1.3%; and American Indian and Alaska Natives makes up 1.1% (City-Data, 2013).

The median age of the residents of Pierce County was 35 years with the median age of whites being 39 years, African Americans being 31 years, and Hispanic or Latinos, 23 years. Forty-three percent of Pierce County's residents were males and 56.2% female (City-Data, 2013).

Pierce County residents excel at fininishing high school with 86.9% of the residents 25 years of age or older having a high school diploma. About 12.3% of Pierce County's population lived in poverty in 2009. This included 10.4% of white non-Hispanic, 25.3% African American, and 19.7% Hispanic or Latino residents, and 16% of residents with more than one race (City-Data, 2013).

Between 2000 and 2006, 14 births per 1000 population occurred. Infant deaths in Pierce County for this same period were 6.5 deaths per 1000 population (City-Data,

2013). For this qualitative study, I focused on recruiting 20 participants or until I reached saturation.

Participant Selection

I developed a flyer (Appendix G) to use as a handout during recruitment. The flyer explained the aim of the study, the study process, and the potential benefit of the study, and participant qualifying questions. The flyer contained my contact information for potential participants to use for further information about the study, and for participating in the study. The flyer clearly indicated a request for volunteer participation (Creswell, 2007). A local home (Rainbow House) for veterans passed out recruitment flyers in the community. This organization did not participate in recruitment beyond what is listed herein (Appendix J- Letters of Agreement to Assist in Recruitment of Participants).

Study Eligibility

Female study participants met the definition of African American in order to participate in the study. They had given birth within the last five years and lived with their children. They were at least 18 years of age. The child that inclusion criteria were based on was alive or lived at least one year. Participation was voluntary. Participants were willing to have at least one in-person or telephonic interview or provide a written response to the questions; and participated in a telephonic follow-up interview as needed. Participants resided within Washington State, primarily in Pierce County. Participants

were not mentally ill or institutionalized. Individuals not meeting the above criteria were excluded from the study.

Sampling Strategy

Purposeful sampling was used in this study of African American females with children between the age of birth to five years. Creswell (2007) found that in a qualitative narrative study, more emphasis is placed on whom to study. Because Washington State does not have a huge African American community to select a sample from, sampling was based on convenience or convenience sampling, a strategy of purposeful sampling (Creswell, 2007; Siegle, n.d.). African Americans make up 6.5% of the population of Pierce County, but 7% of the overall population is under 5 years of age, 24.9% are under 18, and 11% are 65 or older. A little more than half of the county's population were female (ESD, 2012). Criterion sampling, another strategy of purposeful sampling, where participants have experienced the phenomenon was ideal for this study (Creswell, 2007; Siegle, n.d.). Convenience sampling was done economically with minimal time and effort. Both criterion and convenience sampling fitted well with the African American population in Pierce County because of the low census of African Americans that are of childbearing age. These strategies were able to inform the research and helped with gaining an understanding of breastfeeding in the African American Community (ESD, 2012).

Sample size. In this qualitative research, the intent was not to necessarily focus on the research being generalizable, but to get to the root of the phenomena and make it

easy to understand (Creswell, 2007). Because of this, 20 participants or less depending on saturation was a reasonable number for this study (Creswell, 2007). The study reached saturation at 10 participants.

Saturation. When enough data was collected to adequately examine the phenomena and more data did not yield more information, the point of saturation was reached (Mason, 2010). In saturation and sample size, saturation occurs when the sample size is large enough to yield the needed information to conduct an adequate study, and a larger sample would not contribute to the information and understanding of the phenomena. In a qualitative study one occurrence of an issue can be just as important as multiple occurrences in a quantitative study where frequencies are important (Mason, 2010). I used the study aim as a driver in determining sample size of 20 or less, depending on saturation for this study (Charmaz, 2006). This study reached saturation at 10 participants.

Research Quality

Credibility. In qualitative research, participants are able to describe and understand the phenomena from their perspective. Because of this, the participants were the best ones to judge the credibility of the results (Trochim, 2006). I did not have prolonged contact with participants, but enough contact to interview participants. After participants join the study, there was an initial interview; a follow-up interview, when needed; and the last contact to provide the preliminary results, and gather feedback. The results of the final study were shared with the participants to the extent possible.

Triangulation of data gathering methods were helpful with credibility (Shenton, 2004). The methods used were individual participant interview and questionnaire, and observation. I included a thick description of the phenomena under study to help the reader get a clear and concise picture of the phenomena. This was to further help the reader determine if the overall findings are true and consistent with the study (Shenton, 2004).

Transferability. In a qualitative study transferability relies on the group or individual doing the generalizing in other contexts. I did a thorough job of describing the research context and assumptions which gave others the information necessary to determine if transferability to their setting is reasonable (Trochim, 2006). The results of this study are transferable as determined by the context and purpose of usage.

Dependability. I include a detailed methodology that was detailed enough to allow the study to be repeated to the extent possible. In this instance, the results may not be the same. A detailed methodology also allowed others to assess if good research practices were followed (Shenton, 2004; Trochim, 2006).

Confirmability. I have taken steps to ensure that the study findings were clearly based on the participants and not on my personal preferences. Utilizing more than one way to collect data or triangulation helped to minimize researcher bias. I also conducted document checks and rechecks of data throughout the study (Trochim, 2006).

Procedures

Participant selection was started as soon as I receive Institutional Review Board (IRB) approval from Walden University. Shortly after IRB approval, I began recruitment of the participants. The recruitment process continued until I had enough participants to complete the study or reach saturation. I began scheduling and conducting interviews immediately after each participant was selected. Each participant was given a code and all material related to each participant was coded using the same code (Creswell, 2007). The coding system use the first letters of each of the following words "African American Breastfeeding Study", a dash, and sequential numbers beginning with 01. For example, AABS-01, AABS-02, and AABS-03.

After each participant was selected, I contacted nine of them via email with an introductory letter (Appendix H) that further explained the purpose of the study, their role in the study, and scheduled two hour time slots to conduct the in-person or telephonic interviews. One participant did not have email, so I spoke with her by phone and explained the intent of the study, and also mailed the material to her. At the first meeting, I obtain a completed informed consent form (Appendix I) that included permission to conduct interviews, make observations and record interviews. Signed consents were obtained via United Stated mail or email for telephonic interviews and written responses. Follow-up interviews were conducted only if absolutely necessary by phone (Creswell, 2007). Preliminary results of the study was sent by United States mail or email to participants, or shared telephonically with participants as soon as they were available. At

that time, I express my appreciation to participants for participating in the study, ask if they had any questions, shared what the value of their participation has done to help with social changed around the subject of breastfeeding in the African American community.

Data Collection and Analysis

Data collection focused on collecting data in an unbiased manner. I obtained data through the use of a topic driven tool (Appendix A) that consisted of open-ended interview questions focused on eliciting information to answer the research question and any additional information that was shared by the participants. Demographic data (Appendix B) was collected via a questionnaire that the participants either completed or I completed based on information provided by them. Detailed field notes of observations and interviews were kept (Appendix C). All data were categorized under emerging themes, and when applicable, analyzed utilizing NVivo 10 © software. Much of the data analysis was in a written narrative format where participant stories were intertwined into a single story with conclusions drawn. This study was based on one interview per participant and the demographic questionnaire. Follow-up interviews were done to gain clarification from two specific participants. The initial interviews in this study were conducted between September 29 and December 9, 2014. Any follow-up interviews were conducted on or before December 9, 2014. This entire period from September 29 through December 9 was the data collection period.

Discrepant cases. Discrepant issues or cases that surfaced during the project were treated on an individual bases to determine if they have a bearing on the outcome of

the study, or should they be counted as meaningful contribution to the study. The discrepant cases were mentioned in the narrative.

Preliminary analysis. A preliminary analysis was done to determine if there was any missing data or if further interviews needed to be done to complete data collection. Once all data were collected, it was put into a final format for analysis.

Main analysis. The main analysis addressed the overarching research question of: What are the perspectives of African American mothers regarding breastfeeding? The following secondary research questions were used to assist with answering the primary research question:

- How do African American women describe what influenced their decision to breastfeed or not?
- What are factors that African American mothers think encourage or discourage breastfeeding?

The interview questions were formulated to elicit specific responses that addressed barriers to breastfeeding, influence on decision to breastfeed or not, and factors that encouraged or discouraged breastfeeding in the African American community.

Instrumentation

I used a semi-structured interview form (Appendix A), a demographic questionnaire (Appendix B), and an observation form (Appendix C) for data collection. I kept a manual record of interviews and conversations. Appendix A consists of qualitative interview questions that were developed by Street (2011). I modified them with the

addition of questions 5 and 6. Question 5 inquires about the participants' knowledge on the importance of breastfeeding, and question 6 seeks to gain information that addresses the participants' beliefs and knowledge about mothers who breastfeed or not breastfeed. The addition of the two questions was necessary because Street's original questionnaire did not address participants' knowledge about the importance of breastfeeding; nor did it address underlying reasons for breastfeeding or not breastfeeding such as the notion that people breastfeed because they cannot afford formula.

The data collection tool was published in 2011 as part of Street's dissertation. Both documents were appropriate to my study. Street conducted a pilot test on the Prenatal Demographic Data Assessment Instrument. The pilot study validated the tool, revealed that the instrument was easy to read and understand, and the length of time it took for participants to complete it. In this pilot test, three African Americans and three Caucasian women were recruited from a university in Boiling Springs, North Carolina, and a church in Shelby, North Carolina. The questions address culture and breastfeeding, and were appropriate for this study. No changes were made to the original questionnaire except to rename it from Prenatal Demographic Data Assessment to demographic questionnaire, which was a better fit for this study. I obtained permission to use Appendix A and Appendix B from Lewallen (Attachments D and E). Lewallen gave permission to use Street's material used in Appendix A because Street is deceased. Questions from Lewallen's study in 2010 and Street's study in 2011 were included in Attachment A.

Protection of Human Participants and Ethical Procedures

I protected human participants in this study by following the fundamental principles of respect, autonomy, beneficence, and justice as outlined in the Belmont Report (UW, 2010). Ethical issues around safety of participants, informed consent, privacy, managing adverse events and other issues that might fit under protection of human participants and ethics were addressed under this section (DHHS, 2009; DHHS-NIM, 2010; UW). Participants could withdraw from the study at any time by simply letting me know that they no longer wished to participate. I provided participants my contact information to facilitate their withdrawal from the study, if needed. I obtained Institutional Review Board approval for this study (Appendix H).

Autonomy

Participants were provided and explanation of the project, given an opportunity to ask questions and receive appropriate feedback to afford an informed decision on their part about participation in the study. Participants were not coached, intimidated or otherwise coerced into taking part in the study. Their participation was strictly voluntary. Participants with obvious mental health issues or institutionalized were not eligible for the study. Informed consent was obtained in writing. Participants were treated with the upmost courtesy and respect, and given full disclosure as to the nature, rationale, benefits, risks and implications of the study (DHHS, 2009; DHHS-NIM, 2010; UW, 2010).

Participant information was protected from unauthorized use. Codes were assigned to each participant to help protect confidentiality and privacy. Research records

and data were kept under lock and key at all times except during immediate use. I discussed with participants how confidentiality will be maintained. In case there is a breach of confidentiality or unauthorized use of information, participants will be immediately notified (DHHS, 2009; DHHS-NIM, 2010; UW, 2010).

Beneficence

The risk of harm to participants was minimized to the maximum extent possible. The benefits of the research findings will be maximize to the fullest extent possible (DHHS, 2009; DHHS-NIM, 2010; UW, 2010). I am not aware of any possible risks of harm to participants.

Justice

Populations residing in institutions, and vulnerable populations that cannot make decisions for themselves were not included in this study. There were no burdens identified with this research. The benefits of the research was shared and distributed as equally as possible with the population under study (DHHS, 2009; DHHS-NIM, 2010; UW, 2010).

Data Storage

Data are stored under double lock. It is accessible to only me. My computer is password protected and I am the only person with access to the computer. All data collection material is treated as confidential. It will not be disseminated beyond this study. All material except the written dissertation will be destroyed in an irretrievable manner five years after completion of the study.

Dissemination of Findings

The dissemination plan for this study consists of sharing the research findings to the fullest extent possible with the population under study, federal, state and local agencies and communities. Specific audiences such as churches, African American civic clubs and fraternities will be targeted. Other avenues of dissemination include websites, television, radio, journals, various electronic media, meetings, conferences, person-to-person communications, and formal collaborations. Low cost or cost effective methods of disseminations will be used (AHRQ, 2006; Wallack, Woodruff, Dorfman & Diaz, 1999).

Summary and Transition

This chapter provided insight into the research design and approach, the central concept phenomena of what impacts African Americans in their decision to breastfeed or not breastfeed their infants. The role of the researcher and the methodology were covered in this chapter. Chapter 3 further expanded on dissemination, participant selection, data collection and analysis, instrumentation, protection of human participants, and ethical considerations. The results of the data collection and analysis will be provided in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this study was to explore and gain insight into why African Americans initiate and continue to breastfeed at much lower rates than other populations. This study was further designed to gain insight into what impacts the behavior of African Americans and causes the low breastfeeding rates. Particular attention was paid to economic conditions, spouse or significant other, family influence, and culture while searching for the reason African Americans lagged behind others in bridging the breastfeeding gap. A thorough review of the literature revealed only two previous qualitative studies that focused on African Americans and their culture in the context of breastfeeding.

This chapter covers recruitment of participants, demographics of the participants, interviews, data collection and analysis, and processes used to ensure trustworthiness. Chapter 4 concludes with interview results, a summary and transition to Chapter 5.

Recruitment of Participants

The recruitment method used was based on convenience and criterion sampling. Ten participants were recruited that met eligibility requirements for the study. I advertised the study by passing out flyers with the assistance of Rainbow House Adult Family Home staff. Potential subjects were also made aware of the study through word of mouth. As participants were interviewed, they were given flyers to share with others either through email or in-person. Potential subjects called me or I called them as a result

of their name and contact information being passed on to me. At the time of initial contact, I went over the qualifications to ensure they met the criterion for inclusion in the study and that they wanted to participate. When emails of potential subjects were given to me, I contacted the potential participant by email with the recruitment flyer, consent form, participant letter, demographic questions, and interview questionnaire attached.

Arranging the interviews was difficult and was a barrier to recruiting subjects. Some potential participants did not have transportation or childcare; some stated that they were not receiving any gains that would justify their time and expense. As a result, I sent out letters with attachments that included the recruitment flyers, and research questions. I also made phone calls and in-person visits to community service organizations, businesses, and churches such as the African American Reach and Teach Health Ministry, Salishan Community Health Advocates, Altheimer Memorial Church of God in Christ, Rainbow House, and the Rescue Mission seeking leads to potential participants and permission to distribute flyers in order to increase participant recruitment. Of these organizations, only one, Rainbow House, responded both telephonically and in writing. Three other agencies responded telephonically and by email, but never sent letters of agreement. Because of these challenges, the recruitment process was prolonged. It began on or about July 1, 2014, and ended December 9, 2014.

Participant Characteristics

In order to provide a holistic picture of the perspectives of African American mothers about breastfeeding, it was important to have participants with varying incomes,

marital status, ages, education, support systems, employment, WIC recipients, Medicaid recipients, private insurance holders, and backgrounds. For this study, I sought African Americans with these varying characteristics. The participants consisted of 10 African American women with small children ranging from newborn to age five years who were interviewed or provided written responses to the questions. The youngest participant was 21 and the oldest was 40, with the median age being 31.4 years. All participants identified as African American, but three also identified as biracial or multiracial. All of the children's fathers were identified by the participants as African American. In all instances, I asked the participants to review the material ahead of time before each interview.

The information gathering process before interviews began with a demographic questionnaire used during initial contact to determine whether the subject was qualified for this study. The basic requirements for participation were that subjects be 18 years of age or older, African American, and have a child or children residing with them between the ages of birth to five years. The following table describes the demographics of the participants.

Table 1

Demographics of the Participants

ID No.	Age	County of Residence in WA. State	Education	Medicaid	WIC	Employed	Income	Marital Status	# of Children	Breast-Feed
AABS-01	33	Pierce	Some College	Yes	Yes	Yes	$20,000 - $39,999	Single	4	Yes, all, one year, plus
AABS-02	34	Pierce	Some College	Yes	Yes	No	$20,000 - $39,999	Single	4	Yes, all, one year, plus
AABS-03	21	Spokane	High School	No	Yes	Yes	- $20,000	Single	1	Yes, few days
AABS-04	40	Pierce	Some College	No	Yes	Yes	$20,000 - $39,999	Divorced	2	Yes, 2nd child, one year
AABS-05	36	Thurston	Bachelor's Degree	No	No	Yes	$80,000 - $99,999	Married	3	Yes, all children one year, 3 months for youngest
AABS-06	39	Pierce	Master's Degree	No	No	Yes	$100,000 +	Married	3	Yes, all, one year
AABS-07	25	Pierce	High School	Yes	Yes	No	- $20,000	Single	3	Yes, all, one year
AABS-08	23	Pierce	Some College	No	Yes	Yes	$20,000 - $39,999	Divorced	1	Yes, 6.5 mos.
AABS-09	27	Pierce	Some College	Yes	Yes	Yes	$20,000 - $39,999	Married	3	Yes, one month, 3rd child
AABS-10	36	Pierce	Associate Degree	Yes	Yes	Yes	$60,000- $79,999	Married	2	Yes, 2nd child, one year

Research Procedures

Data Collection

During the initial contact calls, I scheduled a time to interview each participant either in-person or by phone. Prior to the interviews, participants were sent or given the

topic driven interview tool that consisted of open-ended questions, the demographic questionnaire, participant letter, and consent form.

Two of the participants declined an in-person or telephonic interview, but responded to the questions in writing and returned the signed consent forms and written responses to me by United States mail. I conducted two face-to-face interviews in areas where privacy was afforded (community center and park) and six telephone interviews. The telephone and in-person interviews lasted from 50 minutes to 1.5 hours. The interview methods were preferred by participants. The in-person and telephonic interviews yielded the richest and most detailed information. Neither in-person nor telephonic interviews provided more information than the other.

The topic-driven interview tool was used to conduct the semi-structured interviews. When indicated, follow-up, probing and clarifying questions were included under the main questions. In some instances participants shared additional information they felt would help shed light on breastfeeding in the African American community. Since participants had a copy of the questions in hand, they began to talk and responded to each question both with and without prompting. I took detailed notes, asking the participants to repeat themselves as needed. I asked clarifying questions, repeated the responses to participants in order to verify or do member checks, and made reflective notes in the margins during interviews and made additional notes directly on my computer immediately after interviews. I then transcribed and analyzed the data.

Data Analysis

I read all of the interviews and demographic data that I collected multiple times, making separate notes each time as new thoughts and ideas surfaced. I transcribed the data from interviews, observational notes and responses mailed to me by participants. NVivo10© software was used to assist in the analysis. I looked for commonality of words, phrases and topics for all data collected.

The interviews consisted of seven questions, with four subquestions under question two. These seven questions are the level-1 priori codes. I then used a template analysis where I produced a list of codes representing themes identified in the interview material. This allowed more flexibility in tailoring the analysis (Cassell & Symon, 2004). The data analysis process used employed the following steps:

1. Read all notes taken as interviews progress and mail in data are received.
2. Record reflective notes and new discoveries throughout this process.
3. Determine when saturation has been reached or no new data are coming in.
4. Once saturation has been reached, stop interviewing.
5. Transcribe notes and other material into Microsoft WORD.
6. Place transcriptions into NVivo 10© Software.
7. Utilize word queries to create a list of commonly recurring words (nouns and descriptive) phrases and topics for all data collected.
8. Carefully reread all of the data collected and develop priori codes utilizing the seven interview questions, and develop inductive codes from additional

information provided by subjects. These will be level-1 coding with sublevels developed under each topic as needed.

a. Develop subcodes and definitions.

b. Keep master list of all codes developed.

c. Reapply codes as new segments of data are observed.

After careful review of the priori codes, I determined which ones should be main themes. Codes that were addressed in two or more interviews or in submitted responses were utilized. I started out with 19 codes. I expanded and reduced them to 13 through definition and, combining and elimination of codes as appropriate. I then recategorized the codes under the two research questions along with subthemes that became the subcodes. Table 2 contains the list of main themes and subcodes.

Table 2

Themes From the Research Questions

Research Question 1: How African American Women Describe Influences on Their Decision to Breastfeed or Not	Research Question 2: What Factors African American Mothers Think Encourage or Discourage Breastfeeding?

Breastfeeding is a part of the African American culture	Family's belief and practices about breastfeeding
Support from spouse, partner, immediate family, or friend	Most influential persons in breastfeeding decision
Spouse or partner support	Beliefs and knowledge about people who typically breastfeed
Family support	Ease of breastfeeding or convenience
Support of friends	Economics, upper income
Breastfeeding is best and healthiest	Cost of formula
Personal choice	Age of mother
Desires the "mommy experience"	Control and manipulation
Breastfeeding follows the "natural order"	Body image, weight loss, mother's health
Breastfeeding encourages connecting and bonding	Religion
Geographical location	Family adoption of healthy lifestyle choice
	Self-efficacy
	Perception about why African Americans breastfeed less and for shorter times
	Lack of support for daughters who have babies out of wedlock
	Breastfeeding is sometimes viewed as dirty or sexual
	Cost of nursing equipment and supplies
	Health care personnel lack of encouragement and help
	Lack of available resources, knowledge and education
	Perception that Hispanics and whites have more support than African Americans from their spouses or partners
	Education factor
	Barriers to breastfeeding

Trustworthiness of the Data

When addressing trustworthiness of data in qualitative research four criteria are generally considered by positivist researchers (Trochim, 2006). They are confirmability, credibility, dependability, and transferability. I discussed these criteria and how they were applied in this study in greater detail in the following sections.

Confirmability

In confirmability, the findings are true and accurate based on the data versus a researcher's predisposition to a particular finding. I worked in a deliberate manner to ensure that the results of the study were objective and based solely on the experiences and ideas of the participants and not my preferences. For example, the demographic questionnaire and five of the seven interview questions were developed and used in another research study about breastfeeding. I developed two questions based solely on the literature review and the TRA/TPB. All of the questions fit one or both of these models or theories.

I made a list of personal biases before beginning the data collection as a reminder and a means of remaining cognizant of the potential impact on the study. For example, based on the literature review, I was convinced that a majority of the participants would not breastfeed their children, and that younger mother's breastfed less than older mothers.

I used triangulation to reduce researcher bias. For example, to reduce measurement bias, various ways of collecting data were used. Participants either were interviewed by phone, in-person or provided written responses to the questions and demographic survey. The survey material (recruitment flyer and participant letter) clearly explained that participants could either breastfeed or not breastfeed. I also explained this before each interview. I further read each question and gave the participants an opportunity to talk without being interrupted for a period before moving on to the next

question or asking for more information or clarification. Because of this, a lot of voluntary information was provided by the participants that helped enhance the study.

To avoid sampling bias, subjects with varying demographics criteria that met the definition of African American were utilized. For example, ages of participants ranged from 21 to 40 years; some were employed and some were unemployed; some were married, single and divorced; the number of children the subjects had ranged from 1 to 4; and incomes ranged from less than $20,000 to over $100,000, annually (see Table 1).

NVivo10© software was used to help organize, analyze, develop findings, and keep with the scientific method. It was instrumental in providing a means of uncovering subtle trends, and allowing a means of consistency in data analysis and findings.

Credibility

In qualitative research, credibility of the research is dependent on a true factual picture of the phenomena being presented based on the participants' perspectives, and the results is believable by the participants. A creditable study measures or tests what it was designed to do. I allowed the data to speak for itself, which led to the findings and results. For example, I provided a detailed description of the participants, procedures and theories so that the study boundaries were well specified.

I followed established research method for qualitative studies in designing the research questions, interacting with participants, when gathering data, and when analyzing data. When conducting interviews, all participants were asked the same open-

ended questions, and participants who gave written responses, responded to the same questions.

Triangulation is beneficial in showing credibility. Triangulation includes utilizing different methods of data collection and examining consistency of data sources. In this study, in-person interviews, written responses, observations and telephonic interviews were used. I recruited a wide range of subjects with varying ages, income, education levels, marital status, and number of children. Iterative questioning was used to probe for more details when needed. I was flexible in scheduling interviews with the participants determining the time that worked best for them.

I consistently verified reported experiences of subjects against each other. For example, some subjects reported their experience when delivering their babies at various hospitals. When subjects utilized the same hospital their experiences were verified against each other. I used tactics to ensure honesty of subjects when providing data. For example, participation was voluntary and each participant was given the opportunity to discontinue the interview at any point during the interviews or prior to initiation of the interviews. Prior to interviews, I went over the consent form, the importance of the study, and the benefit to African Americans. The interview questions and the demographic questionnaire were shared with the participants prior to the interview. I worked to develop a rapport with the participants. I informed participants prior to interviews that I did not work for Washington State Department of Social and Health Services, which is the agency for Medicaid in this state, and that neither state agencies nor law enforcement

had anything to do with this study. This was to alleviate concerns express by some potential subjects, and was a barrier to recruitment.

I made reflective notes as the data collection took place and again as the data were analyzed. I also went over the interview results as soon after each interview and made notes. These notes included my impression of the interviews and emerging patterns.

Member checks were done as the interviews took place, and at the end of the interviews. During interviews, information was repeated back to participants who then verified their comment. As the data were analyzed, five minute follow-up telephonic checks were done with participants AABS-01 and AABS-07. Member checks improve creditability.

Dependability

When a study is dependable in qualitative research, the processes are presented in a clear, logical and detailed fashion which allows the study to easily be repeated in the future while recognizing that in a naturalistic setting, change may occur. This is true of the processes used in this study. Clear, appropriate and accurate documentation was kept throughout the entire process, including surprise occurrences. The research design, implementation of the design, data collecting details, and a reflective evaluation of effectiveness of the process will be included in Chapter 5.

Transferability

When a qualitative study has transferability, enough in depth details are provided of the fieldwork that allows the reader or others to determine if the study fits other similar

situations where a similar study might be conducted. This research was described in detail including the context and assumptions. The results of this study are transferable as determined by the context and purpose of usage (Trochim, 2006).

Presentation of Interview Data

The results of the interviews and written responses are arranged in order of the research questions. I used low-inference descriptors such as direct quotes and quotes as close to the subjects wording as possible to improve validity of my research, and to lend clarity to the findings. Negative or contradictory information was addressed under Discrepant Findings.

The overarching research question for this study asks: What are the perspectives of African American mothers regarding breastfeeding? The two secondary research questions that are informed by this study are addressed below. Themes that emerged from the data are presented under the appropriate research question.

Research Question 1: African American Women Description of Influences on Breastfeeding

Research question one specifically asks: How do African American women describe what influenced their decision to breastfeed or not? The specific interview questions that relate to this research question are listed in Table 3.

Table 3

Specific Interview Questions for Research Question 1

Tell me about how you made up your mind about how to breastfeed your baby.
Tell me about your family's belief and practices in regards to infant feeding.
What are some of the most important reasons that made you decide how to feed your baby?
How we decide to feed our children is sometimes influenced by what we sometimes call culture which can be made up of race, religion, where you are from, what family and friends think you should do, and other things. How do you feel like your culture has influenced how you planned to feed your baby? (After hesitancy or initial response, each subset of culture will be asked separately, i.e., how has race influenced how you plan to feed your baby?)
What is your understanding of the importance of breastfeeding?

The themes derived from the data are: breastfeeding is a part of the African American culture; support from spouse, partner, immediate family, or friend; breastfeeding is best and healthiest; personal choice; desires the "mommy experience"; follows the "natural order"; breastfeeding encourages connecting and bonding; and geographical location. These themes were discussed in detail below.

Breastfeeding is a Part of the African American Culture

Six of 10 participants described breastfeeding as being a part of African American culture that has been practiced for generations. At least two of the participants seemed annoyed at the question or suggestion that breastfeeding was not a part of their culture. Four of the participants were very strong and verbal about breastfeeding being their culture.

> AABS-01 (in a lecture like tone): My great grandmother was a slave. She encouraged the family to breastfed. We were raised to not give a baby formula unless you have issues such as taking medication that would not be good for the baby.

AABS-05: Breastfeeding is part of my culture. I did not have a reason not to breastfeed. Culture strongly influences breastfeeding. If you are a mother you are a mother. You do everything it takes to be a mother even if you work [are employed].

AABS-06: My culture encourages breastfeeding up to 12 months. A majority of my friends nurse [breastfeed] their babies. It is not something we need to think about.

AABS-07: My whole family breastfeeds, my sister did it until her baby was two. My mom did it, her mom did it. It is generation to generation.

Based on the information contained herein, breastfeeding seems to be an integral part of the African American culture.

Support From Spouse, Partner, Immediate Family, or Friend

Spouse or partner support. Seven of 10 participants stated their spouse or partner wanted them to breastfeed their babies. The level of support from spouses described by AABS-05 and AABS-06 was extremely high. For example:

AABS-06: My husband would text me while I was at work and ask if I had an opportunity to express milk during my break. At home, if I was tired he would hook me up to the breast pump and express for me. My spouse playing a role helped in the joy of nurturing our child. During the first six weeks, he would get up and put the baby to my breast, so that I did not need to get up and get the baby. Spousal or partner support has a positive effect on breastfeeding.

Family support. Eight of 10 participants' families supported them in their breastfeeding efforts. AABS-07 was in a unique situation in that her adopted mother did not support breastfeeding, but her birth mother did. She was involved with both mothers, and chose to follow her birth mother's example and breastfeed. AABS-07 faced a lack of support from her second child's family when her breastfeeding was deemed inappropriate in the front of other family members. For example:

> At my baby's father's family gathering, I was told to leave the room where everyone was at and to go into a bedroom to breastfeed.

Support of friends. Three of 10 participants had strong support and coaching from friends or mentors who helped them with breastfeeding. AABS-01's mentor was the first female African American Sheriff in her county.

> AABS-01: She strongly encouraged me to breastfeed.

AABS-04 listed her best friend as being most influential in her breastfeeding decision and efforts.

> AABS-04: She would educate me and when I had my daughter, she would come over and help me until I could do it myself.

AABS-07 baby father's sister was most influential in her choosing to breastfeed her second child.

> AABS-07: I just watched her breastfeed her own child. She taught me how to use the breast pump and just everything about breastfeeding.

Friends support or mentoring seems to have a positive effect on breastfeeding.

Breastfeeding is Best and Healthiest

All participants expressed a belief that breastfeeding was healthier than formula feeding. All participants had knowledge of why breast milk as compared to formula feeding was the healthiest way to feed their children.

AABS-01: Breast milk was best for brain, nervous system and eye development. It helps with continuous development outside of the womb including immune system development. Breast milk was put there for a reason. I don't want to feed my baby dried utter. Breastfed babies are less aggressive. My sister did not breastfed, and her son was so aggressive. My older sister who did not breastfeed and her children were whinny.

AABS-02: Colostrum is straight nutrients. It is not the milk. It is the part before the milk. Breastfeeding is the most healthiest thing to do.

AABS-04: The nutritional value [of breast milk] is important. People who breastfeed have children who are healthier, smarter, and well developed.

AABS-05: My child is less likely to be sick. Children get important nutrients. This made it easy to choose breastfeeding."

AABS-06: They [children] get better nutrients and improved immune systems with breastfeeding as compared to formula.

AABS-07: A baby cannot absorb all of the formula ingredients. It makes the baby colicky, and you don't have these problems with breastfeeding.

AABS-10: All nutrients that come with the breast milk is healthier. I value that. I want her [the baby] to be healthier and smart. Everything she needed, the breast milk provided.

Four other participants used virtually the same wording as AABS-10 to say that children are less likely to get sick when breastfeed.

Personal Choice

Nine of 10 participants believed their decision to breastfeed was a personal and informed choice.

AABS-01: I was encouraged to give formula by the hospital nurses, but I made the choice to breastfeed anyway.

AABS-02: When I first found out I was pregnant I decided to breastfeed. I solely made the decision. I just decided this was what I wanted to do because this was what was best for my baby.

AABS-03: It was my own choice to breastfeed. I have read that it's healthier for babies. I tried it for a few days and it wasn't for me so I switched over.

AABS-04: After learning how important it was for my baby I decided I was going to try when she arrived.

AABS-05: Breastfeeding was my choice.

AABS-06: I can afford formula but nursing [breastfeeding] is my choice.

AABS-07: I just wanted to do it [breastfeed].

AABS-08: It [to breastfeed] was what I wanted to do.

AABS-10: I just made up my mind and did what I needed to do.

The participants' decisions to breastfeed or not was clearly personal and informed.

Desires the "Mommy Experience"

Five of 10 participants described, the "mommy experience." This terminology was used specifically by participants AABS-07 and 10. Two different participants (AABS-05 and 06) indicated the "mommy experience" was a part of their culture, but another three (ASBS-02, 07 and 10) found that they desired the experience too. For example:

AABS-02: One person did not have a mother felt that breastfeeding made her feel like more of a mother.

AABS-07: I wanted the "mommy experience."

The desire for the "mommy experience" is an important indicator in breastfeeding.

Breastfeeding Follows the "Natural Order"

Three of 10 participants used the "natural order" of things in life to describe why people should breastfeed and why they do breastfeed.

AABS-01: One of the reason people breastfeed is that if, they put two and two together, they understand the "natural order" of things.

AABS-06: Now that we [African Americans] are getting back in touch with nature, we are getting in tune with our children.

AABS-09: My husband and I want everything as natural as possible.

Breastfeeding Encourages Connecting and Bonding

Eight of 10 participants expressed that breastfeeding encouraged connecting and bonding with the baby. For example:

AABS-02: It is the bonding and attachment [important reason for breastfeeding].

Geographical Location

Two of 10 participants found that geographical location of the mom contributed to breastfeeding. They expressed that certain geographical locations coupled with lifestyle made a difference in whether breastfeeding was likely to take place. AABS-02 previously lived in Stockton, California and AABS-06 previously lived in Florida.

AABS-02: Stockton was a party atmosphere where you had to raise your kids [formula fed] so that others could care for them.

AABS-06: Washington is a comfortable place to breastfeed. I feel comfortable in restaurants and other places breastfeeding. In Florida I got many uncomfortable looks.

Discrepant Findings

Breastfeeding is a part of the African American culture. Three of 10 participants expressed that breastfeeding was a personal choice over culture being the driver. When the question was posed about how culture has influenced breastfeeding decisions: AABS-03, responded, "By letting me make my own decisions and doing what I feel is best for me and my child." AABS-03 breastfed for a few days and stopped.

AABS-08 responded that she made her choice because "It was what I wanted to do." AABS-10 responded that she was not sure culture impacted her.

Support from spouse, partner, immediate family, or friend. In terms of nonsupport for breastfeeding from spouse, partner, immediate family, or friend, eight of 10 participants indicated they would breastfeed regardless of whether they had adequate support. AABS-01 related that her father's girlfriend encouraged her to not breastfeed. "She would yell at me for breastfeeding, called me a slut and whore. She wanted to bond with my baby. Girls I knew wouldn't breastfeed because others wanted to bond and gain the love and bonding that breastfeeding brought." AABS-07, a single mother whose baby's father was not involved with her or the baby expressed her milk manually without the aid of a breast pump, refrigerated it, and took it to the baby who was primarily being cared for by AABS-07's adopted mother until the baby could be with her permanently. She now has permanent custody of her child and continues to breastfeed at this time. AABS-09 mother wanted her to formula feed out of concern that the baby might not be getting enough milk. AABS-10 was separated from her husband by the time her baby was born. He did not care how the baby was fed, but was not opposed to her efforts and was happy in the end. He expressed concern as to how he would be able to manage when the baby was with him, if she was breastfed. AABS-10 moved forward with her decision to breastfeed her baby. Despite the discouragement participants encountered, they chose to breastfeed their children anyway. None of the participants felt that race was influential in their choice to breastfeed or not.

Breastfeeding encourages connecting and bonding. AABS-01 reported that she knew girls that wouldn't breastfeed because others [family members] wanted to bond with their babies and gain the love of the babies.

Research Question 2: What Factors Do African American Mothers Think Encourage or Discourage Breastfeeding?

What are factors that African American mothers think encourage or discourage breastfeeding? The themes derived from the data are: Family's belief and practices about breastfeeding; most influential persons in breastfeeding decision; beliefs and knowledge about people who typically breastfeed; perception about why African Americans breastfeed less and for shorter times than Hispanics and whites; and barriers to breastfeeding.

The specific interview questions that relate to this research question are listed in Table 4.

Table 4

Specific Interview Questions for Research Question 2

Tell me about your family's belief and practices in regards to infant feeding.
Who has been the most influential in your decision to breastfeed or not breastfeed?
What have those people who were most influential done or said that influenced how you plan to feed your baby?
How does your baby's father or significant other want you to feed the baby?
How does your mother want you to feed your baby?
Tell me about your beliefs and knowledge about people who typically breastfeed their children.
African American women tend to breastfeed less often and for shorter times than Caucasian or Hispanic women. Do you have any ideas about why this might be?

Family's Belief and Practices about Breastfeeding

Immediate and extended family beliefs that breastfeeding was best appears to be an extension of cultural beliefs. Eight of 10 participants indicated their families believed in breastfeeding. One participant (AABS-10) indicated her family [parents and siblings] leaned towards doing both formula and breastfeeding and one did not respond to the related question. Six participants stated they were breastfed as babies, and five stated their aunts also breastfed their children.

> AABS-01: My aunt often said we were not born from cows and formula is cow based and it is a horrible imitation of breast milk. My grandmother had eight children and breastfed them all. It is a family tradition. My grandmother said if you don't breastfeed your baby, your baby will be dumb, and I did not want a dumb baby.

Based on the information above, the families overwhelmingly believe in breastfeeding.

Most Influential Persons in Breastfeeding Decision

Three of 10 participants indicated their mothers were most influential or one of the most influential in their breastfeeding decision. Grandmother, spouse, friend, and self were listed as being most influential or one of the most influential in breastfeeding decision by two of 10 participants in each category.

Beliefs and Knowledge About People Who Typically Breastfeed

Ease of breastfeeding or convenience. Three of 10 participants specifically described convenience as a one of the reasons they breastfed.

> AABS-02: All of my kids slept with me and all I had to do was feed and not get up. AABS-09: In the middle of the night I did not want to get up and go into the kitchen and prepare formula.
>
> AABS-10: I exclusively breastfeeding for a while, then placed her [the baby] on formula during the day and breastfed at night as a convenience for a working mother.

Economics and upper income. Two of 10 participants suggested that economics or having enough money to afford formula might be a reason a person chooses to not breastfeed. These participants described breastfeeding as being equated to with being poor or economically disadvantaged.

> AABS-01: It might be an economic thing, i.e., I can afford formula.
>
> AABS-05: Some blacks feel that if you are poor, you breastfeed.

Cost of formula. Three of 10 participants indicated that the cost of formula might be prohibitive and encourage breastfeeding if the mother does not receive WIC supplements. AABS-05, 07 and 10 found breastfeeding to be cheaper or "more affordable."

> AABS-06: With my first child, I did not qualify for WIC, the formula was expensive, so the decision was made for me to breastfeed.

Age of mother. Two participants expressed that the younger the age of the mother the less likely she was to breastfeed.

AABS-02: Younger females tend to breastfeed for a shorter time so they can party. They drink alcohol and you can't give it to a baby. Blacks have a lot of anger. They want to party, so they look for outlets.

AABS-06: Older parent are now getting in tune with nature, which leans towards breastfeeding.

Control and manipulation. Three participants described having or being in control and being able to manipulate their situations as a rationale for breastfeeding.

AABS-01: I was scolded a lot for breastfeeding by my father's girlfriend. She complained that I wanted to be in control and that she could not bond with the baby because of this.

AABS-02: One girl breastfed her son so that the dad could not take the baby away. It was a sense of control.

AABS-10: I liked the fact that the baby depended on me. Others could hold her, but she had to come back to me for food. Her father was concerned as to how to feed the baby when she was with him [parents were separated and now divorced]. Control is a factor in why people choose to breastfeed.

Body image, weight loss, mother's health. Four participants expressed that breastfeeding improved body image, increased weight loss and improved the health of the mother.

AABS-01: My grandmother taught me that I would lose weight if I breastfed.

AABS-07: Breastfeeding speeds up weight loss and helps the uterus shrink back to normal faster.

AABS-09: Breastfeeding helps with weight loss.

AABS-10: Breastfeeding causes weight loss. Some women don't want their boobs [breasts] to sag.

Religion. Two of the participants raised religion as a contributing factor in breastfeeding in the African American community.

AABS-01: My aunt would ask why would you want to feed your baby like a cow when God gave you breast milk.

AABS-02: My family is Jehovah Witnesses and they encourage modesty and healthy living, and breastfeeding is healthy living.

Family adoption of healthy lifestyle choice. Three participants expressed that people who breastfeed had adopted a healthy life style.

AABS-06: By the time I had my 3rd child, we had a life style shift into natural food and a healthy life style choice. We do not give our children any processed food.

AABS-07: Hispanic and whites are into nature and natural things [as compared to African Americans].

AABS-09: Described a similar perception as AABS-07.

Self-efficacy. Self-efficacy emerged as an important part of breastfeeding. Two of nine participants expressed that mothers need to know how to breastfeed and feel comfortable doing it. Eight of nine participants indicated they had strong self-efficacy skills in breastfeeding. Participant AABS-03 did not provide a written response addressing efficacy, but did say breastfeeding was not for her. Participant AABS-02 stated it was three months post birth before she learned the correct way to breastfeed. She had pain up to that point when breastfeeding, but learning the correct way to breastfeed alleviated her pain. She was confident in her ability to breastfeed. Six participants (AABS-02, 06, 07, 08, 09 and 10) specifically mentioned meeting with a lactation specialist for help in the correct way to breastfeed.

Perception About Why African Americans Breastfeed Less and for Shorter Times

Participants described African Americans as not always supporting their daughters if they have babies out of wedlock; breastfeeding being viewed as dirty or sexual; the cost of nursing equipment and supplies; health care personnel lack of encouragement and help; lack of available resources, knowledge and education; and perception that Hispanics and whites have more support than African Americans as perceived reasons African Americans Breastfeed less than Hispanics and whites. These are also barriers to improve breastfeeding rates in this community.

Lack of support for daughters who have babies out of wedlock. Two participants perceive that African American parents are not as supportive of their daughters who have babies out of wedlock as white parents. For example:

AABS-02: Caucasian parents are more supportive of their unwed daughters when they have babies. A black girl's parents are angry about their daughter getting pregnant and by the time the child comes, the mother don't want her parents involved. It is really a lack of support of the mothers. After my sister had her baby, she had no support. My dad's girlfriend called my sister a slut and whore.

Breastfeeding is sometimes viewed as dirty or sexual. Two participants felt that people view a baby breastfeeding after a certain size and age as dirty or sexual.

AABS-01: We [African Americans] see breastfeeding as something impure if we breastfeed past eight to nine months. I have heard people say you are nasty. Why do you have that baby lying in the bed with you breastfeeding?

AABS-05: People who don't breastfeed say a baby on my breast is gross.

Cost of nursing equipment and supplies. Two participants talked about the cost of nursing equipment and supplies as being prohibitive for breastfeeding. Pain and cracked nipples were a problem for AABS-06, but she was able to afford nipple covers so the baby was not directly on her nipple, which eased the pain.

AABS-06: The cost of nipples covers, pads, hands free bras, breast pumps are cost prohibitive for breastfeeding for low income individuals. Many do not have access to dual incomes so they can afford to buy equipment. Hands free nursing bras were needed and they were expensive; and she used an electric pump because the manual one was not meeting her needs. Good electric pumps costs between $250.00 and $300.00.

AABS-09: We could only afford a cheap manual breast pump. It was difficult to use. An electric one would have made things a lot easier.

Health care personnel lack of encouragement and help. Three participants shared experiences related to a lack of encouragement and help with breastfeeding at local hospitals.

AABS-01: If nurses [Hospital-01] will just stop telling young black girls that formula is better, rates will improve.

AABS-01 gave a new mother her infant clothing two days before she was interviewed for this study and the mother shared a similar experience about the same hospital. This was the only experience participants described that suggested that African Americans were treated or given different information than white mothers.

AABS-06: Lactation counselors at Hospital-03 were not helpful in encouraging breastfeeding. For the most part, the nurses were neutral and did not encourage or discourage breastfeeding. The head nurse finally helped with latching about two hours before I left the hospital.

AABS-09: Hospital-01 did not really seem pro breastfeeding, and gave conflicting messages. They told me I could do both breastfeeding and formula feeding. The lactation specialist visited me in the hospital for a very short time. There was no follow-up. WIC was not helpful. They just gave the formula.

Lack of available resources, knowledge and education. Four participants felt that there is a lack of education and available resources for breastfeeding to African Americans is why there are lower breastfeeding rates.

> AABS-02: It [breastfeeding] was painful and my nipples were cracked. After I learned the correct way to breastfed it was far less painful.
>
> AABS-05: There needs to be more outreach in churches because that is where we [African Americans] get together. Most employers are males and they don't care.

AABS-09 felt that there was not enough proactive education prior to the birth of children. She shared:

> Many people are not getting the right resources to help with breastfeeding. It is important for people to take a class before the child comes rather than learning on the spot. A free of charge proactive class on breastfeeding would be wonderful and is needed. Breastfeeding was painful. I was not aware of nipple covers that could be placed on the breast to help with that.

A follow-up question about the availability or coverage for breast pumps under the Affordable Care Act was posed to each of the participants. None were aware that they could get a breast pump under their insurance coverage or provisions of the Affordable Care Act, 2010 (DHHS, 2015).

Perception that Hispanics and whites have more support than African Americans from their spouses or partners. Four participants felt African Americans

lagged behind Hispanic and whites in breastfeeding their children because of a lack of support from their spouses or significant others.

AABS-02: Hispanic women tend to stay at home versus working much more than black women. Hispanic men step up to the plate. Black women choose men who don't want to settle down.

AABS-05: Mexican mothers have more support. Blacks don't have this. They have to get back to work.

AABS-06: Many do not have access to dual incomes, so they can afford to buy equipment.

AABS-08: Blacks are not stay at home moms as much as others.

Barriers to Breastfeeding

All 10 participants described barriers to breastfeeding. Barriers included cost of nursing equipment and supplies; lack of encouragement from health personnel; inconsistence information from health care personnel; lack of available resources; having children out of wedlock; body image; age of mother; cost of formula; belief that only the poor breastfeed; having to return to work; and geographical location.

Discrepant Findings

Not all of the findings among participants were consistent. For example:

Health care personnel lack of encouragement and help. Three participants indicated local hospital personnel was helpful with their breastfeeding efforts. Twice (AABS-02 and 10) Hospital-01 encouraged breastfeeding and twice (AABS-01, 09)

discouraged breastfeeding or sent a mixed message about breastfeeding. Another local hospital (Hospital-02) also encouraged breastfeeding (AABS-07), and a third hospital (Hospital-03) remained neutral. Not all hospitals in Washington are designated Baby-Friendly. Hospital-01 and 03 does not have the Baby-Friendly designation, but Hospital-02 does. This may be the source of the possible conflict in information given and the difference in the promotion of breastfeeding reported by the participants.

Body image, weight loss, mother's health. AABS-10 reported that some women don't want their breast to sag is why they do not breastfeed. AABS-07 described how breastfeeding did not cause her breasts to sag. She stated, "My breast bounced back and did not sag with my daughter. I do not see sagging breasts as an issue."

Lack of available resources, knowledge and education. AABS-08 was attending a junior college at the time she gave birth to her son. The local WIC clinic was very helpful and loaned her an electrical breast pump to assist with expressing her milk. AABS-09 was not attending college when she gave birth to her last child. She purchased what she described as an inexpensive manual pump that did not work well. Her family receives WIC supplements, but she reported that she was not made aware by WIC of the option of utilizing this resource for an electrical breast pump.

Economics, upper income and cost of formula. The cost of formula was reported as a reason some people breastfeed. AABS-05, 07 and 10 found breastfeeding to be cheaper. AABS-06 had the highest reported income of all participants. She stated, "I can afford formula, but nursing [breastfeeding] is my choice." AABS-01 and 05

described the association of breastfeeding with being poor as a reason people might not breastfeed.

Chapter Summary

This chapter addressed participant demographic characteristics to include age, county of residence in Washington State, education, employment, income, marital status, and number of children; interviews; and specific comments made by the participants. Research procedures to include data collection, analysis, and major research themes were covered. Trustworthiness of data were examined with confirmability, credibility, dependability, and transferability being specifically reviewed.

Secondary research question 1 asked, "How do African American women describe what influenced their decision to breastfeed or not?" Eight specific themes emerged from this question. They were: breastfeeding is a part of the African American culture; support from spouse, partner, immediate family or friend; breastfeeding is best and healthiest; personal choice; desires the "mommy experience"; breastfeeding follows the "natural order"; breastfeeding encourages connecting and bonding; and geographical location. The theme, "Support from spouse, partner, immediate family, or friend" had three subcategories of: spouse or partner support, family support, and support of friends.

Secondary research question 2 asked, "What factors African American mothers think encourage or discourage breastfeeding?" Five major themes emerged from this question. They were: family's belief and practices about breastfeeding, most influential persons in breastfeeding decision, beliefs and knowledge about people who typically

breastfeed, the perception about why African Americans breastfeed less and for shorter times than Hispanics and whites, and barriers to breastfeeding. The theme, "beliefs and knowledge about people who typically breastfeed" had nine subcategories of: ease of breastfeeding or convenience; economics or upper income; cost of formula; age of mother; control and manipulation; body image, weight loss, mother's health; religion; family adoption of healthy lifestyle choice; and self-efficacy.

The theme, "perception about why African Americans breastfeed less and for shorter times" had six subcategories of: lack of support for daughters having babies out of wedlock; breastfeeding is sometimes viewed as dirty or sexual; cost of nursing equipment and supplies; health care personnel lack of encouragement and help; lack of available resources, knowledge, and education; and perception that Hispanics and whites have more support than African Americans.

All 10 of the participants initiated breastfeeding. One breastfed for a few days, one breastfed for about a month, and another breastfed for three months, but discontinued on the advice of her physician. A majority of the participants described breastfeeding as being a strong part of the African American culture with family beliefs and practices supporting this contention. Personal choice was a huge driver in breastfeeding decisions with seven of the 10 participants stating as much. Seven participants had support for breastfeeding from their spouse or partner. Eight participants stated they would breastfeed regardless of whether they had adequate support from their friends and love ones. All 10 participants understood the importance of breastfeeding.

Among the reason people breastfed were convenience, weight loss, religion, control, and healthy life style choices. Some of the reasons given for not breastfeeding included lack of support by African American parents for daughters giving birth out of wedlock, breastfeeding being viewed as dirty or sexual, nursing equipment and supplies being cost prohibitive, lack of encouragement from health care personnel, and lack of available resources. There was a perception that Hispanics and whites have more support from their spouses and families.

One divergent case where hospital personnel seem to give conflicting information or give different information to different participants is noteworthy. The messages given do not always encourage breastfeeding.

Perception, barriers, and facilitators to breastfeeding in the African American community were revealed in this study. This is one of a few studies that I am aware of that focused exclusively on African American breastfeeding. This study utilized convenience and criterion sampling, and participant could either breastfeed or not breastfeed. The study revealed that breastfeeding initiation occurred at 100% in the participants, and continued past six months for seven of the participants. Yet, the literature review showed that African Americans breastfed less than Hispanics and whites, which was in direct contrast to other published data. More exclusive breastfeeding studies need to be conducted in the African American community.

Chapter 5 will include an in-depth analysis of the study and findings. It will address study limitations, social change implications and recommendations for future research.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

I designed this qualitative ethnographic study to gain a deeper understanding of the issues surrounding breastfeeding in the African American community. This study was also designed in part to address a gap in the literature that I identified concerning breastfeeding in this population. Data were collected from 10 participants in the study concerning why African Americans breastfeed less than other groups; their perspectives and perception about breastfeeding; and the importance of certain variables on breastfeeding. The variables tracked in the study included culture; influential people that affected the participants' breastfeeding choices; beliefs about other African Americans and their breastfeeding choices; support from family, spouse or partner, and friends; personal choices; geographical location; family beliefs and practices; desire for the "mommy experience"; "natural order"; and barriers to breastfeeding. The findings of this study revealed the commonalities of the participants' experiences with breastfeeding, and the uniqueness of each participant's experience. I am aware of only a few previous qualitative studies on breastfeeding that are exclusive to African Americans.

African American breastfeeding rates significantly lag behind those of Hispanics and whites (CDC, 2012, 2013e, 2013f). There has been continued overall improvement, but the disparity remains wide (CDC). This appears to be due, in part, to a large focus on quantitative versus qualitative studies on breastfeeding by the research community, and possibly how measurements are taken. A majority of the data for studies on breastfeeding

were collected through nationwide and statewide surveys where data are more suitable for quantitative versus qualitative analysis where rich, in-depth studies of a phenomena occurs.

Another issue that can pose problems in determining accurate rates of breastfeeding for African Americans is how African Americans are defined by the various data collecting agencies both nationally and statewide. According to the United States Census Bureau, the Office of Management and Budget (OMB) for the 2010 census defined black or African American as:

> A person having origins in any of the Black racial groups of Africa. The Black racial category includes people who marked the 'Black, African Am., or Negro' checkbox. It also includes respondents who reported entries such as African American; Sub-Saharan African entries, such as Kenyan and Nigerian; and Afro-Caribbean entries, such as Haitian and Jamaican.
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> Sub-Saharan African entries are classified as Black or African American with the exception of Sudanese and Cape Verdean because of their complex, historical heritage. North African entries are classified as White, as OMB defines White as a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

The National Center for Education Statistics (n.d.) defines black or African American the same as OMB, and defines Hispanic or Latino as "A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race";

and white as "A person having origins in any of the original peoples of Europe, the Middle East, or North Africa" (para. 2). The National Health Interview Survey (NHIS) used groups as Hispanic, non-Hispanic whites, non-Hispanic African Americans, and Asian Americans.

The definition of African American utilized by the OMB is broad, allowing many ethnicities to be counted as African American simply because of their appearance, ignoring whether or not they have a commonality of culture, beliefs, and values. This lack of distinction is important because over 1.6 million foreign-born African individuals immigrated to the United States between 2000 and 2010, bring different ethnicities and cultures with them (Immigration Policy Center, 2012). The OMB, however, classified all of these individuals as African Americans. Such dynamics makes it difficult to isolate cultural issues for African Americans. This problem is not unique to the OMB; Sandefur, Campbell, and Eggerling-Boeck (2004) found that most researchers utilize a categorical scheme that includes Hispanics, whites, blacks or African Americans, Asians, and American Indians.

These categories disguise significant heterogeneity within each group. When subgroups are not identified within the major groups, survey data may not be accurate in identifying the population the data are attributed to. This makes it very difficult to develop appropriate interventions and programs designed to improve the health of this population. Because of this, the currently reported statistics for breastfeeding rates among

African Americans may not be even close to accurate. To deal with this issue in this study, African American was defined as:

> Americans who are descendants of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify as African American and with a common ethnicity. Persons who identify as African American, have spouses that are descendants of slaves that lived under institutionalized slavery in the United States, were born in the United States, and identify as African American and with a common ethnicity. (Cambridge Dictionaries Online, 2013; Merriam-Webster, n.d.; Berlin, 2010).

Research has shown that African Americans experience consistently low prevalence of breastfeeding of 58.9%, compared to 75.2% for whites and 80% for Hispanics (CDC, 2013). There are many influences on the decision to breastfeed. For example, Kaufman, Deenadayalan, and Karpati (2010) found that many African American women place a higher value on formula than breast milk. Some other variables that influence breastfeeding are culture, age, economic status, and housing or living conditions (CDC, 2010b; Kaufman et al., 2009; Pugh et al., 2010). Barriers such as education, self-efficacy, and support, encourage and discourage breastfeeding (CDC, 2010b; Kaufman et al., 2009; Ludington-Hoe et al., 2002; Manstead, 2011; Nommsen-Rivers et al., 2010).

This study was based on the theoretical framework of the theory of reasoned action (TRA) and the theory of planned behavior (TPB). Behavioral beliefs, attitude

toward the behavior, normative beliefs, subjective norms, control beliefs, and perceived behavioral control are the six constructs that make up these theories. According to the TPB, behavior is guided by behavioral beliefs (the likely consequences of the behavior), normative beliefs (normative expectations of others), and control belief or the presence of conditions that help or impede the ability to carry out the behavior (Ajzen, 2006).

This study adds new information to the body of knowledge related to breastfeeding in the African American community. The overarching research question for this study is: What are the perspectives of African American mothers regarding breastfeeding? The following secondary research questions were used to assist with answering the primary research question:

- How do African American women describe what influenced their decision to breastfeed or not?
- What are factors that African American mothers think encourage or discourage breastfeeding?

I used convenience and criterion sampling to select 10 participants for this study. All participants reside in Washington State with eight from Pierce County, and one each from Thurston and Spokane Counties. I used a semi-structured interview form (Appendix A) that consist of seven qualitative interview questions, and a Demographic Questionnaire (Appendix B) for data collection. The semi-structured interview questions consisted of questions designed to provide information about cultural beliefs and influences such as what influenced the mother's decision to breastfeed or not; the most

influential person in the participant's life in making the decision to breastfeed or not; understanding of health implications of breastfeeding; barriers to breastfeeding; and beliefs about why African Americans breastfeed less than other groups. The themes identified from the data are listed in the table below.

Table 5

Main Themes from the Participants

Research Question 1: How African American Women Describe Influences on Their Decision to Breastfeed or Not.	Research Question 2: What Factors African American Mothers Think Encourage or Discourage Breastfeeding?
Breastfeeding is a part of the African American culture	Family's Belief and Practices about Breastfeeding
Support from spouse, partner, immediate family, or friend	Most Influential Persons in Breastfeeding Decision
Spouse or partner support	Beliefs and Knowledge About People who Typically Breastfeed
Family support	Ease of breastfeeding or convenience
Support of friends	Economics, upper income
Breastfeeding is best and healthiest	Cost of formula
Personal choice	Age of mother
Desires the "mommy experience"	Control and manipulation
Breastfeeding follows the "natural order"	Body image, weight loss, mother's health
Breastfeeding encourages connecting and bonding	Religion
Geographical location	Family adoption of healthy lifestyle choice
	Self-efficacy
	Perception about why African Americans breastfeed less and for shorter times
	Lack of support for daughters who have babies out of wedlock
	Breastfeeding is sometimes viewed as dirty or sexual
	Cost of nursing equipment and supplies
	Health care personnel lack of encouragement and help
	Lack of available resources, knowledge and education
	Perception that Hispanics and Whites have more support than African Americans from their spouses or partners
	Education factor
	Barriers to breastfeeding

The 13 main themes and 19 sub-themes were discussed as they relate to the TPB and TRA, and the literature review found in Chapter 2. This discussion addressed how the findings supported or did not support the findings discussed under the literature review; made recommendations for future studies; and listed public health implications, and implications for positive social change.

Interpretation of the Findings

I was particularly impressed with how engaged the participants were during interviews and their interest in providing rich and vivid information about their experiences and perspective on breastfeeding. Nine of the 10 participants were passionate about breastfeeding. All participants were quite versed in the health benefits associated with breastfeeding. Many of the participants' responses were the same or very similar. At the time participants were recruited, I did not know whether they breastfed or not. Breastfeeding was not a prerequisite to participate in the study. While analyzing the data, I noticed that all participants initially tried to breastfeed their babies. This is remarkable and seems contrary to published literature on rates of breastfeeding in the African American community. The subsequent sections below contain a complete analysis of the research findings intertwined with explanations of how the TRA/TPB fit within and support the context of the findings.

Overall Research Question

What are the perspectives of African American mothers regarding breastfeeding? This overall research question was informed by secondary research questions 1 and 2 as discussed below.

Research Question 1

How do African American women describe what influenced their decision to breastfeed or not?

Breastfeeding is a Part of the African American Culture

Culture and the effects of culture on breastfeeding have not been well studied in the African American community (Lewellen & Street, 2010). Researchers found it difficult to isolate cultural influences on breastfeeding with the studies that have been done thus far. This assertion is supported by the very limited qualitative studies available on African American breastfeeding. However, there is much in the literature that supports culture as a dominant factor in overall breastfeeding for the general population (Morse, Jehle, & Gamble, 1990).

A brief review of the history of breastfeeding in African Americans helps to understand the cultural aspects of breastfeeding with this population. Historically, African Americans breastfed their own children, and during slavery, the slave owner's children. A participant explained that her great grandmother who was a slave encouraged the family to breastfeed, and not use formula unless there was no other choice (AABS-01). After slavery ended, many African American women worked as wet nurses. Stevens,

Patrick, & Pickler (2009) found "Wet nursing began as early as 2000 BC and extended until the 20th century."

African American women far outnumbered white women in the labor market first as slaves and then as free people. During the 1960s through the present, married African American women have had significantly higher labor force participation rates relative to their white counterparts (Potamites, 2007). This is attributed to the legacy of slavery making paid work less socially stigmatized among African Americans than white married women (Goldin, 1977). This is also due, in part, to African American spouses or partners having lower income, and higher unemployment than white spouses or partners. African American male mortality has been higher than whites. This has contributed to more African American women heading households (Goldin).

During the 1940s and 1950s, doctors and consumers considered formula a safe substitute for breast milk (Stevens, Patrick, & Pickler, 2009). It was convenient and allowed the mom to work without the concern of expressing breast milk and storing it. During this time, most jobs were not friendly to working mothers such as having maternity leave, or a private space to pump or nurse. This coupled with discrimination in the work place for African American mothers has contributed, out of necessity versus cultural practices, to the use of formula to feed their babies (Dailey, 2014).

Since 1970, this country has promoted breastfeeding and the health benefits of breastfeeding through public awareness campaigns. As a result, a steady increase in

breastfeeding has been observed in all populations (Fomon, 2001; Stevens, Patrick, & Pickler, 2009).

In this study, participants described breastfeeding as part of their culture. The results of this study support constructs and components of TRA/TPB (Ajzen, 2006). The belief that breastfeeding is part of African Americans' culture supports an individual's attitude towards the behavior of breastfeeding. Attitude towards the behavior is a construct of the TRA/TPB. Benoit (n.d.) found "Behavioral intent could be predicted from attitudes towards behavior and subjective norms." In the TRA, social behavior such as decision making is at the individual level. The intent to adopt a behavioral change towards breastfeeding depends on the individual's attitude towards breastfeeding and social influences towards performance of breastfeeding (Godin, 1994). Beliefs are foundational and are formed as a result of culture, how an individual was raised, and overall life experiences. Based on the findings herein, culture impacts breastfeeding, and breastfeeding is an integral part of the African American culture.

Support From Spouse, Partner, Immediate Family, or Friend

Support from spouse or partner, immediate family or friend were discussed as separate issues. The implications were different depending on the support mechanism and where the support came from.

Spouse or partner support. Wanting or desiring a spouse or significant other to breastfeed is different from actually providing breastfeeding support. Seventy percent of the participants stated their spouse or partner wanted them to breastfeed their babies. Two

participants (AABS-05 and 06) described active participation of their spouses in breastfeeding activities. Meier et al. (2007); and Wambach and Koehn (2004) found that support from the infant's father was associated with breastfeeding and initiation. Flower et al. (2008) found that often women who started breastfeeding, would stop because it was uncomfortable or because of embarrassment, and lack of assistance (support).

Support of spouse or partner to breastfeed fits within normative expectations. Beliefs about normative expectations or normative beliefs are one of the constructs for the TRA/TPB (Ajzen, 2006). The findings of this study supported other studies on the positive effects on breastfeeding when spouse or partner was supportive. This study partially supported other research findings discussed in the literature review on the consequences when support was not provided by the spouse or partner. Participants praised their spouses or partners and the support they received. Yet, participants insisted they would breastfeed regardless of support.

Family support. This study found that family support was important, but not the sole catalyst for initiation and continued breastfeeding. Researchers found that not having helper support resulted in less breastfeeding overall; and that lack of support system was a major problem for initiation and continued breastfeeding for African Americans (Lewallen & Street, 2010; Meier et al., 2007; Pugh et al., 2010; Wambach & Koehn, 2004).

Eighty percent of participant reported their families supported them in their breastfeeding efforts. AABS-07 reported that her baby's father's sister was most

influential in her choosing to breastfeed. She would watch her breastfeed her own child and gained proficiency at that time. This participant had perceived behavioral control over the situation, which is a component of TRA/TPB (Ajzen, 2006). Perceived behavioral control is about a person's perception of their ability to perform a behavior. AABS-07 also faced a lack of support from her second child's family when her breastfeeding was deemed inappropriate in the front of other family members. At the time she was asked to breastfeed in a bedroom out of the view of others. None of the instances listed herein deterred her determination to breastfeed.

Support of friends. This study supported the findings of researchers discussed during the literature review in relation to the role of support from friends in promoting breastfeeding. Researchers found that having support from friends was associated positively with breastfeeding and initiation of breastfeeding (Meier et al., 2007; Wambach & Koehn, 2004). Bunik et al. (2010) found that women breastfed longer when they had a friend or other family member who breastfed. Manstead (2011) reflected on the significance of social forces in changing behavior while noting that many behaviors rely on others. What people believe is expected of them is perceived social pressure. This is a normative expectation or belief, which is a component of TRA/TPB (Ajzen, 2006). Thirty percent of participants had strong support and coaching from friends or mentors who encouraged and helped them with breastfeeding. AABS-04 listed her best friend as being most influential in her breastfeeding decision and efforts. Friends support or mentoring had a positive effect on breastfeeding. It is interesting to note that McInnes

and Chambers (2008) found that mothers rated social support for breastfeeding higher than support from their health care providers.

Breastfeeding is Best and Healthiest

This study revealed that all participants were well aware of the benefits of breastfeeding over formula feeding. All participants believed that breastfeeding was healthier. They demonstrated in-depth knowledge of why breastfeeding in comparison to formula feeding was best. Participants listed good brain, nervous system, eyes, and immune system development; and improved behavior and intelligence as drivers for breastfeeding.

Multiple studies related to maternal and child health outcomes show an association between breastfeeding and a decrease in mortality and morbidity in infants and children (Arenz et al., 2004; Ehlayel et al., 2009; Gillman et al., 2001; Li et al., 2005; Meyers & Camp, 2010; Phillips, 2011; Toschke et al., 2002; Woo et al., 2008). This includes risk of obesity, ear infections, asthma, gastrointestinal infections, respiratory tract infections, and infantile diarrhea (Arenz et al.4; Ehlayel et al. 2009; Gillman et al.; Li et al.; Meyers & Camp; Phillips; Toschke et al.; Woo et al.).

According to TRA/TPB, one of the considerations for human behavior is behavioral beliefs (Ajzen, 2006). If mothers believe that their behavior will improve the health of their babies coupled with considerations of normative and control beliefs, the mothers will more likely lean towards the intent to breastfeed. Intent needs to be present

before the action is done. This study suggests that behavioral beliefs was most likely the precept to all 10 of the participants attempting to breastfeed.

Personal Choice

Ninety percent of participants believed their decision to breastfeed or not was a personal and informed choice. This is consistent with TRA/TPB where the assumption is that choices and behaviors of people are a result of rational considerations (Moss, 2008). Personal choice is a new variable for addition to the body of information around breastfeeding. The literature review did not reveal any information around personal choice in breastfeeding. Yet, this study found that of the nine participants who indicated breastfeeding was a personal choice, only one (AABS-3) breastfed for a few days and stopped. Eight of the participants who breastfed as a personal choice breastfed for more than six months. Personal choice is an important variable that needs to be considered when developing interventions for breastfeeding in the African American community.

Desires the "Mommy Experience"

This variable was not identified during the literature review. This is an addition to the body of information on breastfeeding in the African American community. Fifty percent of participants described, the "mommy experience." Two Participants specifically used this terminology. Participants described the "mommy experience" as part of their culture; and as those experiences and emotions that mothers have such as breastfeeding and bonding as a part of parenting. The desire for the "mommy experience" is an important indicator in breastfeeding.

The "mommy experience" is a behavioral belief as defined in the TRA/TPB (Ajzen, 2006; Moss, 2008). This belief produces a favorable attitude towards breastfeeding. This coupled with normative beliefs and perceived control characteristics of TRA/TPB leads to intent to breastfeed.

Breastfeeding Follows the "Natural Order"

This variable of breastfeeding following the “natural order” was not identified during the literature review. This is an addition to the body of information on breastfeeding in the African American community.

Flower et al. (2008) found in ethnographic interviews that many women had never considered breastfeeding. Yet, all of the participants in this study considered breastfeeding when recruitment was for mothers who breastfeed and for mothers who did not breastfeed. Three of 10 participants used the terms "natural order" of things in life to describe why people should breastfeed. The "natural order" is a natural sequence of nature and a behavioral belief as defined in the TRA/TPB (Ajzen, 2006; Moss, 2008). Because participants believe in the "natural order" of breastfeeding it produces a favorable attitude towards breastfeeding. This coupled with other characteristics of TRA/TPB leads to the intent to breastfeed.

Breastfeeding Encourages Connecting and Bonding

This study lends support to previous findings (CDC, 2013; Lewallen & Street, 2010; Phillips, 2011) between connecting, bonding and breastfeeding in the African

American community. Breastfeeding promotes connecting and bonding between mother and child.

Eighty percent of participants in this study felt that connecting and bonding between mother and child was important reasons to breastfeed. This is a behavioral belief that produces a favorable attitude towards breastfeeding as described by the TRA/TPB (Ajzen, 2006; Moss, 2008). This belief along with other characteristics is the antecedent to intent to breastfeed.

Geographical Location

In this study, twenty percent of participants found that geographical location of the mom contributed to breastfeeding. This is consistent with findings by Kogan et al. (2007) who found that breastfeeding was higher in western and northwestern states as compared to other geographical locations. AABS-06 comments supported Kogan et al., but AABS-02 indicated that geographical location played a role in breastfeeding for a different reason than Kogan.

AABS-02 was originally from Stockton, California. This state has one of the highest ever breastfeeding rates in the country at 86.48% (Kogan et al.). AABS-02 explained that the atmosphere in Stockton was largely one of partying, and that women depended on others to take care of their children when they went out to party and socialize. To do this, kids were given formula. This appears to be the expected thing to do. This is a normative belief or normative expectation, which results in perceived social pressure or subjective norm as explained by the TRA/TPB (Ajzen, 2006). Favorable

attitude and subjective norm, and strong perceived control equals to strong intention to carry out the behavior. In this situation, the behavior was rewarded with an opportunity to go out and party. This most likely means less breastfeeding occurs with this population. This information adds to the body of knowledge on breastfeeding around social environments in various geographical locations.

Research Question 2

What are factors that African American mothers think encourage or discourage breastfeeding? The themes derived from the data are: family's belief and practices about breastfeeding; most influential persons in breastfeeding decision; beliefs and knowledge about people who typically breastfeed; perception about why African Americans breastfeed less and for shorter times than Hispanics and whites; and barriers to breastfeeding.

Family's Belief and Practices About Breastfeeding

In this study, eighty percent of participants' families believed in breastfeeding. The families' belief and practices about breastfeeding appear to have had a strong influence on the participants' decision to breastfeed. This is consistent with the findings of Kaufman et al. (2009), Manstead (2011), and Bunik et al. (2010). This study adds support to the body of knowledge that is already known about family beliefs and practices.

This finding appears to be an extension of cultural beliefs. Sixty percent of participants shared they were breastfed, and fifty percent shared their aunts also breastfed

their children. This study do not support Flower et al. (2008) contention that many women did not consider breastfeeding and stopped if they did because of discomfort, embarrassment and lack of support. All 10 participants considered breastfeeding, and nine breastfed for a month or longer.

A family's belief and practices help to establish normative beliefs and expectations, which results in subjective norm as explained by the TRA/TPB (Ajzen, 2006). This coupled with a strong favorable attitude and perceived control towards breastfeeding leads to a strong intent to breastfeed. Women who routinely breastfeed have more support from their mothers, siblings, friends and partners than women who do not.

Most Influential Persons in Breastfeeding Decision

Having role models and other influential people in an individual's life who breastfeed their children is important in breastfeeding decisions. Thirty percent of participants indicated their mothers were most influential or one of the most influential in their breastfeeding decision. Grandmother, spouse, and friend were listed as being most influential or one of the most influential in breastfeeding decision by two of 10 participants in each category. I found it interesting that two of the participants identified themselves as the most influential people in their lives who help with their breastfeeding decisions.

In this study, all of the influential people listed supported breastfeeding, and breastfed their own children. This is consistent with previous findings by Bunik et al.

(2010) about women breastfeeding longer when they have a friend or other family member who breastfed. The influential people served as both validators or what is the norm (social norms or normative beliefs) and the source of perceived social pressures (subjective norms) to perform the activity. Both of these are constructs of the TRA/TPB (Ajzen, 2006; Boston University School of Public Health, 2013). These constructs combined with the other constructs of TRA/TPB leads to intention and actually performance of the behavior of breastfeeding.

Beliefs and Knowledge About People Who Typically Breastfeed

This study found that people who typically breastfed did it for convenience, economics, cost of formula, body image, weight loss, personal health, religion, and self-efficacy. Some who typically breastfed desired to control and manipulate their spouse or partner, and some families chose to live healthy lifestyles. This study brings additional variables that need further investigation to the body of knowledge around breastfeeding.

This study did not support Kaufman et al. (2010) contention that race was significant in breastfeeding and that African Americans placed a higher value on formula than breast milk. None of the 10 participants seem to value formula over breastfeeding, but one participant breastfed for a few days and then moved to formula. This participant (AABS-03) was 21 years of age and her abandonment of breastfeeding may be more related to age, comfort, and self-efficacy than to race or belief that formula is better. When participants were asked what are some of the most important reasons that made them decide how to feed their babies, AABS-03 responded, "What I was comfortable

with." When asked how race has influenced her breastfeeding decisions, AABS-06 responded, "Race has not influenced me. I have multicultural families in my social group and they all nurse [breastfeed]." Further discussion of these findings are under separate headings below.

Ease of breastfeeding or convenience. In this study, 30 percent of the participants specifically described convenience as one of the reasons they breastfed. They stated, not having to get up in the night and prepare a bottle to feed the baby was convenient. The literature review did not reveal convenience as a reason for breastfeeding. When something is convenient, it is favorable or the attitude is favorable over what is perceived as inconvenient. Attitude toward the behavior is a construct of TRA/TPB. Convenience can serve as a motivational factor for a given behavior (Boston University School of Public Health, 2013). In this instance, the more favorable breastfeeding is, the more apt mothers are to perform the behavior that result in breastfeeding. This information adds to the body of current knowledge on breastfeeding. More work should be done to promote the convenience of breastfeeding coupled with the other benefits of breastfeeding.

Economics, upper income. This study did not find that economics had much of a bearing on breastfeeding for the participants. Participants however, suggested that economics was a reason that some African Americans did not breastfeed. The participant with the highest income also stated that with her first child, her income was low and she did not have a choice but to breastfeed.

The equating of breastfeeding with being poor as a reason African Americans may not breastfeed, adds to the body of knowledge on breastfeeding. It helps to understand embarrassment that some may feel because they are poor.

Petry (2013) found that breastfeeding in the United States correlated with higher socioeconomic status for every race and ethnicity except Mexican Americans. This study did not support the findings of Petry. In this study all participants initiated breastfeeding and seven breastfed for more than 6 months.

Two of 10 participants indicated that economics or having enough money to afford formula might be a reason a person chooses to not breastfeed. These participants described breastfeeding as sometimes being equated with being poor versus the healthy thing to do for their children. Participants stated some African Americans feel that only the poor, breastfeed. This study contained participants with incomes ranging from under $20,000 annually to over $100,000 annually (see Table 1). Participants initiated breastfeeding at 100%. Nine participants breastfed for at least a month. Eight participants breastfed for at least 3 months. One participant had to stop breastfeeding at three months for medical reasons. Seven participants breastfed for more than six months. Two participants made less than $20,000 annually; five made between $20,000 and $39,999 annually; one made between $60,000 and $79,999 annually; one made between $80,000 and $99,999; and one made over $100,000 annually.

Housing or living conditions were considered as a separate variable in Chapter 2 based on Petry's (2013) findings. However, housing was not an issue for any of the 10

participants in this study; nor did they indicate housing was an issue when speculating why African Americans had low breastfeeding rates.

Cost of formula. This study shows that the cost of formula and receiving WIC supplements had little to no bearing on whether participants breastfed or not. What the women believed was healthiest for their babies appeared to be the primary driver for breastfeeding.

Kaufman et al. (2010) found that the value of formula was "Bolstered by WIC's formula subsidies and hospitals distributing formula" (p. 699). At least one of the hospitals where the children were delivered no longer distributes formula to new moms and has the Baby Friendly designation. The CDC (2010b) found that breastfeeding rates were significantly lower among WIC and Medicaid recipients. This study does not support these findings. Fifty percent of the participants received Medicaid. Eighty percent (all except AABS-05 and 06) of the participants received WIC supplements. Yet only one (AABS-03) did not breastfeed for more than a few days, and she had private insurance.

Thirty percent of participants felt that the cost of formula might be prohibitive and encourage breastfeeding if mothers did not receive WIC supplements. This was interesting in that the three participants (AABS-05, 07 and 10) who expressed they felt this way were strong supporters of breastfeeding, and two of them received WIC. These women were speculating about why people breastfeed or not breastfeed in general. All three of these participants found breastfeeding to be cheaper than formula, but this was

not the reason they breastfed; nor did the cost of formula appear to be a driver for breastfeeding with any of the participants.

Age of mother. This study's findings are consistent with previous research in relation to the younger the mother, the less breastfeeding occurs. However, the breastfeeding initiation rate for this group was at 100%. Study participants ranged from 21 to 40 years of age. Seventy percent of the participants breastfed for over 6 months. In this study, four participants were between the age of 21 and 29. Three of the participants in this age range breastfed for the shortest length of time, with one breastfeeding for a few days, one for one month, another for 6.5 months, and one for one year. There were six participants between the age of 30 and 40. Five of the participants in this age range breastfed for 12 months, and one had to stop breastfeeding at three months for medical reasons. One participant felt that partying, anger and alcohol consumption was the reason young females breastfeed less.

Previous research indicated that the younger the mothers of infants are, the less likely breastfeeding will occur, and African Americans are significantly less likely to breastfed their infants than whites and Mexican Americans according to the CDC (2010b; 2010c; 2011). The CDC found that mothers less than 20 years of age initiated and continued breastfeeding for six months less than women who were in the 20 to 29 year old age range, and the over 30 range.

Control and manipulation. This variable was not identified as a variable during the literature review. It was identified as an issue by three participants in this study. The

participants described having or being in control and being able to manipulate their situations as a rationale for breastfeeding. This finding adds to the body of knowledge about reasons people may choose to breastfed.

Control belief is a construct of the TRA/TPB. Control is a factor in why people choose to breastfeed. With control beliefs, the individual perceives there are factors present that allow them to control the behavior or perform or not perform it. This study found that some individuals believe they have the ability to perform the behavior of breastfeeding, and in some instances, utilize breastfeeding to control and manipulate others. Ajzen (2006) found that behavioral belief, another construct of TRA/TPB is the subjective probability that a particular behavior will produce and certain outcome or desire. The desire to control and manipulate can be a motivator for breastfeeding.

Body image, weight loss, mother's health. This study supports the finding of previous research; and that body image, weight loss and mother's health contributed to an overall positive attitude towards breastfeeding. In Chapter 2, I addressed research that have shown that a mother's health is significantly improved and risk factors for certain diseases are decreased when she breastfeed (Gonzalez-Jimenez et al., 2013; Liu et al., 2010). Four participants (AABS-01, 07, 09 and 10) specifically mentioned health benefits of breastfeeding such as losing weight; and helping the uterus to shrink back to normal after giving birth. One participant mentioned that some women were concerned about their breast sagging as a result of breastfeeding. Yet, none of the women in this study found this to be an issue or a reason not to breastfeed. A positive attitude towards the

behavior is a motivator for breastfeeding. Attitude toward the behavior is a construct of TRA/TPB (Ajzen, 2006).

Religion. The literature review did not reveal any information on religion as related to breastfeeding in the African American community. Two of the participants (AABS-01 and 02) raised religion as favorable towards breastfeeding. One specifically said her religion encouraged healthy living, which included breastfeeding. Another participant (AABS-05) felt more outreach to churches around breastfeeding needs to take place because this is where African Americans tend to assemble as a whole. Religion should be considered when interventions are designed. This variable should be considered when conducting studies and interventions on breastfeeding. This adds to the body of knowledge on breastfeeding by raising the issue of religion.

Family adoption of healthy lifestyle choice. Adoption of a healthy lifestyle choice was not a variable identified during the literature review. This subject was raised by three of the participants in this study. The participants made a conscious effort to adopt a healthy lifestyle for their immediate family. Participants included breastfeeding as a part of a healthy lifestyle.

Healthy lifestyle is a buzz phrase that conjures up images of the things people need to do to achieve optimal health. Such things include good nutrition, exercise, stress management, and adequate sleep (Clark, 2013). Most people approve of a healthy lifestyle. This belief is a subjective norm, a construct of TRA/TPB (Ajzen, 2006).

This variable, adoption of a healthy lifestyle, adds to the current body of knowledge by providing a new lens to examine breastfeeding in the African American community. It may also provide a new association with being healthy that can be used in public service campaigns and other interventions.

Another interesting note is that I asked the participants why they felt African Americans lag behind in breastfeeding as compared to Hispanics and whites. AABS-07 and 09 responded that Hispanics and whites were more incline to utilize natural foods and other products than African Americans.

Self-efficacy. Self-efficacy was identified during the literature review as an important variable for breastfeeding initiation and continuation. Researchers found that mothers with the highest self-efficacy for breastfeeding had longer breastfeeding rates, and rates were lowest if mothers were concerned with their ability to meet their infants' nutritional needs (Britton & Britton, 2008; Kington et. al., 2007. Palaniappan et al., 2010; Phillips, 2011). This study supports these findings. AABS-09 breastfed for one month. One of the reasons she gave for discontinuing breastfeeding was that she was concerned with her baby getting enough to eat. AABS-09's mother was quite concerned with this issue too and urged her to start formula feeding. During the interviews, it was clear that of all the participants, AABS-09 has less self-efficacy than other participants.

Kingston et al. (2007) found that mothers who needed assistance from a professional to breastfeed and those who experienced pain had low breastfeeding efficacy. This study did not support these findings. AABS-05 was quiet experienced at

breastfeeding and had breastfed all three of her children. She felt that she needed to breastfeed for at least 12 months. AABS-05 experienced severe pain while breastfeeding her third child. She was prescribed pain medication, but felt the medication might be transferred to her baby through her breast milk. At three months, AABS-05's physician advised her to stop breastfeeding.

Kingston et al. (2007) also found that mothers who had breastfeeding role models or received praised for how well they were doing with breastfeeding had the highest level of self-efficacy. McQueen et al. (2011) found that nursing intervention improved self-efficacy. This study supports these findings. Self-efficacy or belief on the part of an individual in their ability to successfully carry out the activity of breastfeeding correctly in order to feed their baby was an important precondition for behavioral change. Perceived behavioral control is a construct of TRA/TPB (Ajzen, 2006). Self-efficacy is a part of perceived behavioral control. Intentions to breastfeed are influenced by women's perception of control over the immediate situation and believing that they can perform the task. Breastfeeding self-efficacy is a strong predictor for breastfeeding (Ajzen, 2006, 2011a; Manstead, 2011; Orr et al., 2013).

Perception About Why African Americans Breastfeed Less and for Shorter Times

Perceptions about why African Americans breastfeed less and for shorter times than Hispanics and whites are described below.

Lack of support for daughters who have babies out of wedlock. Two participants perceive that African American parents are not as supportive of their

daughters who have a baby out of wedlock as white parents. I did not find any research that supported this contention. This study adds a new variable to the body of evidence around breastfeeding. This variable needs further study.

Breastfeeding is sometimes viewed as dirty or sexual. Two participants felt that people view breastfeeding after the baby reaches a certain age and size as impure, dirty or sexual. The American Academy of pediatrics recommends six months of exclusive breastfeeding, followed by breastfeeding and the introduction of complementary foods for 12 months or longer based on the preference of mother and infant (AAP, 2012b). I was unable to find any information on people viewing breastfeeding as dirty or sexual. This is a new variable to add to the body of evidence around breastfeeding. This variable needs further study.

Cost of nursing equipment and supplies. The cost of nursing equipment was not a variable that surfaced during the literature review. Two participants in this study raised the issue that the cost of breastfeeding supplies and equipment can be prohibitive for nursing mothers, especially those with low incomes. Many mothers do not have access to dual incomes so they cannot afford to buy equipment and supplies. Hartshorn (2015) developed a breastfeeding supply checklist. I modified the list, created Table 6, and added cost of items from various online retailers (Destination Maternity, 2015; Giggle, 2015; Mommy and Gear, 2015; Penneys, 2015; Quidsi Solutions, 2015; Target Brands, 2015; Walgreen, 2014).

Table 6

Cost of Breastfeeding Equipment and Supplies

Must Have	Cost	Equipment	Cost
Nursing pads	$4.99 -$8.99	Hand breast pump	$17.49 (low)
Daytime nursing bras	$21.99-$51.99	Electric breast pump (best for pumping often)	$111.99 (low)
Nighttime nursing bras	$16.98-$38.00	Collection bags or bottles for breast milk	$16.99 $40.00 (per kit)
		Cooler to carry milk home, if mother pumps away from home	vary
		Bottles, nipples and flat screw-on bottle covers	vary
Bibs	$5.99 (low)		
Burp cloths	$6.79 (low)		
Comfy chair such as a glider or rocker	Vary		
Nipple shield	$5.29 - $9.99		
Nursing pillow	$9.99-$39.00		

AABS-06 experienced pain and cracked nipples, but she was able to mitigate her pain by purchasing nipple covers or shields so the baby was not directly on her nipple. Nipple shields are helpful with latching issues too. AABS-09 could only afford an inexpensive manual pump that was difficult to use. She was not aware of the requirements under the Affordable Care Act (2010) about the coverage for breastfeeding support and supplies (AAP, 2013).

The cost of nursing equipment and supplies is a new variable for breastfeeding. This adds to the body of knowledge around breastfeeding. More studies need to be done on the cost of breastfeeding as a barrier to breastfeeding.

Health care personnel lack of encouragement and help. A positive association was found when women received individualized information about breastfeeding (Pannu et al., 2010; Phillips, 2011). Phillips (2011) found that knowledgeable professionals were needed to provide initial breastfeeding support and that first time breastfeeding mothers reported they did not know what questions to ask of health care providers. This is consistent with comments from participant AABS-09. Consistent information was reassuring and needed. Flower et al. (2008); Cricco-Lizza (2006); McInnes and Chambers (2008); Miracle et al. (2004); Saunders-Goldson and Edwards (2004); and Sarasua et al. (2009), found that knowledge of the benefits of breastfeeding affected initiation and duration of breastfeeding for all races. When breastfeeding was discussed, it was often late in the pregnancy and after the mother went into labor when questions about which method of feeding the mother would use were asked. AABS-09, a participant in this study felt that the discussion needed to take place early on during the pregnancy or even before.

The findings of this study fully support and confirms the findings noted by Flower et al. (2008); Cricco-Lizza (2006); McInnes and Chambers (2008); Miracle et al. (2004); Pannu et al. (2010); Phillips (2011); Saunders-Goldson and Edwards (2004); and Sarasua et al. (2009). Some participants shared that local hospitals staff gave inconsistent

information about breastfeeding which was confusing. For example AABS-09 was told by hospital staff that she could do both breastfeeding and formula feeding, when the aim was to promote breastfeeding. The lactation staff visited AABS-06 just before discharge from the hospital, which indicate new mothers may not be getting information needed in a timely manner. WIC just gave formula but no information promoting breastfeeding in the instance of AABS-09, a first time breastfeeding mother. She stated she would have benefitted with more information and consistent information.

AABS-01 stated one hospital's staff would tell African American mothers that formula was better than breastfeeding. I have not been able to find more information on this issue, but further studies need to be done on the information given to different racial groups, and rationale for such inconsistencies.

Lack of available resources, knowledge and education. This study indicate there is a breakdown in the system for delivery of information to women about available resources around breastfeeding. Women's Health [DHHS-OWH] (2013b) found that a lack of information on how to breastfeed, stigmas, myths, and the lack of public venues to breastfeed as barriers to breastfeeding. This study has similar findings in that four participants found that a lack of information on how to breastfeed posed a problem for them. AABS-05 felt there needs to be more outreach in churches because that is where many African Americans get together. AABS-09 felt more proactive education prior to child birth was needed. She felt many people are not getting the right resources to help

with breastfeeding. It is important for people to take a class before the child comes rather than learning on the spot.

This study further found that breastfeeding is stigmatized as something that is done by the poor in the African American community (AABS-01 and 05). Work that focus on destigmatizing breastfeeding at the grassroots level in this community needs to be done.

Many of the specific myths outlined by Women's Health were not consistent with the findings. For example, not one of the participants raised the following myths (DHHS-OWH, 2013a) during the interview or in writing:

- Everybody used formula,
- Formula has more vitamins than breast milk,
- Formula feeding is easier,
- Formula is cheaper than breastfeeding,
- Some women’s breasts were too small or large to breastfeed,
- Breast milk sours, and
- Breastfeeding spoiled the baby.

Hurley et al. (2008) found that the most common reason (35.6%) for not initiating breastfeeding among African American and white mothers was a belief or fear that breastfeeding would be painful. None of the participants in this study supported this contention. Three of the participants raised the issue of pain, but they actually breastfed their children despite the pain. AABS -09 experienced pain during breastfeeding. She was

not aware of nipple shields or covers or shields that help eliminate the cracking of her nipples which would help eliminate that pain. AABS-09 received WIC with all three children, but she was not aware that WIC loaned breast pumps; and that under the ACA she was eligible to get a breast pump and other breastfeeding support supplies and equipment.

This study revealed that the health education is not always getting to the African American community. Clearly some participants knew more about the available resources than others, even when their babies were delivered in a hospital setting and they received WIC supplements. More research needs to be done on getting the right information out prior to, during, and after pregnancy.

Education factor. This study does not support the findings under the literature review that education level of the mother had a bearing on breastfeeding initiation and continuation. Ludington-Hoe et al. (2002) found that when education and income were equal in African Americans, Hispanics, and whites the disparities for breastfeeding was considerably minimized.

In this study, all 10 of the participants initiated breastfeeding (see Table 1, demographics of participants). One participant (AABS-03) with a high school education breastfed for a few days. The other participant (AABS-07) with a high school education continues to breastfeed her infant, and she breastfed her other children for at least 12 months. Five participants have some college. One participant (AABS-09) breastfed for one month, one (AABS-08) breastfed for 6.5 months, and the other three (AABS-01, 02,

and 04) breastfed for at least 12 months. One participant (AABS-10) has an associate degree and breastfed for at least 12 months. One participant (AABS-05) has a bachelor's degree and breastfed for three months and stopped for medical reasons. One participant (AABS-06) has a master's degree. She breastfed for at least a year. Knowledge and beliefs about the benefits of breastfeeding and having the right equipment far outweighed education level as a determinant of breastfeeding. This study indicates that formal education might not be as much of a deciding factor in choosing to breastfeed as age and the mother getting the right information and resources.

Perception that Hispanics and Whites have More Support than African Americans from Spouses or Partners. This study supports Hurley et al.'s (2008) contention that African American mothers reported a need to return to work more often than others. Participants linked one of their perception about why African Americans do not breastfeed as much as others to support from spouses or partners or lack thereof. Participants felt that Africans Americans had to return to work and were not stay at home mothers as much as others. This is not new information, but it supports the information that is already in the literature.

Barriers to Breastfeeding

In this study, participants described barriers to breastfeeding such as cost of nursing equipment and supplies, lack of encouragement from health personnel, inconsistence information from health care personnel, lack of available resources, having children out of wedlock, age of mother, cost of formula, belief that only the poor

breastfeed, having to return to work, and geographical location. These barriers add new information to the current body of knowledge.

Kaufman et al. (2009) found ambivalence to be a barrier. Ambivalence about breastfeeding caused various feeding patterns, and many women had competing ideas about which way to feed their babies. Even when they knew the benefits of breastfeeding they expressed bottle feeding was easier (Kaufman et al.). None of the participants in this study were ambivalent about breastfeeding. Manstead (2011) reflected on the significance of social forces in changing behavior while noting that many behaviors rely on others. For example, the role that spouse or partner, family and others play in supporting breastfeeding. This study supports Manstead's finding.

Research Question 1: Summary

How do African American women describe what influenced their decision to breastfeed or not? Breastfeeding figures prominently in the African American culture. However, breastfeeding was viewed more as a personal choice decision of the mother in the African American community. Variables such as support from spouse or partner, immediate family, and friends; and culture did not seem to mean as much as the mothers having the option of making a personal choice. Nine of 10 participants felt strongly that breastfeeding was their choice, and seven expressed they would breastfeed without the support of others, if necessary. There were various other reasons why participants breastfed or did not breastfeed. These reasons included the desire to have the "mommy experience." They also believed that breastfeeding was part of nature, and participants

termed it as following the "natural order" of things. Participants understood the benefits of breastfeeding and that breastfeeding was the healthiest thing they could do for their babies. They recognized the connecting and bonding that goes along with breastfeeding.

Geographical location impacted breastfeeding in two ways. Some areas of the country were more receptive to breastfeeding than others. For example, a participant identified Washington State as a friendly state for breastfeeding as compared to Florida where she had negative experiences breastfeeding in public areas. Another participant talked about the party atmosphere in her previous community in California. The party atmosphere discouraged breastfeeding.

Research Question 2: Summary

What are factors that African American mothers think encourage or discourage breastfeeding? Participants overwhelmingly believed that African American mothers and families believe in breastfeeding. Maternal grandmothers of infants were the most influential in their mother's breastfeeding decisions followed by equal influence on the part of maternal great grandmothers, spouses, and friends.

Participants believed that people who typically breastfed did it for convenience, economics, weight loss, religion, and self-efficacy. Control and manipulation of personal relationships seemed to be an important factors in why people breastfed. Adoption of a healthy lifestyle was another prominent variable in favor of breastfeeding.

Participants further believed that a stigma is attached to breastfeeding in the African American community. For example, some women perceived breastfeeding is

done only by the poor or economically disadvantaged. In order to not be identified as poor some mothers chose formula feeding over breastfeeding. The cost of formula or the women receiving Medicaid or WIC did not appear to have influence on this issue. Other perceptions explored were: African American parents are not as supportive of their daughters if they have children out of wedlock when compared to others, Hispanics and whites have more support than African Americans from their spouses and significant others, and breastfeeding is viewed as dirty or sexual.

The cost of nursing supplies can be a major issue for a breastfeeding mother, especially in a single parent household. Participants were not well informed of free available resources such as the breastfeeding friendly provisions of the Affordable Care Act (2010) that allows free supplies and equipment to breastfeeding mothers (DHHS, 2015).

Participants indicated that health care personnel gave conflicting information; not enough information; and encouraged breastfeeding in some instances, discouraged it in some, and was neutral in others. Education attainment (high school and beyond) of the mother did not have a major bearing on whether she breastfed or not. Major barriers to breastfeeding included consistency in information and assistance given to new mothers by health care personnel.

Limitations of the Study

In Chapter 1, I identified a limitation related to sampling methodology, and one related to the theoretical basis of the study. During the data collection phase of the study I identified additional methodical limitations and researcher related limitations.

There were few current qualitative studies specific to low breastfeeding rates in the African American community, but there were many quantitative studies that focused on the data from large data gathering activities such as through PRAMS. This study can help fill the void in current qualitative research on breastfeeding that is exclusive to African Americans. More studies on other aspects of breastfeeding in African Americans need to be done.

All of the data for this study were self-reported by the participants and cannot be independently verified. Every effort was made to look for signs of deception, and to impress on participants the importance of providing accurate information. Self-reported data may contain biases such as selective memory, telescoping, and exaggeration. I suspected one participant of telescoping an incident, but I investigated further and concluded that the comment of the participant was most likely accurate.

I was the only researcher involved in this research. The findings and conclusions are subject to the interpretations of one researcher.

I am from the community of study. With that I have my own set of biases. To deal with this issue, I recognize my own biases, and constantly remind myself to remain as objective as possible throughout the process of collecting and analyzing data.

Access to participants became an issue in recruitment for this study. The original intent was to conduct in-person interviews of all participants, but that plan fell through as it became increasingly difficult to recruit participants because of skepticism on their part, and their schedules. To help with recruitment, data were obtained through written comments, and both in-person and telephonic interviews. The same data collecting material was used in all three instances.

Participants were not required to breastfeed to take part in the study. This was included in the recruitment flyer and other material. After I finished data collecting, I discovered that all 10 participants actually initiated breastfeeding. I am not clear if more African Americans breastfeed in Washington State or not. Convenience and criterion sampling was done, and the first 10 potential subjects that met the selection criteria listed in Chapter 3 were selected to participate.

There are additional limitations of the TPB that were not mentioned in Chapter 1. TPB does not take into account that behavior can change in a span of time versus being the product of a linear decision making process. TPB addresses perceived behavioral control but not actual control over behavior. The time it takes to get from "intent" to "action" is not addressed in the theory (Boston University School of Public Health, 2013).

Recommendations for Further Research

More research is need to explore and investigate whether low breastfeeding in the African American community is real or a myth. This recommendation is made because

of the difficulty I had in recruiting participants. There was a lot of skepticism and reluctance to participate in the study, even when the intent was clearly explained to potential participants. Some expressed that they thought I was from state social services conducting an undercover investigation on their use of WIC and Medicaid while others simply stated they were not comfortable giving information out about themselves. In some of my outreach, health educators in the African American community shared that they have urged their clients to participate in studies, but they are not always successful.

Personal choice is a new variable that needs further research as it relates to breastfeeding in the African American community, especially in the context of respect. How educators, and health education material is designed and presented, and actual presentations on breastfeeding needs to be reexamined to ensure it is done in a way that respects personal choice as well as culture.

Geographical location is a variable that warrants further investigation as it relates to the social climates or party atmosphere. Party atmosphere is a new variable and warrants further investigation.

More research needs to be done on the role religion plays in breastfeeding. One of the focuses should be on how the religious community can effectively promote breastfeeding in the African American community. Another should be how African American religious practices affect breastfeeding.

Breastfeeding viewed as dirty or sexual after a certain age is another area where more research needs to be done in the African American community. This was a new variable raised during this study.

The stigma of being poor or under privileged if you breastfeed is an issue that need more research. This was a new variable and one that needs further research, especially since African Americans overall have lower incomes (Kochhar and Fry, 2014) and lower breastfeeding rates in comparison to whites.

Implications for Positive Social Change

The results of this study have implications for social change. Breastfeeding provides critical nutrients and protective factors for infants. It improves the health of the mother and facilitates bonding between mother and child. Studies currently show that African Americans lag behind others in breastfeeding rates. This study can be used to develop or improve existing intervention tools that are designed to improve African American breastfeeding rates.

This study identifies gaps in services, resources and information that new mothers need in order to access services. Identification of these gaps helps agencies and medical personnel in the delivery of services and closing the gaps. This will facilitate more breastfeeding and movement towards positive social change.

New knowledge gained as a result of this study can be used to develop new studies or material on breastfeeding in the African American community that leads to positive social change. This includes laying the foundation for religious communities to

have greater participation in breastfeeding promotion in the African American community; and helping to remove the stigmas or beliefs that only the poor breastfeed, and breastfeeding is dirty or sexual after a certain age. The latter will help to improve the mental health of mothers who breastfeed.

This study raises issues about breastfeeding in the African American community that has not been brought to the table before, such as the cost of breastfeeding supplies being cost prohibitive for some low income mothers, and being proactive about getting information out to mothers long before delivery. These things will help to bring about social change, and increase breastfeeding in African American communities.

Conclusions

The overarching research question for this study is: what are the perspectives of African American mothers regarding breastfeeding. To answer this question, two secondary research questions were utilized. They are: How do African American women describe what influenced their decision to breastfeed or not, and what are factors that African American mothers think encourage or discourage breastfeeding.

Ten participants were recruited for the study. A majority of participants were extremely knowledgeable about breastfeeding. Participants articulated what influenced their decision to breastfeed or not breastfeed such as their passion about breastfeeding, how their spouses or partners, and close relatives and friends felt about breastfeeding.

New variables that may impact breastfeeding were revealed during this study. These variables included the cost of supplies and equipment, which may be too costly for

low income mothers to purchase; control or manipulation; and personal choice. This study further revealed that health care personnel often gave inconsistent information or did not share enough information with mothers.

The participants trusted me enough to share very personal insights into breastfeeding in their families, and in the African American community. Their trust and insight will help to improve breastfeeding experiences for others, and to develop interventions and resources that make a difference in the lives of children and families.

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Appendix A: Interview Questions

Qualitative interview questions to be administered to all participants during the interview process.

1. Tell me about how you made up your mind about how to breastfeed your baby (Street 2011). This question will provide input into describing what influenced the mother's decision to breastfeed. Such influences may include the health care professional, spousal or partner wishes, and knowledge about breastfeeding.

2. Tell me about your family's belief and practices in regards to infant feeding. (Pause. After response ask next part of question) (Street). This question focuses on culture and family. It seeks to understand the most influential person in the subject's life in making the decision to breastfeed or not breastfeed. It delves into specific questions about the feeling towards breastfeeding of the of subject's parents, siblings, significant other, baby's father, relatives, and friends.

   2a. Who has been the most influential in your decision to breastfeed or not breastfeed (Street).

   2b. What have those people who were most influential done or said that influenced how you plan to feed your baby? (Pause and follow-up with next question as appropriate) (Street).

   2c. How does your baby's father or significant other want you to feed the baby (Street)?

   2d. How does your mother want you to feed your baby (Street)?

3. What are some of the most important reasons that made you decide how to feed your baby (Street)? This question seeks reasons for breastfeeding or not breastfeeding that are not otherwise discussed.

4. How we decide to feed our children is sometimes influenced by what we sometimes call culture which can be made up of race, religion, where you are from, what family and friends think you should do, and other things. How do you feel like your culture has influenced how you planned to feed your baby (Street)? (After hesitancy or initial response, each subset of culture will be asked separately, i.e., how has race influenced how you plan to feed your baby?) (Street). This question dives into other factors such as race, cultural practices in the part of the country where the participant was raised.

5. What is your understanding of the importance of breastfeeding? This question seeks to understand the knowledge the participant has around breastfeeding. This will be compared to age, whether the participant breastfeeds or not, and education level. This will reveal if participant's age and education level have a bearing on knowledge about breastfeeding.

6. Tell me about your beliefs and knowledge about people who typically breastfeed their children. This question is designed to illicit the participants view of people who breastfeed. This will give insight into the perception the participant has around mothers who breastfeed.

7. African American women tend to breastfeed less often and for shorter times than Caucasian or Hispanic women. Do you have any ideas about why this might be (Lewallen, 2006)? This question will help to answer the overarching research question, and help reach or bring forth information that has not otherwise been given.

Appendix B: Demographic Questionnaire

Derived from Street (2011)

The Demographic Questionnaire will help to paint a picture of the participants and help with drawing conclusions about participant responses to the interview questions. This questionnaire will help answer the overarching research question.

Please answer the following questions by placing a check in the correct blank.

1. How old are you?

   Less than 18 _____

   18-20_____

   21-25_____

   26-30_____

   31-35_____

36-40_____

40-45_____

More than 45_____

2. What is your race?

   African American_____

   Caucasian_____

   Other_____

3. What is your level of education?

   Did not complete high school_____

   High school graduate_____

   Some College_____

   Associate Degree_____

   Baccalaureate Degree_____

   Graduate Degree_____

4. What is your marital status?

   Single_____

   Married_____

   Separated_____

   Divorced_____

   Widowed_____

5. Are you a WIC (Women's Infants and Children) program participant?

Yes_____

No_____

6. What type of insurance do you have?

   Medicaid_____

   Private Insurance_____

   Self-pay_____

7. What is your household income?

   Less than $20,000_____

   $20,000-$39,999_____

   $40,000-$59,999_____

   $60,000-$79,999_____

   $80,000-$99,999_____

   $100,000 or more_____

8. Are you currently employed?

   Yes_____

   How many hours per week?_____

   No_____

9. Are you pregnant, if so, how many weeks pregnant are you?

   27 weeks or below_____

   28 weeks or above_____

10. Have you had any previous births?

Yes_____

No_____

If yes, how many?_____

If previous births, how are babies fed?

Baby #1:

Formula_____ Breastfed _____Breast milk in a bottle_____ Combination_____

Baby #2:

Formula_____ Breastfed _____ Breast milk in a bottle_____ Combination_____

Baby #3:

Formula_____ Breastfed_____ Breast milk in a bottle_____ Combination_____

Others:_____

11. How do you plan to feed your baby?

    Formula_____Breastfeed_____Breast milk in a bottle_____

    Combination of formula and breast milk_____

12. How does your baby's father or significant other want you to feed the baby?

    Formula_____Breastfeed_____Breast milk in a bottle_____

    Combination of formula and breast milk_____

13. How does your mother want you to feed the baby?

Formula_____Breastfeed_____Breast milk in a bottle_____

Combination of formula and breast milk_____

14. Has anyone else besides your baby's father, significant other or your mother helped you decide how to feed your baby?

    No_____

    Yes_____If yes, who_____

        What did that person recommend?_____

15. What is your due date?

    Month_____ Date_____

16. The word culture means beliefs and traditions passed down by your family and friends.

    How has your culture affected how you plan to feed your baby?

Contact information

Name_____Home phone_____Cell phone_____

If we can't reach you at the above phone numbers, who else could we call that would know how to reach you? (neighbor, family member or friend)

Name_____Phone number_____

This person's relationship to you:_____

Appendix C: Detailed Field Notes Form

Participant Code: _____

Date of Interview:_____

Time of Interview:_____

Location of Interview:_____

Questions	**Participant comments and observations**
1. Tell me about how you made up your mind about how to breastfeed your baby (Street 2011).	

2. Tell me about your family's belief and practices in regards to infant feeding. (Pause. After response ask next part of question) (Street). 2a. Who has been the most influential in your decision to breastfeed or not breastfeed (Street). 2b. What have those people who were most influential done or said that influenced how you plan to feed your baby? (Pause and follow-up with next question as appropriate) (Street). 2c. How does your baby's father or significant other want you to feed the baby (Street)? 2d. How does your mother want you to feed your baby (Street).	
3. What are some of the most important reasons that made you decide how to feed your baby (Street)?	

4. How we decide to feed our children is sometimes influenced by what we sometimes call culture which can be made up of race, religion, where you are from, what family and friends think you should do, and other things. How do you feel like your culture has influenced how you planned to feed your baby (Street)? (After hesitancy or initial response, each subset of culture will be asked separately, i.e., how has race influenced how you plan to feed your baby?) (Street).	
5. What is your understanding of the importance of breastfeeding?	
6. Tell me about your beliefs and knowledge about people who typically breastfeed their children.	
7. African American women tend to breastfeed less often and for shorter times than Caucasian or Hispanic women. Do you have any ideas about why this might be (Lewallen & Street, 2010)?	
Other comments and observations:	

Appendix D: Permission to Use Questions and Demographic Tool

Re: Permission to Include Your Research Tools in my Dissertation Publication
From: Lynne Lewallen <lplewall@uncg.edu>
To: jeffuh <jeffuh@aol.com>
Date: Tue, Apr 28, 2015 7:39 am

Yes, you have my permission to use the tools in your published dissertation. Please let me know if you need a formal letter. Best wishes.

On Tue, Apr 28, 2015 at 10:07 AM, <jeffuh@aol.com> wrote:
Dr. Lewallen, thank you so very much for giving me permission to use yours and Dr. Street's research tools in my dissertation on breastfeeding in African American communities. My dissertation is going through its final review at this time. I received a note back from our writing center that I need permission to include the three documents in my published dissertation. I hope you can give me permission to do so. For you reference, I have pasted our original correspondence regarding utilizing your focus group guiding questions and Dr. Street's Prenatal Demographic Data Assessment and qualitative interview questions below. I will forward the link to my dissertation to you as soon as it is published. The study has provided some wonderful new information on breastfeeding in African Americans, and I am eager to share it.

Thank you very much.

Lowest Jefferson, REHS/RS, MS, Ph.D. Candidate
Walden University

Subject : Re: Permission to Use Your Research Tool
Date : Tue, Nov 19, 2013 09:45 AM CST
From : Lynne Lewallen <lplewall@uncg.edu>
To : Lowest Jefferson <lowest.jefferson@waldenu.edu>
Attachment :
Street_dissertation.pdf

Yes, we lost Darlene way too early! I have attached a pdf of her dissertation, which contains the instruments in the appendix. Hope this is helpful. You may use them,

although you will need additional permission to use the quantitative instrument if you choose to--she has information in the appendix about how she got permission to use it that may be helpful to you. Please reference her when/if you use these. Best wishes.

On Mon, Nov 18, 2013 at 10:01 PM, Lowest Jefferson <lowest.jefferson@waldenu.edu> wrote:
Thank you, Dr. Lewallen. I hope you can help me with two other tools I am trying to get permission to use. I sent Dr. Darlene Street a request to use her *Prenatal Demographic Data Assessment Tool* (Appendix F) and her Q*ualitative Interview Questions* (Appendix I) that were used in her dissertation titled *Infant Feeding Attitudes, Feeding Method Choice, and Breastfeeding Initiation among African American and Caucasian Women.* Both of these tools fit well for my study, and with minor modifications would be perfect tools. I assumed that her email address had changed, so I searched the internet only to locate her obituary, which made me sad. I noticed that you were the chair of her dissertation committee. My co-worker suggested that I seek permission to use the tools from you. If you are able to give permission please respond with a note giving me permission to use them. If not please advise me on how to get permission. I want to thank you in advance for your assistance.

Lowest Jefferson, REHS/RS, MS, Ph.D. Candidate
Walden University
253-589-2621

Original E-mail

From : Lynne Lewallen [lplewall@uncg.edu]

Date : 11/18/2013 08:29 AM

To : Lowest Jefferson [lowest.jefferson@waldenu.edu]

Subject : Re: Permission to Use Your Research Tool

No problem, I have attached them. Best wishes on your research! Let me know if I can be of any more help.
On Sun, Nov 17, 2013 at 7:44 PM, Lowest Jefferson <lowest.jefferson@waldenu.edu> wrote:
Dear Dr. Lewallen, I am a student at Walden University. I am working on my dissertation which relates to breastfeeding by African Americans. It examines the reason for the low rates of breastfeeding in this population. I just reviewed your research on *Initiating and Sustaining Breastfeeding in African American Women.* I am seeking permission to use your *Focus Group Guiding Questions* for my study. If you are able to give permission I would certainly appreciate it. Thank you very much for considering this request.

Lowest Jefferson, REHS/RS, MS, Ph.D. Candidate
Walden University
253-589-2621

--

Lynne P. Lewallen, PhD, RN, CNE, ANEF
Professor, UNCG School of Nursing
419 Moore Building
PO Box 26170
Greensboro, NC 27402-6170
336-334-5170

Appendix E: Permission to Use Questions

Subject : Re: Permission to Use Your Research Tool
Date : Mon, Nov 18, 2013 08:29 AM CST
From : Lynne Lewallen <lplewall@uncg.edu>
To : Lowest Jefferson <lowest.jefferson@waldenu.edu>
Attachment :
Focus_group_questions.doc

No problem, I have attached them. Best wishes on your research! Let me know if I can be of any more help.

On Sun, Nov 17, 2013 at 7:44 PM, Lowest Jefferson <lowest.jefferson@waldenu.edu> wrote:
Dear Dr. Lewallen, I am a student at Walden University. I am working on my dissertation which relates to breastfeeding by African Americans. It examines the reason for the low rates of breastfeeding in this population. I just reviewed your research on *Initiating and Sustaining Breastfeeding in African American Women.* I am seeking permission to use your *Focus Group Guiding Questions* for my study. If you are able to give permission I would certainly appreciate it. Thank you very much for considering this request.

Lowest Jefferson, REHS/RS, MS, Ph.D. Candidate
Walden University
253-589-2621
--

Lynne P. Lewallen, PhD, RN, CNE, ANEF
Professor, UNCG School of Nursing
419 Moore Building
PO Box 26170
Greensboro, NC 27402-6170
336-334-5170

Appendix F: Original Focus Group Questions

From Lewallen's & Street's (2010) Study

When you had your baby, how long did you think you would breastfeed? (could be on demographic sheet)

How long did you breastfeed? (could be on demographic sheet)

Tell me about what your breastfeeding experience was like.

Why did you stop breastfeeding?

Was there anything that could have helped you keep breastfeeding? If so, what?

Need probes here: what could nurses have done? Would written information have helped? If so, when would you want to have received it (in hospital, after got home, some other time).

African American women tend to breastfeed less often and for shorter times than Caucasian or Hispanic women. Do you have any ideas about why this might be?

Is there anything that you think that nurses can do to help women breastfeed longer

- While the woman is in the hospital
- After the woman and the baby go home

Appendix G: Recruitment Flyer

Invitation to Join the Breastfeeding Study

Breastfeeding for the first 6 months of an infant's life yields improved well-being. Studies show improved bonding between mother and child, fewer behavioral problems in children, and improvements in health outcomes of the mother and child when the mother breastfeeds.

Breastfeeding rates continue to improve in the United States, but blacks/African Americans still lag behind other groups in breastfeeding. It has been estimated that promotion of proper breastfeeding can cut the infant and child (5 and under) death rate by 13%.

This study examines why blacks/African Americans continue to lag behind other groups in breastfeeding in the context of the black/African American culture while searching for the reason why blacks/African Americans lag behind others in bridging the breastfeeding gap.

I am seeking 20 black/African American female volunteers who are 18 years or older; not currently pregnant; and have a small child or children who are 5 years old or younger to participate in this study as part of my doctoral dissertation. One interview of 1.5 to 2 hours, and a possible follow-up short interview will be required. Identity of participants will be kept confidential. Participants will receive a small monetary incentive for participating in the study. If you are interested in volunteering for this study or hearing more about it, please contact Lowe Jefferson at:

E-mail: lowetaylorann@yahoo.com or 253-589-2621

Thanks!

Appendix H: Letter to Potential Participants

Dear Potential Breastfeeding Study Participant,

My name is Lowest Jefferson. I am a doctoral student at Walden University. I am pursuing a doctorate in Public Health with a concentration in Community Health. My interest centers on children, breast feeding and solutions for making our children healthier and having improved health outcomes over their lives.

I am conducting a study around breastfeeding in the black/African American community titled: *Primary Factors Affecting Breastfeeding in African American Communities.* The purpose of this study is to gain an understanding of why blacks/African American breastfeed at a rate much less than other groups when there is an abundance of evidence that show babies that are breastfed are healthier. Factors that influence breastfeeding decisions such as barriers and culture will be examined. This study can inform policy makers, legislators and others on designing interventions that promote breastfeeding in this community.

If you choose to be a part of this study, your participation will be kept strictly confidential. I will spend about 1.5 to 2 hours conducting an interview of you by phone or in a mutually agreed on place. If it works better for you to complete the forms and respond to the interview questions in writing and call me with any questions for further discussion, that will be acceptable too. You will be asked to complete a short Demographic Questionnaire in addition to the interview questions. I will also record in person interviews with your permission.

Participation in this study is voluntary. You may withdraw from the study at any time. There are no anticipated risks associated with this study. A small monetary incentive will be provided for your participation.

If you have questions or concerns, please contact me by email or phone. My email address is: lowetaylorann@yahoo.com. My phone number is 253-589-2621.

Thank you so much for participating in this study. Please return the forms to me as soon as possible. If you need my address, please contact me. Thank you.

Lowest Jefferson, REHS/RS, MS, PhD Candidate
Walden University Student

Appendix I: Consent Form

Dear Breastfeeding Study Participant:

This study is being conducted by Lowest Jefferson, a doctoral student at Walden University. The title of the study is: *Primary Factors Affecting Breastfeeding in African American Communities.* You are invited to take part in this research study to help provide insight into breastfeeding in the black/African American community. You were chosen for this study because you are black/African American, and identify as such; over 18 years of age; have a child that is 3 years old or less; and your child lives with you. This form is part of a process called "informed consent."

Background Information:

The literature identifies African Americans as being most at risk for not breastfeeding, leaving African American children most at risk for poor outcomes associated with the lack of breastfeeding. Few studies actually asked black/African American women why (or why not) they choose to breastfeed or continue to breastfeed. This study will help to bridge the gap in literature by looking at these variables and others to gain a further understanding of the impact they may have on breastfeeding by African American mothers.

Procedures:

As a participant in this study you will be asked to complete a Demographic Questionnaire, and respond to 7 questions during a one on one in-person interview. A follow-up interview might be needed in some cases. The interview questions relate to

factors that contribute to your decision to breastfeed or not breastfeed. These factors may be related to culture, housing, education, knowledge, spousal or partner preference, etc. An example of an interview questions is: African American women tend to breastfeed less often and for shorter times than Caucasian or Hispanic women. Do you have any ideas about why this might be?

Voluntary Nature of the Study:

Participation in this study is strictly voluntary. You may discontinue participation at any time.

If there are questions that are too personal, you do not have to answer them. It will take approximately 1.5 – 2 hours for the initial face-to-face data collection interview. A second interview is not anticipated, but in case one is required it will take approximately 0.5 hours or less, and will be conducted by phone. You will be treated with the upmost respect while participating in this study. No one from Walden University will contact you if you decide not to participate in the study or end your participation before the study is completed.

Risks and Benefits of Being in the Study:

There are no risks associated with this study. There are no potential conflicts of interest that the researcher is aware of. The potential benefits of the study are an infusion of knowledge for policy makers and those designing breastfeeding interventions for blacks/African Americans; and a greater understanding of how culture impacts breastfeeding in the black/African American community.

Compensation:

Participants will be given a small monetary "thank you" incentive of $5.00 - $10.00 at the time of the data collection interview.

Privacy/Confidentiality:

All information provided will be kept strictly confidential. Your information and result of the interview (s) will not be used for any purpose other than this research project. All research documents except for this document will be coded with a code number versus your name or other identifying information. Research data will be kept secure for 5 years, as required by Walden University.

Contacts and Questions:

If you have questions feel free to contact the researcher Lowest Jefferson by email at: lowetaylorann@yahoo.com or call me at 253-589-2621. If you want to talk privately about your

rights as a participant, you can call Dr. Leilani Endicott at: (612) 312-1210. She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is **06-27-14-0118644** and it expires on **June 26, 2015.** You will be provided a copy of this form for your records during the initial face-to-face in-person data collection interview. Please keep this consent from for your records.

Statement of Consent:

I have read the above information, and the researcher has explained the study to me and my role in it. I feel I understand enough about the study to make an informed decision to

participate. By signing below, I agree to participate in the study, the interview and any follow-up. I understand that the interview or interviews will be tape recorded.

Participant's contact phone number _____

Printed Name of Participant:_____

Participant Signature:_____

Date of Consent:_____

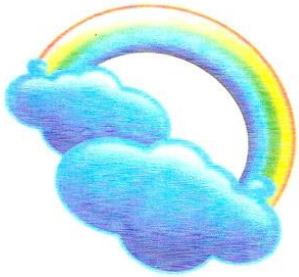
Researcher's

Signature:_____

Appendix J: Letters of Agreement for Recruitment of Participants

Rainbow House

8807 Carol Ave South
Lakewood, Washington 98499
Telephone 253-581-4851
Cell: 253-297-1363
Fax 253-584-8790



May 25, 2014

Lowest Jefferson
10118 – 101st St SW
Lakewood, Washington 98498

Dear Lowest Jefferson,

Thank you for your inquiry about Rainbow House distributing flyers to help with recruitment of participants for your study about breastfeeding in the African American community. Based on my review of your research proposal, I am pleased to have Rainbow House pass out your flyers. I understand that my organization will not take part in the recruitment or the study beyond what is contained herein. We do not expect compensation for allowing you to pass out flyers. I understand that individuals participating in the study will do so on a strictly voluntary basis. I reserve the right to not distribute the flyers if circumstances change at any time.

As owner/operator of Rainbow House, I confirm that I have the authority to approve this arrangement.

Thank you, and good luck in completing your dissertation.

Sincerely,

Pamela Rawlins, Owner/Operator

Cc: irb@waldenu.edu

-----Original Message-----
From: BLUEPR10 <BLUEPR10@aol.com>
To: jeffuh <jeffuh@aol.com>
Sent: Sun, May 4, 2014 5:44 pm
Subject: (no subject)

May 4, 2014

Dear Ms. Jefferson,

Rainbow House is happy to volunteer to help pass out your recruitment brochures in support of your dissertation efforts on "Primary Factors Affecting Breastfeeding in African American Communities." Please deliver about 15 brochures to Rainbow House when you are ready for them to be passed out in the community. This outlines the scope of Rainbow House's commitment to your study. Rainbow House
wish you much success in your future endeavors. Please share the outcome of your study with us when it is completed.

Thank you.

Pamela Rawlins, Owner of Rainbow House

-----Original Message-----
From: jeffuh <jeffuh@aol.com>
To: BLUEPR10 <BLUEPR10@aol.com>
Sent: Sun, May 4, 2014 10:47 am
Subject: Recruitment of Participants for Study on Breastfeeding in the
African American Community

Dear Ms. Rawlins (Owner of Rainbow House)

I am a Ph.D. student at Walden University. My dissertation research is titled: "Primary Factors Affecting Breastfeeding in African American Communities." This is an important subject that needs more examination because of the low breastfeedning rates among African Americans as compared to other racial and ethnic groups. We know that breastfeeding is best and helps to give babies a healthy start in life. I have prepared the attached brochure to hand out when recruiting participants for this study. Based on our previous conversation, Rainbow House will voluntarily pass out recruitment brochures in latter May or early June to assist with recruitment of participants for the study. Beyond passing out brochures, Rainbow House will not participate in the study; nor is there an expectation of compensation. A copy of the brochure is attached for your review. The brochure contains information about the study. Participation in the study is strictly voluntary and confidential.

If you have questions, please contact me at: 253-589-2621. I want to thank you in advance for your assistance.

Sincerely,
Lowest Jefferson, REHS/RS, MS