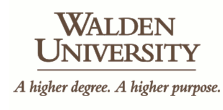

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Deborah Jarrett

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University
2017

Abstract

Breastfeeding Perceptions of First-Time African American Mothers

by

Deborah Annmarie Jarrett

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2017

Abstract

Breastfeeding is associated with numerous health and social benefits. Although support for breastfeeding is promoted globally, disparities in breastfeeding rates and support continue. African American mothers have lower breastfeeding rates than do Hispanic and Caucasian mothers. Several researchers have focused on the benefits of breastfeeding support, but no available research has explained any specific ethnic group perceptions of breastfeeding. This study explored 10 first-time African American mothers' perceptions of the breastfeeding support they received from physicians, nurses, midwives, and lactation consultants. The purposeful criterion sampling strategy was used to recruit participants, and data were collected through semistructured telephone interviews. The phenomenological research strategy, the social constructivist philosophical framework, and the breastfeeding self-efficacy theory guided the research process and helped in understanding the lived experiences of the participants. Data were analyzed thematically, revealing motivating factors for breastfeeding, experiences in getting breastfeeding support, types of breastfeeding support groups, and overall breastfeeding experiences. All participants felt it was important to breastfeed for their children's health. Their main concern was a lack of adequate professional support after they gave birth. The findings from this study can contribute to positive social change by increasing awareness related to first-time African American mothers' breastfeeding experiences and perceptions. Such awareness can assist in creating culturally sensitive programs to assist more first-time African American mothers increase their self-efficacy and promote successful breastfeeding.

Breastfeeding Perceptions of First-Time African American Mothers

by

Deborah Annmarie Jarrett

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

August 2017

Dedication

I dedicate this study to my heavenly Father, who has done exceeding and abundantly above all that I asked or thought. God's mercies kept me strong and enabled me to endure the challenges of completing this arduous journey. I also dedicate this study to my grandfather Samuel Jarrett, and my dad Wilfred Jarrett who departed this life but live tenderly in my heart. Undoubtedly, their belief in my ability to excel has been a constant motivator in my life. Additionally, this study is dedicated to my family and friends, for their continued support and understanding throughout this journey.

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Next, I would like to thank my mother, siblings, aunts, and uncles for their kind words, especially during the dark days. A special thank you to my niece Antoinette Mosley and my brother Dr. Michael Jarrett, whose unwavering support helped me not to give up on my dreams. Finally, I would like to acknowledge and thank Kiddada Green and the 10 breastfeeding mothers who contributed to making this study a reality.

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Chapter 1: Introduction to the Study

Introduction

The health value of breastfeeding to mothers and infants has been established over several decades (Centers for Disease Control and Prevention [CDC], 2011, 2013; Eidelman, 2012; Hauck et al., 2011; U.S. Breastfeeding Committee, 2013a; U.S. Department of Health and Human Services, 2013). Exclusive breastfeeding, or the use of human milk, is the preferred diet for infants for at least the first 6 months of life (American Academy of Pediatrics [AAP], 2003; American Public Health Association [APHA], 2007; CDC, 2014; Drago, Hayes & Yi, 2010; International Lactation Consultant Association [ILCA], 2007). Breastfeeding is considered to be the best type of infant nutrition and is used as a model to compare and determine the efficacy of other types of infant feeding methods such as formula feeding (Salone, Vann, & Dee, 2013). Research findings revealed breastfeeding is superior to infant formula feeding due to its numerous health, financial, and socioeconomic benefits (Amin et al., 2000; Blaymore et al., 2002; Horwood, Darlow, & Mogridge, 2001; Hylander et al., 2001; Salone, Vann, & Dee, 2013; Schanler, 2001; Singhal et al., 2002). Skin-to-skin contact between the mother and the baby directly after birth helps to promote bonding and improve breastfeeding outcomes (Drago et al., 2010; Hauck et al., 2011; U.S. Breastfeeding Committee, 2013a).

Breastfeeding offers major health benefits in that it helps to enhance infants' growth and development as well as offer protection against diseases such as sudden infant death syndrome, obesity, bacterial meningitis, gastroenteritis, respiratory tract infections, necrotizing enterocolitis, and urinary tract infections (AAP, 2003; Bhandari et

al., 2003; Chulada et al., 2003; Hauck et al., 2011; Horne et al., 2004; Ip et al., 2007; Kramer et al., 2003; Oddy et al., 2003; U.S. Department of Health and Human Services, 2013; World Health Organization [WHO], 2003). Additionally, mothers who breastfeed have a lower risk for postpartum hemorrhage, obesity, osteoporosis, ovarian and breast cancer, and diabetes (AAP, 2005; Coalition for Improving Maternity Services, 2009; Collaborative Group on Hormonal Factors in Breast Cancer, 2002; Ip et al., 2007; Jernstrom et al., 2004; Lee et al., 2003; Schwarz et al., 2009; World Alliance for Breastfeeding Action, 2009). The Center of Advancing Health (2014) and Gartner et al. (2005) also found a strong association between breastfeeding and financial benefits. Breastfeeding has many financial benefits including reduced cost to purchase formula, decreased cost related to transportation needed to purchase formula and bottles, and less wages lost by the mother when caring for an ill infant (Center of Advancing Health, 2014; Gartner et al., 2005). Breastfeeding infants are also less likely to acquire infectious diseases than formula-fed infants (AAP, 2005). Major professional groups support breastfeeding as a primary goal for public health (AAP, 2003; American College of Obstetricians and Gynecologists [ACOG], 2007; APHA, 2007; Amin et al., 2000; Association of Women's Health Obstetrics and Neonatal Nurses [AWHONN], 2007; CDC, 2014; Drago et al., 2010; ILCA, 2007; National Conference of State Legislatures, 2011; WHO, 2003). Further, the CDC (2011) noted an increase in breastfeeding practices could reduce infant morbidity and mortality. In addition, the reduction in infant and maternal morbidity rates help reduce the overall health care cost burden in the United States (Ahluwalia et al., 2005; Coalition for Improving Maternity Services, 2009; Leung & Sauve, 2005). The health of mothers generates socio-economic benefits due to more

productivity and earning power (AAP, 2005; Coalition for Improving Maternity Services, 2009; Lamaze International, 2007).

In 2012, the breastfeeding rates in the United States for infants was 80% (Woznicki, 2016). Despite the high rate of infants that breastfed at birth, the rates drop dramatically as the infants' ages increased: 51% were breastfed at 6 months and 29% at 12 months (Woznicki, 2016). Forty-three percent of infants were breastfed exclusively through 3 months and 21% through 6 months (Woznicki, 2016). Breastfeeding rates in the United States vary greatly by race and ethnicity. According to a telephone survey conducted by the CDC (2011), 54.4% of African American mothers, 74.3% Caucasian mothers, and 80.4% of Hispanic mothers attempted to breastfeed. The CDC noted that effective breastfeeding support strategies from healthcare professionals can help increase breastfeeding rates.

My review of the literature in the field revealed accounts of mothers' breastfeeding experiences for several decades. Vulnerable populations such as African American mothers receive little breastfeeding support and education from healthcare providers (Hauck et al., 2011). In this study, I focused on first-time African American mothers' perceptions about breastfeeding support received from healthcare providers. The results of this study may contribute to positive social change by examining perceptions of first-time African American mothers and why breastfeeding rates are low among them, which could reduce infant morbidity and mortality among African American infants. Such awareness can assist first-time African American mothers to enhance their self-efficacy related to breastfeeding by effectively using breastfeeding support services. The findings of this study may provide healthcare professionals with

evidence-based information to assist first-time African American mothers with support to reduce difficulty with breastfeeding as well as increase self-efficacy regarding breastfeeding. First-time mothers experience more difficulty with breastfeeding and early discontinuation of breastfeeding than multiparous mothers because of the lack of supportive behaviors from healthcare professionals (Hauck et al., 2011).

The results of this study are important because the personal accounts of the participants provided clarity about their breastfeeding issues and also helped to determine how breastfeeding services are perceived by first-time African American mothers. With this study, I am the first to focus on first-time African American mothers' perceptions about breastfeeding support after the implementation of the Affordable Care Act (ACA). In this study, I explored first-time African American mothers' experiences and perceptions about breastfeeding support. Chapter 1 will include the problem statement, purpose, research question, and the theoretical and conceptual framework I used in this study. Chapter 1 will also contain a discussion regarding the nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance.

Background

Researchers have confirmed that breastfeeding has numerous benefits to infants, mothers, and society (AAP, 2005; CDC, 2013; Eidelman, 2012; Hauck et al., 2011; Kramer et al., 2001; U.S. Breastfeeding Committee, 2013a; U.S. Department of Health and Human Services, 2013). Nonsupportive breastfeeding behaviors and antibreastfeeding hospital practices negatively impact breastfeeding outcomes (Hauck et al., 2011; Hong, Callister, & Schwartz, 2003; Tarrant, Dodgson, & Choi, 2004). These nonsupportive behaviors include limited assistance from physicians, nurses, and

midwives to latch the infant to the breast (Hauck et al., 2011; Hong et al., 2003). The promotion of formula use and dissemination of conflicting or incorrect breastfeeding information were listed as barriers to breastfeeding initiation and continuation (Ekström et al., 2011; Hauck et al., 2011; Hong et al., 2003; Tarrant et al., 2004). Recent research on mothers' perceptions and experiences with breastfeeding support revealed various views (Cross-Barnet et al., 2012; Jessri, Farmer, & Olson, 2013; Kaufman et al., 2009; Lewallen et al., 2010; MacLean, 2011; Rossman & Ayoola, 2012; Schmied et al., 2011; Simpson, 2012). Results from an intervention trial conducted by Ekström et al. (2011) in 10 Swedish municipalities confirmed that some mothers perceived that breastfeeding support from midwives and child health nurses was better than other study participants.

Breastfeeding initiation and duration are also influenced by ethnic disparities, parity, and health care systems policies and practices (CDC, 2011; Cottrell & Detman, 2013; Drago et al., 2010; Hauck et al., 2011; Hong et al., 2003; Hurley et al., 2008; Jessri et al., 2013; Krystal, 2012; Li & Grummer-Strawn, 2002; Taveras et al., 2004a; Tarrant et al., 2004). Hurley et al. (2008) reported a lower rate of breastfeeding initiation and continuation among African American mothers (65%) than among Hispanic mothers (91%). Another cross-sectional study conducted in Australia revealed first-time mothers experienced greater dissatisfaction with breastfeeding support and shorter duration of breastfeeding than mothers with previous breastfeeding experiences (Hauck et al., 2011).

The Baby Friendly Hospital Initiative (BFHI) was launched in the United States in 1991 to increase breastfeeding rates (Baby- Friendly USA, 2012; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013). This combined initiative by the WHO and the United Nations Children Fund (UNICEF) facilitated a rise in

breastfeeding rates globally (Philipp et al., 2001; Saadeh & Casanovas, 2009). The BFHI was identified as an evidence-based strategy that promotes breastfeeding as the optimum infant feeding method and health keeper (WHO, 2003). Physicians, nurses, midwives, lactation consultants, nutritionists, and nursing assistants have been trained as experts to implement BFHI breastfeeding support strategies (Baby- Friendly USA, 2012; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013; VanDevanter et al., 2014). Despite the strengths of BFHI, the following limitations exist as identified by researchers:

1. Only 90% of BFHI steps were partially or fully implemented in a diverse New York City population (VanDevanter et al., 2014).
2. Almost 50% of the Baby Friendly hospitals in the United States are in areas with significantly low African American population (Jensen, 2013).
3. Only two certified Baby Friendly hospitals are located in New York City which consists of a large African American population (Drago et al., 2010).
4. The number of trained lactation support providers falls below the quota to meet BFHI requirements (Eidelman, 2012; Taveras et al., 2004b).
5. Less than 5% of BFHI facilities comply with the WHO standards, thereby influencing first-time African American mothers' breastfeeding experiences and outcome (Drago et al., 2010).

The ACA was enforced in 2010 to promote breastfeeding and attain the Healthy People 2020 breastfeeding goals (Drago et al., 2010). The provisions of the ACA ensure all mothers, including those from disadvantaged populations, have access to professional breastfeeding support services (Drago et al., 2010). Breastfeeding support in recent years

has expanded beyond encouraging mothers to breastfeed and now seeks to create environments that support breastfeeding (California Department of Public Health, 2015). Support groups provide an environment for mothers to share their experiences and obtain breastfeeding support (Romano, 2007). The Internet provides a special opportunity for mothers with similar interests and circumstances to convene as a virtual community, and this type of support can encourage mothers to overcome barriers and sustain breastfeeding (Romano, 2007).

For example, the California Breastfeeding Coalition (CBC) is a breastfeeding support group that strives to enhance the health and wellbeing of individuals through partnership directed at protecting, promoting, and supporting breastfeeding (CBC, n.d.). CBC utilizes a multifaceted approach to achieve its vision of removing barriers to breastfeeding in California (CBC, n.d.). CBC disseminates breastfeeding support information through local face-to-face forum as well as through online social media such as Facebook (CBC, n.d.). CBC's ability to achieve its goal of (a) sharing breastfeeding information, (b) coordinating services, (c) providing breastfeeding education in the community, (d) fostering coalition and networks, and (e) influencing policy changes has been linked to its collaborative work (CBC, n.d.).

Similarly, the Black Mothers Breast-Feeding Association (BMBFA) is a nonprofit organization that seeks to reduce racial disparities in breastfeeding support for African American mothers (BMBFA, n.d.). The BMBFA utilizes a system of social networks to provide breastfeeding education, support, and resources such as breast pumps to African American families as well as agencies serving African American mothers (BMBFA, n.d.). The mission of BMBFA is to assist African American families to overcome

historical and social hindrances to successful breastfeeding (BMBFA, n.d.). Besides participating in community events such as summits, fairs, and community baby showers, BMBFA is actively involved in social media activities through its Facebook page (BMBFA, n.d.). Additionally, BMBFA membership comprises of mothers and healthcare professionals who serve as breastfeeding advocates, educators, and supporters (BMBFA, n.d.). BMBFA is currently working with the CDC to increase the percentage of African American mothers who breastfeed (W.K. Kellogg Foundation, n.d). To achieve this goal, the BMBFA works with mothers who are referred from local hospitals; Women, Infants, and Children (WIC) program; and other Maternal Infant Health programs (W.K. Kellogg Foundation, n.d.). These strategies have been identified as measures to eliminate disparities in breastfeeding (Declercq et al., 2009; Drago et al., 2010; National Conference of State Legislatures, 2011; U.S. Department of Health and Human Services, n.d., 2011, 2013, 2015).

In addition to the ACA and virtual breastfeeding support communities, the WIC program is a supplemental nutrition program that offers financial assistance to breastfeeding women. One of the goals of the WIC program is to provide adequate nutrition for women who are pregnant, recently gave birth, or are breastfeeding, as well as for infants and children 5 years old and younger in low-income families (WIC, n.d.). The WIC program is funded by the federal government and managed at the state level (WIC, n.d.). Breastfeeding promotion and support, nutrition education, and health care referrals are major activities of the WIC program (WIC, n.d.). Acceptance to the WIC program requires that recipients (a) are pregnant, (b) are an infant or child 5 years old or younger, (c) are a breastfeeding mother, (d) are evaluated at the WIC clinic by a

healthcare professional, and (e) meet the income guidelines (WIC, n.d.). The income eligibility guidelines for WIC applicants are issued yearly by the U.S. Department of Health and Human Services (WIC, n.d.). WIC applicants must have an income at or below the standard level determined by the state (WIC, n.d.). This standard level is also referred to as the federal poverty level (U.S. Department of Agriculture Food and Nutrition Service, 2016; WIC, n.d.).

In 2014, the number of individuals who benefited from WIC programs was greater than 8 million (Families USA, 2016; WIC, n.d.). Research findings on the other hand show a negative association between involvement in the WIC program and breastfeeding rates at all levels in the United States (Jensen, 2012). Other researchers also confirmed ethnic/race differences in mothers' perceptions of the WIC breastfeeding program (Hurley et al., 2008; McCann, Baydar, &Williams, 2007).

Several researchers focused on the value of breastfeeding support, but no available research explained mothers' perceptions of breastfeeding support following the ACA guidelines (Kaunonen, Hannula, & Tarkka, 2012; Saadeh & Casanovas, 2009). Furthermore, no previous researchers have explored any specific ethnicities and their perceptions of breastfeeding. As a result, it is not known why breastfeeding rates for African American women are notably lower than for other ethnic groups. Researchers have postulated that potential factors for poor breastfeeding rates include breastfeeding ambivalence, ease of access and availability to free formula through programs such as WIC, comfort with formula feeding, oversaturation of supplemental support from programs such as WIC, and trust issues regarding support from health care providers (Chapman & Perez, 2012).

In this study, I am the first to explore the breastfeeding experiences of first-time African American mothers after the implementation of the ACA. I selected first-time African American mothers for this study because of their consistently low breastfeeding rates compared to other ethnicities (Drago et al., 2010). The results of this study have the potential to contribute to social change by promoting positive breastfeeding support behaviors and perceptions. I believed an exploration of first-time African American mothers' perceptions of breastfeeding support was likely to increase awareness of their lived experiences. Understanding of these experiences and the meanings women ascribe to their breastfeeding support experiences could assist health care providers to target evidence-based breastfeeding support strategies more effectively to the mothers' concerns and experiences. This may assist first-time African American mothers in overcoming breastfeeding barriers and may also increase their breastfeeding rates to achieve the Healthy People 2020 national breastfeeding rate of 82%.

Problem Statement

Breastfeeding is linked to improved health outcomes for mothers and children (CDC, 2013; U.S. Breastfeeding Committee, 2013a; U.S. Department of Health and Human Services, 2013). The BFHI efforts are directed at supporting breastfeeding globally through education, psychological support, and tangible or interpersonal assistance (Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2011). The BFHI program supports and rewards institutions that empower mothers to breastfeed (Baby-Friendly USA, 2012). Healthy People 2020 established a goal to increase the percentage of breastfeeding mothers from 79% to 82% (U.S. Department of Health and Human Services, 2013).

As evidenced by the literature, perceptions and experiences of breastfeeding support vary by ethnicity and parity (Hong et al., 2003; Hurley et al., 2008). It is not known what the current perceptions are of first-time African American mothers who are seeking breastfeeding support (Kaunonen et al., 2012; Saadeh & Casanovas, 2009). Only 29% of African American mothers breastfed, and first-time mothers were less likely to have positive perceptions of the experience or maintain breastfeeding (Drago et al., 2010).

Researchers hypothesized that beliefs, cultural practices, and theories related to infant feeding practices influence perceptions of breastfeeding (Drago et al., 2010; Hurley et al., 2008; Krystal, 2012; Lee et al., 2007). Poor cultural competency and hospital policies were linked to perceptions of inadequate breastfeeding support provided to migrants (Jessri et al., 2013; Taveras et al., 2003). Mothers from the Middle East reported inadequate support from health care professionals and language barriers as key hindrances to their breastfeeding experiences in Western societies (Jessri et al., 2013; Taveras et al., 2003). The goal of this qualitative phenomenological study was to understand the perceptions and experiences of first-time African American mothers' with healthy, full-term, uncomplicated births on the breastfeeding support provided to them. The results could help healthcare providers and policy makers design culturally competent breastfeeding support strategies to improve breastfeeding rates.

Purpose of the Study

The purpose of this qualitative phenomenological study was to explore 10 first-time African American mothers' experiences and perceptions about breastfeeding while seeking breastfeeding support. According to Creswell (2007), a sample size of five to 25

individuals is appropriate for qualitative phenomenological studies. This is necessary since the sample size and sampling strategy are influenced by the unit of analysis, the study purpose, data requirement, and available resources (Patton, 2002). My selected sample size for this study was appropriate to provide adequate in-depth information and fulfil the study purpose (see Onwuegbuzie & Leech, 2007). The purposeful sample consisted of English speaking mothers who delivered full-term infants who required only well newborn care. I recruited the participants through advertisements on the BMBFA Facebook page. My data collection for this study included audio-recorded, semistructured telephone interviews comprised of open-ended questions (see Appendix C) and a demographic survey (see Appendix D). The results of this study may increase first-time African American mothers' understanding of why they have low breastfeeding rates and enhance their self-efficacy related to breastfeeding. The findings of this study may also provide healthcare professionals with evidence-based information to develop a model staff development program on cultural competency and a culturally sensitive breastfeeding education program to assist first-time African American mothers.

Research Question

The single research question that I developed to guide this study focused on first-time African American mothers' perceptions and experiences of breastfeeding support. The research question guided my exploration of the mothers' personal meaning of breastfeeding support and revealed new information about the ways breastfeeding support is perceived by first-time African American mothers. The research question was: What are first-time African American mothers' perceptions and experiences of breastfeeding support?

Theoretical and Conceptual Framework for the Study

This study was guided by the phenomenological research strategy, the social constructivist philosophical framework, and the breastfeeding self-efficacy theory. These theoretical frameworks were essential in helping me (a) explore the lived experiences of first-time African American mothers, (b) understand how individuals construct reality, and (c) explain and predict maternal self-confidence level. The theories were instrumental in guiding my research process, and I will discuss them extensively in Chapter 2 of this study.

Phenomenology

Phenomenology is a philosophy and research strategy used to understand individuals' perceptions of their lived experiences (Aspers, 2004; Kafle, 2011). According to Wilson (2002), phenomenology is the study of human lived experiences, rather than causes, objective reality, or appearances. The key elements of phenomenology are description, reduction, essences, and intentionality (Wilson, 2002). In a phenomenological study, the researcher seeks to describe the individual's personal experience of the phenomena by facilitating the emergence of hidden meanings without influencing the results of the study; this process is referred to as reduction (Wilson, 2002). Essence is considered to be the individual's interpretation and feelings related to the experience, while intentionality is the conscious awareness and value of the experience to the individual (Kafle, 2011).

Phenomenology can be further divided into hermeneutic phenomenology. I used hermeneutic phenomenology in this study due to its descriptive and interpretive components. Hermeneutic phenomenology is the theory and practice used to understand

an individual's understanding and feelings about an experience (Higgs, Paterson, & Kinsella, 2012). The key constructs of hermeneutic phenomenology are (a) fusion of horizons, (b) dialogue of questions and answers, and (c) the hermeneutic circle (Higgs et al., 2012). Fusion of horizons is the use of dialogue to obtain different interpretations and understanding of a phenomenon being studied (Higgs et al., 2012). Dialogue of questions and answers is similar to analysis of textual data to understand the participants' account fully (Higgs et al., 2012). The hermeneutic circle involves reading, reflective writing, and interpretation (Embree, 1997; Higgs et al., 2012; Kafle, 2011; Langdridge, 2007; van Manen, 1990). In this type of study, the researcher is required to reflect deeply on the textual data to understand the meaning of the experience and reveal hidden meanings and intentions in the data; rich textural accounts of the lived experience can then be obtained (Embree, 1997; Higgs et al., 2012; Kafle, 2011; Langdridge, 2007; van Manen, 1990).

My application of the hermeneutic phenomenological constructs to this study included the use of semistructured interviews to dialogue with the participants. I obtained rich textual data related to the participants' perception of breastfeeding support using the open-ended interview questions. A sequence of questions and answers facilitated reflective writing and clear interpretation of the participants' breastfeeding account (see Higgs et al., 2012; Kafle, 2011).

Social Constructivist Philosophical Framework

The second theoretical framework I used in this study was the social constructivist philosophical framework as discussed by the works of Berger and Luekmann (1967), Lincoln and Guba (1985), Schwandt (2007), Neuman (2000), and Crotty (1998). The social constructivist perspective involves interpretivism that allows the researcher to

understand how individuals construct meanings from lived experiences (Creswell, 2007, 2009; Patton, 2002; Research Methodology, 2014; Robert Wood Johnson Foundation, 2008). The social constructivist framework is suitable for qualitative research methods because it is based on the premise that individuals interpret and develop personal meanings from experiences gained through social interactions (Research Methodology, 2014; Robert Wood Johnson Foundation, 2008). My application of the social constructivist philosophical framework allowed me to explore the complex views of the participants of the study. These views were used to understand first-time African American mothers' personal meanings about breastfeeding support services.

Breastfeeding Self-Efficacy Theory

Incorporating Bandura's (1977) social cognitive theory, the breastfeeding self-efficacy theory was created by Dr. Dennis in 1999. The breastfeeding self-efficacy theory has been used to improve mothers' breastfeeding confidence as well as breastfeeding support strategies. This theory has been used to explain and predict breastfeeding behaviors. The breastfeeding self-efficacy scales are used to identify individuals' level of self-confidence (Dennis, 1999; Dennis & Faux, 1999; Phillips, 2010).

Breastfeeding self-efficacy is defined as a mother's belief in her ability to breastfeed her baby; self-efficacy has been known to influence breastfeeding decisions and outcomes (Dennis, 1999; Dennis & Faux, 1999; Eidman, 2011; Phillips, 2010). The four key constructs of the breast feeding self-efficacy theory are performance accomplishment, vicarious experiences, verbal persuasion, and physiological and affective state inferences (Dennis, 1999; Dennis & Faux, 1999; Phillips, 2010).

According to Dennis (1999), a mother's self-efficacy is enhanced after having a positive or successful breastfeeding experience in contrast to a mother who failed at breastfeeding. Vicarious experiences through observational learning influence self-efficacy (Dennis, 1999; Dennis & Faux, 1999; Phillips, 2010). Researchers suggest lactation experts can positively influence a mother's breastfeeding experience by providing clear step-by-step breastfeeding instructions and tangible support (Hauck et al., 2011), which are support services available to all African Americans and new mothers. Verbal persuasion in the form of encouragement from healthcare professionals, family, and friends can increase breastfeeding self-efficacy skills. Physiological and affective state inferences, such as feelings of satisfaction or pain, impact individuals' self-efficacy, decisions, performance, and breastfeeding continuation (Dennis & Faux, 1999; Phillips, 2010; Dennis, 1999). In this study, I incorporated the key constructs of the breastfeeding self-efficacy theory to empower first-time African American mothers to breastfeed their newborn confidently.

Nature of the Study

In this qualitative phenomenological study, I explored first-time African American mothers' experiences and perceptions about breastfeeding support obtained from healthcare providers, based on the lack of research on specific ethnicities' experiences with the program. The phenomenological research approach I took in this study involved interaction with individuals. This approach facilitated the identification and understanding of individuals' experiences about a phenomenon (see Creswell, 2009; Rudestam & Newton, 2007).

I selected a purposeful sample of 10 first-time African American mothers who delivered term infants requiring only well-newborn care. I recruited the participants through advertisements on the BMBFA Facebook page. I then used multiple semistructured in-depth interviews to collect data from the participants. The interview questions consisted of open-ended questions with an emerging design. I transcribed the data using interview notes and audio-recording. Data analysis for this study included content and inductive analysis procedures. I used the NVivo, Version 11 computer software to auto-code and store data. The data analysis process generated emerging themes and provided an understanding of how breastfeeding support was experienced by the study participants. Ethical issues and personal biases were eliminated by establishing my role as the researcher. The achievement of data validity and accuracy occurred by allowing the themes to emerge and ensuring the credibility, authenticity, transferability, and confirmability of the study findings.

Definitions

For reader clarity, I will define the following terms used in this study:

Breastfeeding: The practice of feeding an infant with milk through the act of suckling at the mother's breast (Breastfeeding, 2012).

Breast-feeding continuation: The ongoing process of breastfeeding with or without supplements (CDC, 2013).

Breast-feeding duration: The length of time the infant is breastfed (CDC, 2013).

Breast-feeding initiation: The first time a mother puts the baby to the breast for feed (CDC, 2013).

Breast-feeding intent: A mother's desire during the prenatal period to breastfeed her baby (Perrine et al., 2012).

Breastfeeding self-efficacy: A mother's belief in her ability to breastfeed her baby (Dennis & Faux, 1999; Phillips, 2010; Dennis, 1999; Eidman, 2011).

Breastfeeding support: The physical, emotional, and educational support provided by healthcare givers to women during the prenatal and the intrapartum and postpartum periods (Hong et al., 2003).

Early breast-feeding initiation: Beginning breast-feeding within the first hour after birth (CDC, 2013).

Exclusive breast-feeding: The use of only human milk to feed an infant (CDC, 2013; Rossman & Ayoola, 2012).

Hermeneutics: The theory and practice of uncovering human understanding and emotions about an experience (Higgs et al., 2012; Kafle, 2011).

Informational support: Assistance provided by healthcare givers such as information about breastfeeding resources, teaching and assessing breast-feeding techniques and positions, and answering questions adequately (Hong et al., 2003).

Intrapartum period: Extends from the beginning of labor to complete delivery of the infant and placenta (CDC, 2013).

Lived experience: The daily personal experience of individuals (Aspers, 2004; Kafle, 2011).

Parity: The number of times a woman as given birth ("Parity," 2015).

Prenatal period: The time of pregnancy until the period before giving birth (CDC, 2013).

Phenomenology: A research strategy and philosophy used to understand individuals lived experiences and perception of the experiences (Aspers, 2004; Kafle, 2011).

Postpartum period: The first 6 weeks after giving birth to a child (CDC, 2013).

Psychological/emotional support: Provision of reassuranc, and direct assistance with breastfeeding (CDC, 2013).

Room in: The practice of allowing mother and baby to remain together at all times (U.S. Department of Health and Human Services, 2013).

Tangible support: The provision of aids to enhance breastfeeding such as nipple cream, contact information for support groups, and audio-visual materials (Hong et al., 2003).

Term infants: Babies born between 37 and 42 weeks gestation (American Congress of Obstetricians and Gynecologists, 2015).

Assumption

The following assumptions framed this phenomenological study. I assumed first-time African American mothers would openly share their breastfeeding experience. I assumed the psychological and physiological changes created by breastfeeding were worthy of a study to highlight the individual's lived experiences. I also assumed the mothers' perceptions could reveal what they consider to be the truth about their breastfeeding experience. Finally, I assumed the targeted breastfeeding support strategies could increase the breastfeeding rate among first-time African American mothers because as the participants use breastfeeding support services and become more knowledgeable, their self-efficacy of breastfeeding will increase. These assumptions were based on the

theoretical frameworks guiding the study and the idea that arriving at an understanding of the participants' lived breastfeeding experience could create more appropriate breastfeeding support strategies.

Scope and Delimitations

The scope of this study was first-time African American mothers who intended to breastfeed. All participants had uncomplicated vaginal deliveries of term infants who required only well-newborn care. Only English speaking mothers participated in the current study to prevent translation problems. I selected a purposeful sample of 10 first-time African American mothers 18 years and older. Purposeful sampling was used to accomplish the study purpose and research question. The participants were recruited through advertisements on BMBFA Facebook page. I instructed interested participants to e-mail me directly with a statement of interest to participate. A second e-mail containing a copy of the consent form was sent to each of the 10 selected participants to be signed and returned to my e-mail address. A third follow-up e-mail was sent requesting a convenient date and time to conduct the telephone interview once the signed consent was obtained. I then collected data using one-on-one telephone interviews. Audio-recorded, open-ended, semistructured interview questions yielded breastfeeding (see Appendix D) and demographic data (see Appendix E). I conducted the interviews within the first 6 to 7 months after delivery to minimize bias due to recollection and to increase the retention rate. Data collection continued until no new information was obtained.

I excluded mothers who had complications associated with labor and delivery and were not able to initiate breastfeeding from the study population. Mothers who delivered preterm infants (less than 37 weeks gestation), had previous births, and mental health

issues were not eligible to participate in the study. The main delimitation was to explore the perceptions of African American mothers with no prior breastfeeding experience. The phenomenological research strategy, the social constructivist philosophical framework, and the breastfeeding self-efficacy theory informed my research process to provide a deeper understanding regarding the perceptions and lived experiences of first-time African American breastfeeding mothers. I considered other qualitative research strategies as well as quantitative and mixed-methods research designs but rejected them since these methods would not provide an opportunity to interact with the participants and deeply explore the phenomenon.

Limitations

The phenomenological qualitative research design and purposeful selected sample were limitations to this study. These methods do not employ rigorous random sampling or generalization to other populations (Aspers, 2004; Kafle, 2011; Patton, 2002). I addressed the trustworthiness of this study by ensuring the credibility, authenticity, transferability, dependability, and confirmability of the study findings. The use of open-ended interview questions facilitated data triangulation and emergence of rich data.

The second limitation was that I, as the researcher, was the key person to collect and analyze the data. Interaction between the researcher and the participants can lead to personal biases and minimize the validity of the study (van Manen, 1990; Wojnar & Swanson, 2007). A potential bias could have resulted from my role as a labor and delivery nurse with knowledge of breastfeeding support strategies. I used self-reflection and bracketing to avoid influencing the data collection and analysis process. As the researcher and key data collection and analysis instrument, I openly disclosed my

personal interests and biases related to breastfeeding. I also actively listened and transcribed the participants' experiences verbatim to minimize bias (see Chan, Fung, & Chien, 2013).

Significance

While there are several studies focusing on the benefits of breastfeeding support, there is a paucity of research explaining African American mothers' perceptions of breastfeeding support (Kaunonen et al., 2012; Saadeh & Casanovas, 2009). In this study, I am the first to focus on any specific ethnicity of first-time mothers' perceptions about breastfeeding support after the implementation of the ACA. The results of this study may lead to positive social change as first-time African American mothers' perceptions of breastfeeding support strategies are explored. Such awareness can assist first-time African American mothers to enhance their self-efficacy related to breastfeeding by effectively utilizing breastfeeding support services. An understanding of why breastfeeding rates are low among African American mothers could reduce morbidity and mortality among African American infants.

This study may empower first-time African American mothers who use breastfeeding support services to overcome barriers hindering positive breastfeeding experiences. As such, empowering these women can help to eliminate disparities in breastfeeding as it may encourage more first-time African American mothers to breastfeed. The findings of this study could provide additional information to guide the development of effective and culturally competent evidence-based breastfeeding support guidelines as well as assist in attainment of the Healthy People 2020 goals by increasing the number of first-time African American mothers who breastfeed. Understanding of

the experiences and meanings women ascribe to their breastfeeding support experiences may assist healthcare providers to target evidence-based breastfeeding support strategies more effectively to the mothers' concerns and experiences.

Summary

Breastfeeding offers several maternal, pediatric, and social benefits. Considering its health benefits and nutritional value, breastfeeding is promoted as the optimum form of nutrition for infants (CDC, 2013; Eidelman, 2012; 2012; Hauck et al., 2011; Kramer et al., 2001; U.S. Breastfeeding Committee, 2013a; U.S. Department of Health and Human Services, 2013). Global support for breastfeeding has also been enhanced through the efforts of various organizations such as the BFHI (CDC, 2013). Access to professional breastfeeding support is now being provided through the ACA services, and these breastfeeding support services were created to equalize breastfeeding opportunities and choices for all mothers (Drago et al., 2010).

According to Ekström et al. (2011), a mother's perception of breastfeeding support may be influenced by her personal experiences. Research evidence also confirmed that African American mothers have lower rates of breastfeeding because of lack of support (Drago et al., 2010). In this study, I explored first-time African American mothers' perceptions and experiences with breastfeeding support.

In Chapter 1, I highlighted the problem statement, purpose, research question, conceptual framework, nature, definitions, assumptions, scope and delimitations, limitations, and significance of this study. Chapter 2 will contain a review of the existing literature on the subjects related to mothers' perceptions of breastfeeding support in

order. In the literature review, I will cover historical breastfeeding information, current breastfeeding information, the theoretical framework, and provide a conclusion.

Chapter 2: Literature Review

Introduction

The purpose of this phenomenological study was to learn about first-time African American mothers' perceptions of the breastfeeding support they received from healthcare providers. My goal with this research was to empower first-time African American mothers to enhance their breastfeeding self-efficacy skills and overcome barriers that impede positive breastfeeding experiences. The findings of this study may provide additional information to guide the development of effective and culturally competent evidence-based breastfeeding support guidelines as well as assist in attainment of the Healthy People 2020 breastfeeding goals. With this study, I am the first to focus on first-time African American mothers' perceptions about breastfeeding support after the implementation of the ACA. This chapter will include an analysis of the existing literature on the subjects related to the research topic. In this literature review, I will critically evaluate the designs, methodologies, findings, controversies, and implications of relevant studies about mothers' perceptions of breastfeeding support.

Organization and Research Strategy

I organized the literature review to cover four major topic segments: (a) the background, including breastfeeding as a public health promotion strategy; (b) the current situation, including breastfeeding support strategies and perceptions of breastfeeding support; (c) a discussion on phenomenology, social constructivist philosophical framework, and breastfeeding self-efficacy theory; and (d) the conclusion. I used both formal and informal approaches to obtain data from the sources. I conducted a

systematic search of multidisciplinary databases through Walden University Library, Google Scholar, and the *American Journal of Maternal and Child Health Nursing*.

The main databases that I used were Medline, Science Direct, EBSCO Host, Pubmed, ProQuest, and *American Journal of Maternal and Child Health*. I also included websites for organizations such as the Centers for Disease Control and Prevention (CDC), Baby- Friendly USA, and U.S. Department of Health and Human Services. Keyword search terms used included *first-time mothers' perceptions of breastfeeding support*, *African American mothers' perceptions of breastfeeding support*, *breastfeeding perceptions according to ethnicity and parity*, and *breastfeeding support strategies*. I also reviewed the reference list of articles I located to obtain additional studies to strengthen the literature review and establish the framework for this study. My review of the literature revealed a deficiency of available studies on any specific ethnicity of first-time mothers' perceptions of breastfeeding support. This clearly confirmed the need for this study, in which I attempted to explain how first-time African American mothers experience the breastfeeding support provided to them.

Theoretical Framework

Theoretical Connections to Study

These current study was shaped by three elements: the phenomenological research strategy, the social constructivist philosophical framework, and the breastfeeding self-efficacy theory. Phenomenology as the foundation to identify the essence of first-time African American mothers' breastfeeding experiences. The social constructivist philosophical framework provided guidance on how individuals construct reality. The breastfeeding self-efficacy theory was used to explain and predict maternal self-

confidence levels. Together, these theories and philosophical frameworks informed my research process and provided a deeper understanding of the perceptions and lived experiences of first-time African American breastfeeding mothers.

Phenomenology

Phenomenology is a theory used to understand individuals' lived experiences and their perceptions of those experiences (van Manen, 1990; Wilson, 2002). Phenomenology employs a reflective process between the researcher and the participant to solve problems, since individuals reflect on an experience as a means to develop an understanding of a given phenomenon (Armour et al., 2009; Bloomberg & Volpe, 2008; Cohen et al., 2000; Creswell, 2009; Ehrich, 2005; Langdridge, 2007; Mapp, 2008; Patton, 2002; Polit et al., 2001; van Manen, 1990; Wilson, 2002). The key qualities of phenomenology are description, reduction, essences, and intentionality (Ehrich, 2005). Wilson (2002) explained that phenomenology is the study of human phenomena without focusing on causes, certainty, or appearances.

The aim of phenomenology is to study how humans consciously experience a phenomenon and how such experiences may be valued. In a phenomenological study, the researcher aims to describe the phenomena, while using bracketing as a reduction strategy to facilitate emergence of hidden meanings (Chan et al., 2013; Creswell, 2007). Bracketing is used by qualitative researchers to minimize bias by putting aside personal values, beliefs, knowledge, and assumptions that could influence the results of the study (Chan et al., 2013; Creswell, 2007). Essence is defined as an individual's basic interpretation and inner feeling about an experience, while intentionality is the conscious awareness of the experience and what it means to the individual (Ehrich, 2005).

Phenomenology is also further divided into subsections (Kafle, 2011). I used the hermeneutic phenomenology approach since its descriptive and interpretive elements are relevant to this qualitative study.

Hermeneutics is the approach and practice of uncovering human understanding and emotions about an experience (Higgs et al., 2012; Kafle, 2011). Hermeneutic phenomenology seeks to understand human experiences about a phenomenon as interpreted and described by participants. The key philosophical constructs of hermeneutic phenomenology are (a) fusion of horizons, (b) dialogue of questions and answers, and (c) the hermeneutic circle (Higgs et al., 2012). Fusion of horizons relates to the use of dialogue to generate different interpretations and a shared understanding of a phenomenon (Higgs et al., 2012). Dialogue of questions and answers refers to analysis of the textual data by the researcher to get a better understanding of the account (Higgs et al., 2012). The hermeneutic circle is the repeated analysis of parts of the textual data in order to allow emergence of the entire phenomenon (Higgs et al., 2012). Key areas of this hermeneutic circle are reading, reflective writing, and interpretation (Higgs et al., 2012). In applying these principles, the researcher is required to reflect deeply on the textual data to understand the meaning of the experience and illuminate hidden meanings and intentions in the textual data (Higgs et al., 2012). Rich textural descriptions of the lived experience can then be obtained (Creswell, 2007; Embree, 1997; Higgs et al., 2012; Kafle, 2011; Langdridge, 2007; van Manen, 1990).

Intersubjectivity is another facet of hermeneutic phenomenology that focuses on how individuals construct meanings while interacting with others (Wilson, 2002) explaining the *what* and *how* or nature of the participants' experiences (Creswell, 2007).

Qualitative researchers believe this is necessary since reality differs between people, creating the need to understand the core value of the experience to the individual (Bloomberg & Volpe, 2008; Cohen et al., 2000; Mapp, 2008; Polit et al., 2001; van Manen, 1990). The hermeneutic phenomenological research strategy was relevant to this study as awareness of African American mothers' low breastfeeding rates and an exploration of their lived breastfeeding experiences facilitated a deeper understanding of the essence of their experiences. Awareness of the problem can help to create better protocols and programs to assist first-time African American mothers with breastfeeding.

My application of hermeneutic phenomenological constructs to this study included interacting with participants through semistructured interviews. The open-ended interview questions I asked generated rich textual data related to the participants' perception of breastfeeding support. A series of questions and answers facilitated reflective writing and clear interpretation of the participants' account of breastfeeding (Higgs et al., 2012; Kafle, 2011).

Social Constructivist Philosophical Framework

Alongside the phenomenological research approach, I used the social constructivist philosophical framework in this study to understand how first-time African American mothers construct meaning from their breastfeeding experiences. The social constructivist philosophical framework was conceptualized by Mannheim (1936) and further developed by Berger and Luekmann (1967), Lincoln and Guba (1985), Schwandt (2007), Neuman (2000), Crotty (1998), and others (including Creswell, 2009). This philosophical perspective also incorporates interpretivism, which allows the researcher to rely on the participants' complex views of the phenomena as well as understand how

individuals construct knowledge from lived experiences (Creswell, 2007, 2009; Patton, 2002; Research Methodology, 2014; Robert Wood Johnson Foundation, 2008).

Social constructivist researchers assert that individuals develop personal meanings from their experiences of social interactions (Research Methodology, 2014; Robert Wood Johnson Foundation, 2008). The social constructivist philosophical framework has been used by Courtenay (2000) in healthcare to understand why individuals adopt certain health beliefs and behaviors. Thomas et al. (2014) also used the social constructivist theory to understand the translation of knowledge for best practices in healthcare. My review reaffirmed that although the use of the social constructivist theory was inadequate in the literature of the field, its value in supporting clinicians' expression of knowledge through professional interactions was emphasized. Such knowledge translation facilitated the integration of new knowledge and evidence-based practice that directly improved patient outcomes (Courtenay, 2000; Thomas et al., 2014). Despite the absence of documented evidence regarding the application of the social constructivist theory to this research topic, the application of this framework was relevant to guide the research design of this study because I explored the complexity of views and subsequently provided understanding of the subjective meanings first-time African American mothers develop from their breastfeeding experiences.

Breastfeeding Self-Efficacy Theory

The breastfeeding self-efficacy theory was created by Dennis in 1999, incorporating Bandura's (1977) social cognitive theory, to enhance breastfeeding confidence and support strategies. The breastfeeding self-efficacy theory has been used to explain and predict breastfeeding behaviors (Dennis, 1999; Dennis & Faux, 1999).

This theory is based on the concept that a specific breastfeeding behavior is selected, executed, or maintained to achieve an expected result and ability to master the behavior (Dennis, 1999; Dennis & Faux, 1999). Behavior specific breastfeeding self-efficacy scales have also been designed to identify individuals' levels of self-confidence (Dennis, 1999; Dennis & Faux, 1999). Breastfeeding self-efficacy is defined as a mother's belief in her ability to breastfeed her baby; this confidence will influence a mother's decision to breastfeed and deal with breastfeeding challenges (Dennis, 1999; Dennis & Faux, 1999; Eidman, 2011; Phillips, 2010).

My review of literature revealed the association between maternal breastfeeding self-efficacy and breastfeeding continuation. Maternal confidence has been recognized as a key element to sustain breastfeeding; therefore, strategies to enhance self-efficacy have been identified to improve breastfeeding outcomes (Dennis & Faux, 1999). According to Dennis (1999) a mother's self-efficacy perception is linked to four key factors: performance accomplishment, vicarious experiences, verbal persuasion, and physiological and affective state inferences.

The first component of a mother's self-efficacy perception is performance accomplishment. Scientific evidence confirms that personal experience or successful performance enhances self-efficacy (Dennis, 1999; Dennis & Faux, 1999; Phillips, 2010). Equally, perceived self-efficacy is influenced by conditional factors that may facilitate or hinder performance (Dennis, 1999; Dennis & Faux, 1999; Phillips, 2010). For example, a first-time mother who required minimum assistance to initiate breastfeeding may have more positive feelings about self-efficacy than a mother who failed at a similar task (Dennis, 1999; Dennis & Faux, 1999; Phillips, 2010).

Secondly, vicarious experiences such as observational learning influence self-efficacy. Previous researchers have suggested that positive role models can promote breastfeeding behaviors in first-time mothers (Tarrant et al., 2004; U.S. Department of Health and Human Services, 2013). This goal can be achieved by using experts such as physicians, nurses, and lactation consultants to provide simple step-by-step direction to accomplish the task (Dennis & Faux, 1999; Hauck et al., 2011).

The third component is verbal persuasion, which can be obtained through appraisal from healthcare professionals, family, and friends. Valid assessment or praise from credible lactation support personnel increases mothers' perceptions of self-efficacy regarding breastfeeding skills (Dennis, 1999; Dennis & Faux, 1999). The fourth component, physiological and affective state inferences, impacts individuals' choice, performance, and maintenance of a specific behavior. For example, positive interpretation of cues experienced while performing a task may enhance self-efficacy; such feelings of satisfaction enhance self-efficacy and breastfeeding outcomes in contrast to pain or stress which may diminish self-efficacy (Dennis, 1999; Dennis & Faux, 1999; Phillips, 2010). Research evidence has suggested a mother's breastfeeding confidence may be impacted by healthcare professionals' actions (CDC, 2013; Dennis & Faux, 1999; Taveras et al., 2003).

Background

Breastfeeding has been shown to provide numerous benefits to infants, mothers, and the society (CDC, 2013; Eidelman, 2012; Hauck et al., 2011; U.S. Breastfeeding Committee, 2013; U.S. Department of Health and Human Services, 2013). Given its health benefits, breastfeeding is recognized as the gold standard for feeding infants

(CDC, 2013; Eidelman, 2012; Hauck et al., 2011; Kramer et al., 2001). Exclusive breastfeeding is endorsed as the best feeding choice for the first 6 months of an infant's life, followed by sustained supplemental breastfeeding for at least 12 months (CDC, 2013; Eidelman et al., 2012; Hauck et al., 2011).

However, recent scientific evidence confirms that although breastfeeding initiation and duration rates increased among African American, Caucasian, and Hispanic infants, African American infants had the lowest prevalence related to breastfeeding initiation (57% and duration 27%; CDC, 2013, 2014; National Conference of State Legislatures, 2011). In 2010, the national breastfeeding initiation rate was 75%, the duration rate at 6 months was 50%, and 25% at 12 months. This data revealed that the actual rates were significantly less than the Healthy People 2020 goal of 82% breastfeeding initiation rate, 61% at 6 months, and 35% at 12 months. Worksite lactation support was documented as 25% in 2007, which is less than the national goal of 38% (CDC, 2014; Drago et al., 2010; Eidelman et al., 2012; National Conference of State Legislatures, 2011; Renfrew, 2012). The discrepancy in the actual breastfeeding practices calls for an understanding of mothers' perceptions of breastfeeding support, and targeted interventions to enhance support for breastfeeding (CDC, 2013; Drago et al., 2010; Perrine et al., 2012; Saadeh & Casanovas, 2009; U.S. Breastfeeding Committee, 2013; U.S. Department of Health and Human Services, 2011, 2013).

Breastfeeding as an Important Public Health Promotion Strategy

Innovative research and technological methods prompted strong support for breastfeeding as an important health promotion strategy in the 21st century. Studies conducted by researchers highlighted numerous pediatric, maternal, and social benefits of

breastfeeding (Kramer et al., 2001). During the late 1900s, researchers at the AAP reported breastfeeding to be the most suitable strategy to promote the health and wellbeing of infants, mothers, families, and communities. The nutritional and immunologic benefits of breastmilk makes it the optimal food for newborns (CDC, 2013; Eidelman, 2012; Hauck et al., 2011; U.S. Breastfeeding Committee, 2013b; U.S. Department of Health and Human Services, 2013). Several scientific experts and healthcare practitioners such as AAP, UNICEF, WHO, CDC, AWHONN, ILCA, the ACOG, and APHA have endorsed exclusive breastfeeding as a new model of care (AAP, 2003; ACOG, 2007; APHA, 2007; Amin et al., 2000; AWHONN; 2007; CDC, 2014; Drago et al., 2010; ILCA, 2007; National Conference of State Legislatures, 2011; WHO, 2003).

Pediatric Benefits

Research findings have shown that breastfed infants receive more protection against diseases and have better growth and development outcomes (AAP, 2003; Ip et al., 2007; U.S. Department of Health and Human Services; 2013; WHO, 2003). Researchers throughout the world have already established that breastfeeding reduces the prevalence of neonatal diseases such as obesity, bacterial meningitis, ear infections, respiratory tract infections, bacteremia, gastroenteritis, necrotizing enterocolitis, and urinary tract infections (Bhandar et al., 2003; Chulada et al., 2003; Kramer et al., 2003; Oddy et al., 2003;). Studies have also revealed breastfeeding decreases the rate of sudden infant death syndrome (SIDS). This decreases infant mortality by 21% in the United States (Hauck et al., 2011; Horne et al., 2004). Such empirical evidence has been shown in a recent meta-analysis in which the researchers examined the correlation between

breastfeeding and SIDS. Findings from 18 case control studies revealed a higher odds ratio for infants who were breastfed. Breastfed infants, especially those exclusively breastfed, had a lower risk for SIDS (Hauck et al., 2011).

Breastfeeding is also considered to be a significant contributor to the prevention of chronic diseases in children. Scientific evidence confirms a lower incidence of type 1 and 2 diabetes mellitus (Bonzon, Mullen & McCoy, 2014; Freemark, 2012), Hodgkins disease, leukemia, lymphoma, obesity, hyperlipidemia (AAP, 2003, 2005; Arenz et al., 2004; Grummer-Strawn & Mei, 2004), and asthma among children who were breastfed (AAP, 2003; Chulada et al., 2003). A systematic review by Salone, Vann, and Dee (2013) on the health outcomes of breastfed infants suggested children who were breastfed had a greater chance for better dentition than formula-fed infants. In addition, for several years breastfeeding has been found to be an enhancer to neurodevelopment (Batstra, Neeleman, & Hadders-Algra, 2003; Feldman & Eidelman, 2003). Findings from a more recent randomized trial showed that children who were exclusively breastfed had better scores on the Wechsler Abbreviated Scales of Intelligence and other academic outcome evaluation measures such as performance in reading, writing, and mathematics. The results confirmed a positive correlation between breastfeeding and enhanced intellectual development in the study population of 17,046 healthy breastfeeding Belarusian infants (Kramer et al., 2008).

Other recent studies focusing on the association between breastfeeding and cognitive development in children revealed similar results. For example, Quigley et al. (2012) found a two-point score increase in cognitive development in term infants and a four-point score increase in preterm infants who were breastfed more than 4 months.

Quigley et al. analyzed breastfeeding, gestational age, and cognitive development data on term (*n* = 11,101) and preterm (*n* = 778) White singleton infants from the United Kingdom Millennium Cohort Study. After administering the British Ability Scales tests to the study population at age 5, the researchers concluded that breastfed children's cognitive development capabilities would advance by 1 to 6 months ahead of their nonbreastfed counterparts.

Maternal Benefits

Several maternal benefits have been linked to breastfeeding (Ip et al., 2007; Schwarz et al., 2009; Taylor et al., 2006). These include increased levels of oxytocin resulting in reduced risk for postpartum hemorrhage, faster uterine involution, speedy adjustment to non-pregnant weight, and less chance for obesity (AAP, 2005; Coalition for Improving Maternity Services [CIMS], 2009). Mood enhancing hormones related to breastfeeding also contribute to maternal health and wellbeing by reducing stress and the risk for osteoporosis, as well as promoting family planning through fertility regulation (AAP, 2005; CIMS, 2009; World Alliance for Breastfeeding Action, 2009). Researchers have also found certain chronic diseases can be prevented due to the maternal benefits derived from breastfeeding. Schwartz et al. (2009) reaffirmed that postmenopausal women who had a lifetime history of breastfeeding for greater than one year had less chance for developing hyperlipidemia, hypertension, cardiovascular disease, and diabetes in contrast to women who never breastfed. Researchers analyzed data from 139,681 postmenopausal women who participated in the Women's Health Initiative Study to determine the dose-response relationship between breastfeeding and cardiovascular disease risk factors. Besides the cardiovascular benefits, breastfeeding decreases the risk

for ovarian and breast cancer (Collaborative Group, 2002; CIMS, 2009; Ip et al., 2007; Jernstrom et al., 2004; Lee et al., 2003).

Social Benefits

In addition to promoting the health of the population, breastfeeding is a cost-effective measure that provides financial benefits for families, communities and the wider society (Center of Advancing Health, 2014; Gartner et al., 2005). The health of mothers and infants contributes to more productivity and attainment of organizational goals through reduced employee absenteeism (Ahluwalia et al., 2005; Reiss, 2007). Morbidity results in increased medical cost and also reduces the earning power of families (AAP, 2005; CIMS, 2009; Lamaze International, 2007). According to the AAP (2005) the socioeconomic benefits of breastfeeding result in savings for the family and nation that can be used to offset the cost for breastfeeding support strategies.

Breastfeeding helps to decrease infant and maternal morbidity rates and can contribute to a reduction in the health burden (Ahluwalia et al., 2005; CIMS, 2009; Leung & Sauve, 2005). Such benefits can significantly reduce the current high healthcare costs in the United States, which increased by 2.7% annually from 2001 to 2009 (Center of Advancing Health, 2014; Weimer, 2001). A projected decrease of $3.6 billion in the annual health care cost can be achieved by reducing the special supplemental nutrition programs for women, infants and children (AAP, 2005). In the United States, an average of $2 billion is spent annually across households that have chosen to formula feed (CIMS, 2009; Lamaze International, 2007; World Alliance for Breastfeeding Action, 2009). Financial savings can be generated through breastfeeding

since the need to purchase, maintain, and dispose of formula feeding supplies will not be necessary (AAP, 2005; Gartner et al., 2005).

Current Situation: Breastfeeding Support Strategies

Breastfeeding –Baby Friendly Hospital Initiative (BFHI)

Breastfeeding promotion gained momentum in the technological era as modern clinical views influenced administrative measures. The BFHI is considered to be a major success in promoting breastfeeding. This joint initiative by UNICEF and WHO was initiated in the 1990s to encourage breastfeeding and bonding between mother and baby (Baby- Friendly USA, 2012; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013). The collaborative efforts of mothers, healthcare providers, health system administrators and policy makers yielded positive outcomes as breastfeeding rates increased globally (Philipp et al., 2001; Saadeh & Casanovas, 2009). The BFHI was accepted at the 55th World Health Assembly in 2002 as an outstanding global achievement that would ensure optimum infant nutrition and health (WHO, 2003).

The BFHI incorporates new research and reports of breastfeeding experiences to enhance its 10 essential steps to successful breastfeeding. For example, VanDevanter et al. (2014) observed that approximately 90% of BFHI steps were partially or fully implemented in New York City. Jensen (2013) reported that despite the strengths of BFHI, system level weaknesses were present. These reports affirmed the need for strategies to strengthen BFHI (Jensen, 2013; U.S. Department of Health and Human Services, 2013.

In an effort to promote BFHI, maternity facilities are recognized and rewarded for implementing strategies to empower mothers to initiate and maintain breastfeeding

(Baby- Friendly USA, 2012; U.S. Department of Health and Human Services, 2013). Mothers are provided with appropriate evidence-based breastfeeding education and support. This includes information regarding the advantages of breastfeeding, early initiation and continuity of breastfeeding for a minimum of 6 months after birth, exclusive breastfeeding, proper breastfeeding techniques, rooming in, and strategies to overcome barriers to breastfeeding. These 10 strategies as outlined in Appendix A were identified as the BFHI basic mode of operation and provide all healthcare providers with appropriate skills and knowledge to support breastfeeding (Baby- Friendly USA, 2012; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013; VanDevanter et al., 2014).

Apart from empowering mothers, physicians, nurses, midwives, lactation consultants, nutritionists, and other healthcare providers working in maternity centers are trained to implement these evidenced-based breastfeeding support strategies. Research shows that 86% of Americans seek health information from healthcare providers. These healthcare providers are capable of influencing mothers' breastfeeding decisions (U.S. Department of Health and Human Services, 2013). Therefore, all levels of healthcare providers are expected to participate in breastfeeding training and skill-building sessions. These intense sessions may extend from one day to several weeks, and are designed to enhance health care providers' knowledge, competence, and attitudes regarding breastfeeding support (U.S. Department of Health and Human Services, 2013). Results from the Breastfeeding Residency Curriculum developed to increase doctors' breastfeeding knowledge confirmed such association. A significant increase in the knowledge, practice, and confidence of residents at the intervention sites was evident in

contrast to residents at the control sites. A three-fold increase was reported in exclusive breastfeeding rates at the intervention sites. The control sites were half as likely to report exclusive breastfeeding rates (U.S. Department of Health and Human Services, 2013).

Despite the rigorous process to attain BFHI status, the facilities, employees, and clients benefit tremendously. Quality standards in maternity care are implemented, capacity building is guaranteed, and patient satisfaction improves (Baby- Friendly USA, 2012; U.S. Department of Health and Human Services, 2013). These strategies align with the Healthy People 2020 goal to increase the health of families. To fulfill the millennium goal of increasing the breastfeeding rate from 74% to 82%, efforts are made to encourage all maternity facilities to adopt the standards of BFHI (Declercq et al., 2009; U.S. Department of Health and Human Services, 2013).

Affordable Care Act (ACA)

The ACA was enacted in 2010 with support for breastfeeding being a major strategy (Drago et al., 2010; National Conference of State Legislatures, 2011; U.S. Department of Health and Human Services, 2011, 2015, n.d.). The position of ACA is to ensure professional breastfeeding support, counseling, and breast pumps for all mothers through adequate insurance coverage. Under the ACA guidelines, it is mandatory to allow breastfeeding in public places, ensure health and safety standards for breast pumps, and subsidize breastfeeding support education, counselling and equipment (Drago et al., 2010; National Conference of State Legislatures, 2011). Researchers concluded these ACA breastfeeding support services will help equalize breastfeeding opportunities and choices for new mothers (Drago et al., 2010). According to the U.S. Department of Health and Human Services (2013) reimbursement for breastfeeding support services

offered by doctors, nurses, lactation consultants, and other healthcare providers may encourage more women to seek professional breastfeeding support. This will help to eliminate barriers to breastfeeding. Support for breastfeeding through ACA is valuable since mothers no longer pay out-of-pocket for breastfeeding support, especially in the critical period after birth. An understanding of their lived experiences may help to empower first-time African American mothers to embrace the provision of the ACA, overcome barriers to breastfeeding, and improve breastfeeding rates.

Criticism of the Baby Friendly Hospital Initiative and Affordable Care Act

The BFHI and ACA services have been associated with maternity care practices that support breastfeeding (Bonzon et al., 2014; Drago et al., 2010; National Conference of State Legislatures, 2011; Perrine et al., 2012; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013; VanDevanter et al., 2014). These supportive maternity care practices include maintaining skin-to-skin bonding with mother and baby directly after birth, start breastfeeding within one hour after birth, and *room in* practices. Room in is the practice of allowing mother and baby to remain together at all times.

Maternity care practices such as formula and water supplementation when not medically indicated have been shown to negatively affect infants' breastfeeding behaviors and health (Baby Friendly USA, 2012; CDC, 2013; CIMS, 2010; Leung & Sauve, 2005; Perrine et al., 2012; Reis, 2007; U.S. Department of Health and Human Services, 2011, 2013). For example, results from a study in Oregon confirmed that mothers who did not receive samples of infant formula exclusively breastfed for up to 10 weeks more than mothers who received the samples. Skin-to-skin contact and room in

have also been associated with longer breastfeeding duration (U.S. Department of Health and Human Services, 2013). A randomized trial of maternity facilities in Belarus revealed facilities that implemented BFHI guidelines reported a higher percentage of breastfeeding rates, improved maternal and infant health outcomes, as well as better patient and staff satisfaction (Kramer et., 2001; U.S. Department of Health and Human Services, 2013).

Although BFHI and ACA drew attention to the importance of breastfeeding, there are concerns regarding the following observed institutional weaknesses (Baby- Friendly USA, 2012; Bonzon et al., 2014; Drago et al., 2010; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013). According to Jensen (2013), 45% of the Baby-Friendly facilities throughout the United States are located in areas with an African American population of less than 3%. The evidence affirms that U.S. cities such as New York with a larger African American population have only two certified Baby-Friendly hospitals. Despite the growing numbers of Baby-Friendly Hospitals, less than 5% of these facilities adhere to the WHO standards.

Some researchers have found the number of trained lactation support providers is less than what is required to meet the requirements of BFHI (Eidelman et al., 2012; Taveras et al., 2004b). Such evidence confirms institutional differences in BFHI implementation could significantly influence first-time African American mothers' perceptions and experiences of breastfeeding support. These weaknesses can negatively impact perceptions of breastfeeding support and breastfeeding rates. Support for breastfeeding throughout hospitalization and after discharge is highly recommended since

a mother's breastfeeding experience can influence breastfeeding initiation and duration (Perrine et al., 2012; U.S. Department of Health and Human Services, 2013).

Women, Infant and Children (WIC) Program

The WIC program is a nutrition program financed by the federal government. Each state is responsible for managing its WIC program to meet the needs of the residents. The primary goal of the WIC program is to provide food for pregnant, postpartum, and breastfeeding women within the low-income group, as well as infants and children 5 years old and younger. Breastfeeding promotion and support, nutrition education, and health care referrals are also key activities of the WIC program (WIC, n.d.). Breastfeeding is promoted as the optimal feed for WIC infants. WIC participants receive breastfeeding counselling, education, and follow-up support. Breastfeeding mothers are also allowed to enroll in the WIC program 6 months longer than mothers who are not breastfeeding. These mothers receive enhanced nutritional supplies, and breastfeeding aids to maintain breastfeeding. WIC agencies which demonstrate outstanding breastfeeding promotion functions are rewarded with the Loving Support Award for Excellence (WIC, n.d.). This award serves as an incentive to strengthen breastfeeding. Standards and policies are also developed at the national level to promote WIC breastfeeding support efforts. These include funding to enhance breastfeeding initiation and continuation, addition of a breastfeeding support expert on the National Advisory Council on Maternal, Infant and Fetal Nutrition, annual evaluation of breastfeeding promotion programs, and breastfeeding training for WIC staff providing breastfeeding support (WIC, n.d.). In 2014 the number of individuals who benefited

from WIC programs was greater than 8 million (U.S. Department of Agriculture Food and Nutrition Service, 2016; WIC, n.d.).

The criteria for acceptance to the WIC program includes (a) being pregnant, (b) being an infant or child 5 years old or younger, (c) being a breastfeeding mother, (d) being evaluated at the WIC clinic by a healthcare professional, and (e) meeting the income guidelines. In addition to the general requirements, qualification for the California WIC program includes being a California resident, having a nutritional problem that requires nutritional interventions, and giving birth in the previous 6 months (WIC, n.d.). To meet the income eligibility guidelines for WIC, applicants must have an income at or below the standard level determined by the state. This standard level is also referred to as the federal poverty level (FPL). The FPL guidelines are issued every year by the Department of Health and Human Services. For example, according to the 2016 FPL guidelines the annual income for a household consisting of one individual must be less than or equal to $11,880 to be accepted within the FPL income. Eligible WIC applicants' income cannot be greater than 185% of the FPL income guidelines. Individuals who participate in certain State administered programs such as Food Stamps, Medicaid, Temporary Assistance for Needy Families, and Aid to Families with Dependent Children may also be considered income eligible to receive WIC benefits (Families USA, 2016; WIC, n.d.).

Breastfeeding Behaviors

Various professional groups such as the AAP, WHO, CDC, AWHONN, ILCA, ACOG, and APHA have endorsed their support for breastfeeding by publishing evidence-based information that outlines the value of supportive breastfeeding behaviors (AAP,

2003; ACOG, 2007; APHA, 2007; Amin et al., 2000; AWHONN, 2007; CDC, 2014; Drago et al., 2010; ICLA, 2007; National Conference of State Legislatures, 2011; WHO, 2003). Emotional, informational, and tangible support have been identified as key roles for nurses when promoting breastfeeding. Researchers also identified nonsupportive behaviors such as inadequate breastfeeding assistance during the first hour of birth, limited breastfeeding knowledge, promotion of formula feeding, and conflicting or unclear breastfeeding information. These nonsupportive behaviors were considered to be barriers to breastfeeding initiation and continuation (Cottrell & Detman, 2013). Hong et al. (2003) recommended the need for nurses' to be equipped with appropriate knowledge, skills, and attitudes that can support first time mothers with breastfeeding. Tarrant et al. (2004) concluded some hospital practices, and healthcare providers who did not support breastfeeding behaviors were hindered from successful breastfeeding. Seventeen first-time mothers were interviewed in Hong Kong to understand their breastfeeding experiences for the first 6 months after giving birth. Seventy percent of the participants reported that an extended hospital stay and contradictory breastfeeding advice from doctors negatively influenced their breastfeeding experience. The importance of the physicians, nurses, and midwives' roles in providing appropriate breastfeeding support was also validated by other researchers. According to Hauck et al. (2011) 53.4% of Western Australian mothers in a 2010 study indicated unsupportive hospital midwives and child health nurses, alongside breastfeeding problems led to early discontinuation of breastfeeding.

Mothers' Perceptions and Experiences of Breastfeeding Support

Research has shown that mothers' perceptions and experiences with breastfeeding support varies. Schmied et al. (2011) evaluated the impact of healthcare professionals' breastfeeding support strategies during the prenatal period and found that mothers who received structured breastfeeding support strategies were satisfied with the level of breastfeeding support from caregivers. Mothers who received routine breastfeeding support perceived that breastfeeding support from care givers was inadequate due to limited provision of breastfeeding information and preparation for parenting. These findings led to the conclusion that some mothers perceive patient-centered care, effective communication skills, and relationship building as key breastfeeding supporting strategies. According to the participants, patient-centered care was identified as individualized and practical support, as well as provision of adequate time to share experiences and offer encouragement to meet each of the patient's needs. Effective communication skills were associated with provision of accurate and detailed information related to the benefits and challenges of breastfeeding. These practices were viewed by the participants as ways to empower mothers to breastfeed (Schmied et al., 2011).

Rossman and Ayoola (2012) discussed the breastfeeding experiences of two educated, first-time Caucasian mothers. Although these two women were highly motivated and knowledgeable about breastfeeding, their real-life experiences revealed that even with adequate breastfeeding education and resources, mothers can become frustrated. The study clearly reinforced the necessity of individualized patient-centered interactions and adequate post discharge follow-up care in promoting successful breastfeeding. Evaluation and clarification of mothers' interpretation of breastfeeding

information were also identified as necessary tools to promote and sustain breastfeeding (Rossman & Ayoola, 2012).

In another study, MacLean (2011) explored the breastfeeding experiences of mothers in the Metropolitan Philadelphia area. The 10 Steps to Successful Breastfeeding were applied as an evaluation tool to determine mothers' perceptions of the strengths and weaknesses of hospital breastfeeding support strategies. Women who received breastfeeding assistance in the form of printed and audio-visual material, assistance with proper breastfeeding technique, and room in practice were more likely to breastfeed for longer periods. These findings led to the recommendation for improved practices and policies supporting breastfeeding in Philadelphia hospitals (MacLean, 2011). Analysis by Cross-Barnet et al. (2012) revealed collective views of mothers' perceptions of breastfeeding support. Several mothers perceive breastfeeding instructions and support from healthcare professionals during the prenatal period was cursory and inadequate. Some mothers reported they received misinformation and encountered hostility or indifference from healthcare professionals offering breastfeeding support. Others reported inconsistency in breastfeeding information as well as insufficient assistance to overcome breastfeeding challenges. Cross-Barnet et al. subsequently asserted that mothers require consistent and reliable breastfeeding information, as well as support to meet individualized breastfeeding goals. Healthcare professionals are encouraged to coordinate breastfeeding practices in the prenatal, postnatal, and pediatric stages to adhere to recommended guidelines from the U.S. Surgeon General, Healthy People 2020, BFHI, and their institutions (Cross-Barnet et al., 2012).

WIC Mothers Perceptions of Breastfeeding Support

Breastfeeding is promoted in the WIC program as the ideal form of infant nutrition unless medically contradicted (U.S. Department of Agriculture Food and Nutrition Service, 2016). Scientific evidence on the other hand shows negative outcomes between enrollment in the WIC program and breastfeeding rates in the United States (Jensen, 2012). Research evidence also confirms that mothers' perceptions of the WIC breastfeeding program differ. Hurley et al. (2008) conducted a cross-sectional survey of 767 WIC mothers, and found that African American and Caucasian mothers had greater perceptions of breastfeeding difficulties than Hispanic mothers. Breastfeeding rates were also lower among African American and Caucasian mothers. The results of the study affirmed the need for culturally sensitive breastfeeding programs.

Research findings also indicated that breastfeeding rates are lower among WIC participants in contrast to other mothers in the United States. According to McCann, Baydar, and Williams (2007) results from a 1 year national longitudinal study revealed differences in breastfeeding experiences and perceptions of WIC mothers. Hispanic mothers agreed more with statements confirming the benefits of breastfeeding and positive attitudes related to infant feeding practices than African American mothers. These findings led to the recommendation for an improved WIC breastfeeding program that alleviates mothers' anxiety related to milk supply (Baydar et al., 2007).

Ethnic Disparities

Disparities in breastfeeding statistics among ethnic groups has been a major concern for breastfeeding advocates. Scientific evidence confirms a lower rate of breastfeeding initiation and exclusive breastfeeding rates among African American

women when compared to other ethnic groups (CDC, 2011; Drago et al., 2010; Hurley et al., 2008; Krystal, 2012; Li & Grummer-Strawn, 2002). Hurley et al. (2008) affirmed disparities in breastfeeding statistics. The breastfeeding initiation rate among Hispanic mothers was higher (91%) than African American mothers (65%) and Caucasian mothers (61%). Hispanic mothers were also more likely to breastfeed for a longer duration (5 months) than the recorded average 3.5 months for African American mothers and 3 months for Caucasian mothers (Hurley et al., 2008).

African American mothers cited breastfeeding difficulties and inadequate milk production as the major barriers to successful breastfeeding. These barriers contributed to more reports of negative perceptions of breastfeeding among African American mothers in comparison to what Hispanic mothers reported (Hurley et al., 2008). According to the CDC (2011) breastfeeding initiation rates among African American mothers in 2010 was 59%, in contrast to 77% among Caucasian mothers and 80% among Hispanic mothers. African American mothers were more likely to supplement with formula during the first 2 days after birth. In addition, they discontinued breastfeeding after 6 months, sooner than Caucasian and Hispanic mothers (CDC, 2011). Such findings are relevant because the rates are significantly less than the Healthy People 2020 goals of achieving 82% breastfeeding initiation rates, 60% breastfeeding rates at 6 months, and 14% formula supplementation in the first 2 days of an infant's life (U.S. Department of Health and Human Services, 2010).

Observations by Cottrell and Detman (2013) indicated adequate breastfeeding support and provision of breastfeeding education during the perinatal period promoted breastfeeding among African American women. Nipple pain, latching issues, formula

supplementation, mother-baby separation, and ideas of inadequate milk supply were considered to be breastfeeding hindrances. Researchers such as Taveras et al. (2004b) argued that early initiation into breastfeeding and adequate professional breastfeeding support positively influence mothers' decisions to continue breastfeeding. African American mothers often rely on breastfeeding support from healthcare givers. However, due to low numbers of adequately trained breastfeeding support professionals, the demand for this type of service among African American mothers is high (Taveras et al., 2004b). These findings confirm a positive correlation between perceptions of breastfeeding support and breastfeeding rates among African American mothers (Cottrell & Detman, 2013).

Disparity Based on Parity

The effect of parity on perceptions of breastfeeding support need to be explored because several researchers have concluded first time mothers experience more difficulty with breastfeeding than multiparous women (Hauck et al., 2011; Hong et al., 2004). New mothers often reported difficulty with breastfeeding support and subsequent early discontinuation of breastfeeding due to nonsupportive healthcare professionals, conflicting information, and breastfeeding problems (Hauck et al., 2011). Hong et al. (2003) established conformity between the results of their phenomenological study and other research findings. The interview report of first-time mothers confirmed supportive attitudes from nurses contributed to successful initiation and continuation of breastfeeding. More than 70% of first-time mothers in a Hong Kong study reported receiving incorrect breastfeeding information from physicians (Tarrant et al., 2004)

Impact of Social Influences on Breastfeeding Support

Impact of Health Care System

A review of the healthcare system is necessary to determine how breastfeeding policies and practices influence African American mothers' perceptions of breastfeeding support. Despite several organizational strategies to improve breastfeeding rates, the gap between the actual national breastfeeding rate (74%) and Healthy People 2020 goal (82%) continues (U.S. Breastfeeding Committee, 2013a). In response to the low breastfeeding rates, Taveras et al. (2003a) conducted a prospective cohort study to identify the relationship between breastfeeding cessation and organizational factors such as support from healthcare professionals. The findings confirmed that reduction in breastfeeding initiation and continuation rates were linked to lack of breastfeeding support and supplies. Jessri et al. (2013) identified gaps in the healthcare system that influence mothers' abilities to breastfeed successfully. These issues included mistrust in the healthcare system due to inconsistency in information, inadequate support from healthcare givers, and cultural incompetence. Healthcare providers' preconceived ideas about their feeding preferences further added to their negative perceptions of the healthcare system in supporting breastfeeding (Jessri et al., 2013).

Impact of Socio-Cultural Beliefs

Research has shown that sociocultural factors often influence African American mothers' breastfeeding practices (Kaufman et al., 2009; Lewallen & Street, 2010; Simpson, 2012). These sociocultural factors include local mores, body image, and influence from social networks. In the United States, cultural practices and beliefs related to breastfeeding are linked to the concept of (a) the female breast being an organ

for pleasure, (b) only neonates should be breastfed, and (c) breastfeeding should be restricted to private spaces (Daglas & Evangelia, 2012). In addition, the breastfeeding practices of some African American mothers are influenced by cultural practices such as pressures to be a "strong black woman" as well as the culture of using formula as a sign of wealth (Gross et al., 2015, p. 106). These practices can significantly impact the African American mother's ability to successfully breastfeed after discharge from hospital (Gross et al., 2015).

According to Street and Lewallen (2013) culture as well as family influences, knowledge of breastfeeding benefits, influences of friends, and individual choice have been known to influence African American mothers' breastfeeding decisions. Senior women and grandmothers within the African American family play an important role in providing guidance on infants' nutrition and health. Grandmothers are therefore influential in African American mothers' breastfeeding decisions (Aubel, 2012). Lutenbacher et al. (2016) also agreed that, support from family members, myths, and the internet played a major role in African American mothers' breastfeeding choices. Mothers who experienced positive attitudes from family and friends were more inclined to breastfeed than mothers with negative and opposing influences (Fabiyi et al., 2016). Likewise fathers who were supportive of breastfeeding helped their partners to successful breastfeed for more than 6 months. Research has shown that fathers from African American families who received breastfeeding education contributed to a 20% increase in breastfeeding rates (CDC, 2011).

Although the benefits of breastfeeding to mothers and infants are known, low breastfeeding rates among African American mothers are linked to inadequate support

from family and healthcare providers (Gross, 2013). Areas with large African American populations such as New York City frequently have fewer BFHI facilities, and trained lactation support providers to assist first-time African American mothers (Drago et al., 2010; Eidelman, 2012; Taveras et al., 2004a). Furthermore, studies have shown that some healthcare providers have negative stereotypes of minority groups such as African American mothers (Cuevas, 2013, Lutenbacher et al., 2016). Alongside poor access to healthcare, the quality of African American patients' relationship with their healthcare providers also influence their health decisions and outcomes. For example, an African American patient who perceives discrimination and unfair treatment by a healthcare provider may refuse to comply with the plan of care. Similarly, African American patients with negative views of their healthcare providers may show a preference for a healthcare provider of similar race (Cuevas, 2013). Therefore, it is important for healthcare providers to understand not only the historical and sociocultural factors associated with the breastfeeding practices of African American mothers, but also their perspectives and experiences with healthcare providers in order to develop more cultural sensitivity breastfeeding support programs (Gross et al., 2015).

Furthermore, results from a qualitative study of five African American women confirmed that adequate support from healthcare providers and family members, as well as effective communication with healthcare providers influenced their decision to breastfeed (Street & Lewallen, 2013). Simpson (2012) also agreed that communication related to breastfeeding during the prenatal period may enhance mothers' intention to breastfeed. On the other hand, researchers reported that some African American mothers may not choose to breastfeed because of (a) immaturity, (b) poor education, (c)

selfishness, (d) laziness, (e) the idea of the breast being a sex object, (f) nonsupportive partners, and (g) easy access to formula (Street & Lewallen, 2013). African American mothers also reported that cultural norms and pressure from social networks were barriers to sustained breastfeeding. These social networks were identified as family, friends, and spouses/partners/father of the child (Simpson, 2012). Similarly, Lewallen and Street (2010) documented mixed reports from African American mothers who participated in focus groups to explore issues related to breastfeeding. According to the authors, some family members and friends were supportive of breastfeeding efforts, while others offered negative comments and horror stories (Lewallen & Street, 2010). One participant reported being told that breastmilk is harmful and may lead to dental problems, and may cause the male child to be too dependent. Such lack of support led to early cessation of breastfeeding (Lewallen & Street, 2010). Ambivalence related to breastfeeding practices may result in complementary feeding practices and early discontinuation of breastfeeding (Kaufman et al., 2009). These factors can also influence the breastfeeding decisions of African American mothers, and their ability to continue to breastfeed their infants (Gross, 2013; Drago et al., 2010).

The ACA was implemented to promote breastfeeding among mothers with low socio economic status, and who were not likely to breastfeed (Drago et al., 2010). These mothers include African American women and new mothers with low levels of education. The ACA appropriately target these mothers by providing breast pumps and breastfeeding counseling and education in order to promote continuation of breastfeeding following discharge from hospital (Drago et al., 2010). Mickens (2009) discussed the effect of breastfeeding support groups on promoting successful breastfeeding outcomes.

The author reported that mothers who received supportive breastfeeding interventions demonstrated greater potential to initiate and maintain breastfeeding than their counterparts. These findings confirm the need to empower African American women to initiate and sustain breastfeeding practices (Mickens, 2009).

Summary

A detailed review of the literature provided accounts of mothers' breastfeeding experiences spanning over two decades. However, there is a scarcity of studies focusing on any ethnicity of first-time mothers perceptions of breastfeeding support (Kaunonen et al., 2012; Saadeh & Casanovas, 2009). The evidence confirms variation in mothers' perceptions of breastfeeding support, as well as personal, organizational and cultural influences impacting breastfeeding promotion and outcomes (Burns et al., 2013; Cross-Barnet et al., 2012; Ekström et al., 2011; Graffy & Taylor, 2005; Maastrup et al., 2012; Powel, Davis, & Anderson, 2014; Schmied et al., 2011; Sikorski et al., 2003). For example, the U.S. Department of Health and Human Services (2011) reported a discrepancy in hospitals that reported cases of adequate breastfeeding education and support. Although reports of adequate breastfeeding support were provided by the facilities, only 25% of mothers surveyed thought it was adequate.

Evidence shows that issues related to breastfeeding support have affected breastfeeding initiation and continuity rates during the first 6 months after birth (Rozga et al., 2014). This highlights the disparities between actual breastfeeding rates and the Healthy People 2020 national goal (CDC, 2014; National Conference of State Legislatures, 2011). Adequate and consistent support for breastfeeding from healthcare

providers, policy makers, and the community is an effective strategy that can address this critical need throughout the United States (CDC, 2011).

In this study, I explored first-time African American mothers' perceptions about breastfeeding support. The information led to clarity regarding first-time African American mothers' experiences and perceptions about breastfeeding. Such in-depth understanding can be used to assist health care providers in designing evidence-based breastfeeding support strategies to address the mothers' concerns and experiences.

Chapter 3 will contain an explanation of the study purpose as well as a description of the phenomenological study design and relevance to the current study. The chapter will also include a detailed discussion of the methodology, the target population, participant selection, data instrumentation, participant recruitment, data collection, and data analysis. Other sections of Chapter 3 will include information related to ensuring credibility, transferability, dependability, and confirmability. I will also incorporate ethical considerations, such as informed consent, interview protocol, Institutional Review Board (IRB) approval, confidentiality and data protection, in Chapter 3.

Chapter 3: Research Method

Introduction

Through my review of the literature in the field in Chapter 2, I revealed the problem of the scarcity in studies on first-time African American mothers' perceptions of breastfeeding support. Support for breastfeeding is critical throughout the United States, as the CDC (2011) indicated that effective breastfeeding support programs are highly influential to increasing breastfeeding rates. Nevertheless, African American mothers have lower breastfeeding rates than Hispanic and Caucasian mothers (CDC, 2011; Drago et al., 2002, 2010; Hurley et al., 2008; Krystal, 2012; Li & Grummer-Strawn, 2002). Though these rates were found to be lower, there is a lack of understanding regarding the reason or reasons for this disparity. The purpose of this qualitative phenomenological study was to address this gap in the literature and explore the problem. To conduct this study, I selected a purposeful sample of 10 first-time African American mothers who delivered term infants requiring only well-newborn care. I recruited the participants through advertisement on BMBFA Facebook page.

Chapter 3 will contain an explanation of the qualitative research tradition and my rationale for its selection in this study, a description of the phenomenological research design and rationale, and a discussion of my role as researcher. In the chapter, I will also present a description of the methodology, including the target population, participant selection, participant recruitment, data instrumentation, data collection, and data analysis plan. I will conclude Chapter 3 by addressing both the issues of trustworthiness and the ethical considerations.

Research Design and Rationale

I developed the following central research question to guide this research study: What are first-time African American mothers' perceptions and experiences of breastfeeding support? In qualitative research, research questions may be stated as a central question or subquestions (Crosby et al., 2006; Patton, 2002). The central question is also referred to as the broad question regarding the central phenomenon in the study, while the subquestions are more specific (Crosby et al., 2006; Patton, 2002). I constructed this research question to link with the purpose statement, the theoretical framework, and research methods. As prescribed by Crosby et al. (2006) and Patton (2002), the research question in this phenomenological study was broadly stated, focused on a single phenomenon, consisted of exploratory nondirectional verbs, used an open-ended design, and clearly identified the participants and research site. I developed the single research question to focus on first-time African American mothers' personal meaning behind their experience of seeking and using breastfeeding support. With its emerging design, the research question guided my exploration of the central phenomenon and generated new understanding related to the ways women experienced and perceived breastfeeding support.

There are three research traditions: quantitative, qualitative, and mixed methods (Creswell, 2009; Crosby et al., 2006; Patton, 2002). The quantitative researcher seeks to answer quantifiable questions, such as what number of people experience a certain phenomenon or what relationship exists between two variables, within a positivist and objective research paradigm (Creswell, 2009; Crosby et al., 2006; Patton, 2002). This research tradition is not capable of answering complex questions concerning human

behavior and thought, such as why a phenomenon exists and how that phenomenon is experienced differently by different groups of people (Creswell, 2009; Crosby et al., 2006; Patton, 2002). The qualitative research tradition is more apt and appropriate to answer questions like the one I posited earlier in the paragraph. Mixed methodology is a research tradition that combines both quantitative and qualitative research traditions into one multimethod research tradition (Creswell, 2009; Patton, 2002). This research tradition is suitable and appropriate when quantifying a phenomenon and further qualifying the circumstances or experiences of the phenomenon (Creswell, 2009; Patton, 2002). Since in this research study, I explored the lived experiences of African American women receiving breastfeeding support, a qualitative research tradition was most appropriate to qualify such experiences.

For this study, I adopted a qualitative research tradition and phenomenology as the research design with the intention of focusing on the lived breastfeeding experiences of first-time African American mothers who sought support. Researchers use the qualitative research design to explore and understand a social phenomenon within the social constructive worldview (Coyle & Tickoo, 2007; Creswell, 2009; Crosby et al., 2006; Patton, 2002). The qualitative research design was appropriate for this study since my aim was to identify and understand the particular lived experiences of the participants. Early identification of the research problem and the need to empower African American mothers to sustain breastfeeding reinforced the need for this qualitative phenomenological study.

The qualitative method of inquiry is inductive, holistic, in-depth, and associated with coded themes (Creswell, 2009; Crosby et al., 2006; Patton, 2002). Data analysis is

ongoing and based on the interpretation of the researcher and participants (Creswell, 2009; Crosby et al., 2006; Patton, 2002). Qualitative research occurs in a natural setting (Bloomberg & Volpe, 2008; Coyle & Tickoo, 2007; Crosby et al., 2006; Patton, 2002; Remshardt & Flowers, 2007). The qualitative research design encompasses several other strategies of inquiry, such as ethnography, grounded theory, case study, and narrative research (Crosby et al., 2006; Patton, 2002). I considered these strategies for this study, but they were not appropriate for the following reasons.

Ethnography is a research design based on cultural anthropology (Crosby et al., 2006; Patton, 2002). This design involves prolonged time in the field observing, interviewing, and collecting data from a cultural group within a natural setting (Crosby et al., 2006; Patton, 2002). Ethnography often focuses on the intersection of everyday life and cultural meaning generation, whereby comprehensive understanding of an experience or phenomena is embedded within the cultural context where it exists (Crosby et al., 2006; Patton, 2002). This often occurs within remote and isolated cultural groups, where there is limited understanding of cultural factors (Crosby et al., 2006; Patton, 2002). Due to the fact that in this study I examined the cognitive issues such as perceptions of breastfeeding support (see Crosby et al., 2006; Patton, 2002), this research design was not compatible with the aim of the study.

Qualitative researchers who seek to develop new theories to explain a phenomenon or experience utilize a grounded theory research design. Grounded theory involves several stages of data collection, coding, and analysis that result in the emergence of a new theory (Crosby et al., 2006; Patton, 2002). It is an inductive approach to theory generation, which is not the intended purpose of this research study.

This strategy of inquiry was inappropriate since I identified existing relevant theories for this study and the qualitative researcher does not seek to develop a theory.

A qualitative researcher who employs the case study research design does so in order to assess a bound case, which is the unit of analysis and measurement (Crosby et al., 2006; Patton, 2002). This offers an opportunity to bind a complex phenomenon into smaller and manageable parts, such as activities, programs, events, and even classrooms. Due to the fact that in this research study, I attempted to understand shared experiences, such as perceptions of breastfeeding support of first-time African American mothers (see Crosby et al., 2006; Patton, 2002), this strategy was inapplicable based on the research purpose of assessing experiences with breastfeeding support, rather than explaining a particular case.

Qualitative researchers make use of narrative inquiry by examining the stories of individuals, either of a particular phenomenon or general life history (Crosby et al., 2006; Patton, 2002). This research design is similar to phenomenology, whereby a qualitative researcher seeks to make sense of the participants' making sense of their lived experience (Crosby et al., 2006; Patton, 2002). This strategy, though close to the intended purpose of the study, would not have allowed for the essence of the experience to be extracted for further examination. This research design would also have limited the sample size of 10 individuals to a smaller number of participants (Crosby et al., 2006; Patton, 2002), which would have failed to result in an accurate summary of the overall lived experience.

Phenomenological researchers investigate the lived experiences of a phenomenon by examining how individuals make sense and generate meaning from them. The phenomenological qualitative approach enables the researcher to maintain adequate

contact with the participants to understand their experiences and meaning of the phenomenon (Aspers, 2004). The use of phenomenology allowed me to describe and interpret participants' shared experiences such as the essential features of what they experienced with breastfeeding support and how they perceived breastfeeding support (see Aspers, 2004; Patton, 2002). Other considerations I made in selecting the qualitative phenomenological research design for this study included the unit of analysis, each first-time African American breastfeeding mother, as well as the use of open-ended interview questions for data collection, thematic data analysis to find patterns of meanings, and textural description of the complex issues as viewed by the participants. This is exactly what I attempted to measure and assess in this study in order to fill the gap in the literature and explore the disparities of breastfeeding support among African American women. A detailed study of the qualitative research strategies led me to the decision that the phenomenological research strategy would appropriately align with my research problem and question, since in-depth information related to first-time African American mothers' views of breastfeeding support can be obtained by using this approach (see Bloomberg & Volpe, 2008; Coyle & Tickoo, 2007; Crosby et al., 2006; Patton, 2002; Remshardt & Flowers, 2007).

Role of the Researcher

The phenomenological researcher performs the role of an investigator and interpreter (Crosby et al., 2006; Patton, 2002) because the qualitative researcher is the key person collecting and interpreting data (Denzin & Lincoln, 2011). Phenomenology involves interaction between the researcher and the participants to develop an in-depth understanding of the phenomenon being studied; such interaction may facilitate the

introduction of personal biases and preconceived ideas in the data collection and analysis process and interfere with the validity of the study (van Manen, 1990; Wojnar & Swanson, 2007). To ensure my integrity, I disclosed my personal interests, professional experiences, and knowledge related to breastfeeding support through the process of epoché, also known as bracketing. Moustakas (1994) posited that such acknowledgement minimizes possible biases by allowing the researcher to continuously assess their own biases in reference to the emergent findings to ensure that findings are driven by the data only and not by personal preconceptions.

I obtained access to the participants through IRB approval, written approval from the community partner, and informed consent from participants. On completion of their role in the study, all participants received a $20 gift card from Walmart as a reward and thank you for participating in the research study. I maintained openness and flexibility throughout the research process to facilitate the emergence of themes and well-grounded breastfeeding support data.

Reflexivity is an important aspect of both the data collection and data analysis process because phenomenological research requires a qualitative researcher to part with their biases in order to identify the essences of the lived experiences from participants (Crosby et al., 2006; Moustakas, 1994; Patton, 2002; Roberts et al., 2006; Suzuki et al., 2007). Bracketing and self-reflection minimize biases and are effective in studies related to exploring human experiences (Moustakas, 1994). This process allows the researcher to put aside personal values, beliefs, knowledge, and assumptions, thereby not influencing the participants' perception of the phenomenon (Crosby et al., 2006; Moustakas, 1994). Self-reflection allows the researcher to consciously determine their

ability to conduct the phenomenological study without introducing personal biases (Chan et al., 2013; Creswell, 2007). As the researcher and the key instrument of data collection and analysis, I bracketed my personal preconceptions and biases through constant consideration of my self-acknowledged biases. I also participated in active listening and took thorough notes throughout the interview to note anything that stood out to me (see Chan et al., 2013).

Methodology

Participant Selection

I recruited the participants for this study through advertisements on the Facebook page of the BMBFA. I allowed participants to contact me if they were interested, rather than making initial contact with them, which have been considered intrusive. No contact was made with participants prior to obtaining IRB approval. I also used the purposeful criterion sampling to select 10 first-time African American mothers 18 years and older who responded to the advertisement with interest and delivered term infants who required only well-newborn care. The study population consisted of women who had vaginal deliveries and who intended to breastfeed. Mothers who had complications associated with labor and delivery and were not able to initiate breastfeeding early were not eligible to participate in this study. In addition, mothers who delivered preterm infants (i.e., less than 37 weeks of gestation), who had previous live births, and mental health issues were also excluded from the study. Only English speaking mothers were allowed to participate so as to eliminate language translation issues. This homogenous population was suitable for this study since the purpose was to explore the perceptions of African American mothers with no prior breastfeeding experience. I screened interested participants upon

initial contact to ascertain whether they met these criteria and asked to provide confirmed interest and sign the informed consent form to participate.

Sampling Strategy

Purposeful sampling is usually utilized in qualitative studies as a method to find participants who will provide detailed information about the phenomenon being explored. These individuals generally meet specific criteria designed to accomplish the study purpose and research questions (Creswell, 2007, 2009; Crosby et al., 2006; Patton, 2002). Patton (2002) stated qualitative research strategies typically involve relatively small purposely selected samples. Consequently, I used the purposeful criterion sampling strategy to identify first-time African American mothers who had experienced the phenomenon (i.e., breastfeeding support). This particular experience was appropriate to answer the research question and inform the gap in literature. The rich information obtained from this purposeful sampling method facilitated a deeper understanding of breastfeeding support. Such information could not be obtained using the random sampling strategy (Bloomberg &Volpe, 2008; Mapp, 2008).

Creswell (2007) recommended a sample size of five to 25 individuals for qualitative phenomenological studies. The decision regarding the sample size and sampling strategy in qualitative phenomenological research is influenced by the unit of analysis, the study purpose, information required, utility of the study, available resources, and the intention of achieving saturation (Patton, 2002). Appropriate selection of the sample size in qualitative research is essential to ensure data saturation and generalizations (Onwuegbuzie & Leech, 2007).

I recruited 10 first-time African American mothers who sought breastfeeding support and delivered full-term infants requiring only well-newborn care. This method of recruitment was appropriate to provide adequate in-depth information and fulfil the study purpose within time and budgetary constraints. I concluded data collection with a total of 10 participants, as suggested by Moustakas (1994) as a generally acceptable sample size. Saturation was also achieved with this initial sample.

Instrumentation

Researchers use data collection instruments to document, measure, and observe data. In terms of qualitative research, the data collection instrument is the interview, and is guided by the interview protocol. Qualitative research employs a variety of methods to collect data throughout the research study such as participant observation, structured interviews, semistructured interviews, unstructured interviews, surveying, administering questionnaires, artifacts, and archival investigation. Following is a brief discussion of each data collection method and the rationale for selecting the methods for this research study. Participant observation is when a qualitative researcher maintains a sufficient amount of professional distance while still participating “in the lives of the people being studied” (Fetterman, 1998, p. 34) in order to adequately observe and record data.

As listed above, there are three types of interviews: (a) structured interviews, (b) unstructured interviews, and (c) semistructured interviews. The factors of time and opportunity impact a qualitative researchers’ decision on which format is the most appropriate and beneficial for the research study. These types differ by the format that each utilizes, where a structured interview follows the interview protocol explicitly, often without the opportunity explore themes or experiences not anticipated. This drastically

contrasts with the unstructured interview format, which employs a conversational and natural style.

This unstructured format is beneficial under certain circumstances, whereby a qualitative researcher has the time and opportunity to interview each participant multiple times. It is extremely beneficial when building rapport and trust with vulnerable populations by prolonging the engagement and interaction with the specific population. Falling between the two of these formats lies the semistructured interview, which utilizes an interview protocol. The semistructured interview offers the flexibility to explore emerging themes and topics that may otherwise go unexplored in a structured format. When a qualitative researcher explores these emerging themes and topics, they are utilizing a technique known as probing. This technique is appropriate when vague information is given so that the qualitative researcher can probe and obtain more comprehensive data. The following are some examples of common probes:

1. I'm not quite sure I understand. Could you please tell me more about. . .
2. What makes you feel that way?
3. I'm not certain what you mean by. . . Could you give me examples?
4. You mentioned. . . What stands out in your mind about that?
5. Could you tell me more about your thinking on that?
6. This is what I thought I heard. . . Did I understand you correctly?

Surveys are qualitative instruments that measure the characteristics of the populations under study. This is different to quantitative surveys due to the fact that qualitative surveys do not count the number of people that share characteristics, but

instead identify and establish the meaningful variation and depth of detail among thoughts and perceptions within the specific population (Jansen, 2010). Questionnaires are instruments that can be employed when a qualitative researcher is not able to interview every respondent. These measure values, facts, or attitudes through either close-ended or open-ended questions. Close-ended questions are questions that close off possible answer choices to either yes/no or selecting from predetermined answer choices. Open-ended questions are questions that leave possible answers open to individual determinant, without selecting from predetermined answer choices (Crosby et al., 2006; Patton, 2002).

Due to the fact that the lived experiences are of the upmost importance, I utilized semi-structured interviews as my primary data collection technique and administered a demographic survey as a secondary data collection technique. Interviewing instead of observation is a suitable method to obtain subjective data from the participants. These were the most appropriate choices due to the fact that I employed prolonged engagement as a technique to establish the study's credibility. For these reasons, the current phenomenological study incorporated the use of semistructured, open-ended, in-depth interviews designed to understand the participants' experiences with breastfeeding support.

Qualitative researchers generally design their data collection instrument to facilitate in-depth and descriptive discussion of the phenomenon (Crosby et al., 2006; Patton, 2002). In phenomenological research, the researcher is the primary data collection instrument, and uses this interview protocol and interview questions to collect data. The interview questions typically align to the research questions. Often they are

open-ended questions, allowing the participants to freely express their views about the lived experience (Coyle & Tickoo, 2007; Crosby et al., 2006; Patton, 2002). An interview protocol consisting of a brief introduction, and an opportunity for the participant to ask questions and become comfortable, will help participants build rapport and trust with the qualitative researcher.

The validity and reliability of the interview protocol must be determined since the integrity of the data can be influenced by the degree of depth and focus of the interview questions (Patton, 2002). As a result, a panel of subject matter experts tested and reviewed the data collection instrument and method for reliability and validity. The subject matter expert panel consisted of a certified lactation consultant and a lead breastfeeding consultant and educator. These individuals have been recognized for their commitment to support families and train health care providers to implement culturally appropriate breastfeeding support strategies. The initial review of the interview protocol was useful in determining if the interview questions were clear and comprehensive for use with the selected sample of 10 first-time African American mothers who delivered full-term infants requiring only well-newborn care. After this initial review of the interview questions and survey, no changes were required prior to conducting the final study. Feedback received from the panel of subject matter experts usually guide the refinement of the final interview protocol (Crosby et al., 2006; Patton, 2002).

I conducted interviews through one-on-one telephone interview sessions with the participants. Telephone interviews provided the best source of information since the researcher was unable to have face to face interviews with the participants (Aspers, 2004; Creswell, 2007). The interview data were audio-recorded for later transcription. To

prevent equipment failure, the recorders were tested immediately before each interview and a backup recorder was available. The transcripts were then provided to participants in order to verify their accuracy and make corrections to the completed transcripts in the process of transcript review. These corrections were incorporated as I deemed appropriate.

Using a separate demographic survey tool during the interview, I collected demographic data such as age, marital status, and breastfeeding data. The breastfeeding data consisted of breastfeeding intention, preparation, initiation, and duration information. I designed the interview questionnaire and demographic survey, and these were the only instruments used for data collection in the study. As stated previously, these instruments were reviewed by a panel of subject matter experts and no amendment was necessary.

Procedures for Recruitment, Participation, and Data Collection

The recruiting approach is an essential factor in determining the success of the study. The approach should align with the needs and perceptions of the prospective participants (Crosby et al., 2006). Participants for the current study were recruited using the BMBFA Facebook page. An advertisement on the Facebook page was used to announce the study and invite first-time African American mothers to participate (see Appendix E). This advertisement contained the purpose of the research, the role of the participant, as well as the inclusion criteria and my contact information for those who were interested. I then asked interested potential participants to respond by e-mail to my personal e-mail address.

When interested parties contacted me, I reviewed the purpose, objectives, time commitment for telephone interviews, and data collection process for the study to the prospective participants. Participants were selected according to the order of e-mail response confirming interest and eligibility. Recruitment continued until I obtained 10 participants. A second e-mail with the consent form was sent to each of the 10 prospective participants to be read, dated, signed, and returned to my e-mail address prior to any form of data collection. After obtaining the signed consent to participate, I sent a follow-up e-mail, requesting a convenient date and time to conduct the telephone interview. The e-mail correspondence was confidential and adhered to all ethical principles of research as outlined in the IRB form. Data collection included a sequence of related activities designed to obtain relevant information to answer the research questions (Crosby et al., 2006; Patton, 2002).

For a phenomenological study, data collection primarily involves in-depth interviews to obtain information about individuals' lived experiences (Patton, 2002). The data collection process requires self-reflection and the use of open-ended questions (Crosby et al., 2006; Patton, 2002; Suzuki et al., 2007). Consequently, the data collection process for this phenomenological study included the use of semi-structured in-depth interviews. One on one interviews are more appropriate than observation since the goal of the current study was to understand the participants' meaning of breastfeeding support. This provided an opportunity to interact with the participants and deeply explore the phenomenon (Crosby et al., 2006; Patton, 2002; Suzuki et al., 2007).

I recorded the data using digital audio-recording. Data collection was conducted through telephone interviews over a two week period. Each interview lasted

approximately 30 minutes or until adequate and quality information was obtained. Interviews did not exceed 60 minutes in totality. The interview started with questions inquiring about demographic data such as age, parity/number of children, and marital status (see Appendix D). I used open-ended questions to determine breastfeeding intention, initiation and duration, current breastfeeding status, and perceptions of breastfeeding experience (see Appendix C). The interview protocol used for each participant included assignment of a number, instead of real name, to ensure anonymity and confidentiality. I then secured the data in a confidential folder on my personal password protected computer, located in my home office- which only I had the ability to access.

I conducted the interviews within the first 6 to 7 months after delivery to minimize bias due to retrospective reflection and also to increase the retention rate. Interviews took place at a time and date convenient to the participants. This was necessary as the comfort and privacy of participants was essential when discussing personal experiences (Suzuki et al., 2007) such as breastfeeding. Participants obtained a copy of the transcribed interview if desired and were informed that the study, without their identity, would be published on completion.

Data Analysis

Data analysis in qualitative research closely relates to the data collection process and may not be easily distinguished (Patton, 2002). The research questions and interpretation developed during data collection serve as the key sources in organizing qualitative data analysis (Creswell, 2009; Patton, 2002). Braun and Clarke (2006) thematic data analysis is commonly used in qualitative research to identify, analyze,

report patterns/themes within data, as well as interpret essential characteristics of the research topic. This method of thematic analysis can be applied irrespective of the theoretical and epistemological approach used in the research.

Braun and Clarke's (2006) thematic data analysis can be used to (a) provide a report of the participants' experiences, meanings, or reality; (b) examine the effects of social discourses on events, realities, meanings, and experiences; and (c) identify how individuals ascribe meanings to their experiences and how society influences those meanings. Thematic analysis provides flexibility which can be useful in generating rich, detailed, and complex data. Thematic data analysis begins during the data collection stage, when the researcher begins to identify and search for patterns, and areas of interest in the data. This analytic process is recursive, develops over time, and involves the following six phases:

During Phase 1 the researcher reads the data several times to identify meanings, and patterns, as well as become familiar with the data. Transcription of verbal data is an interpretive act which helps the researcher to become familiar with the data. Phase 2 involves generating initial codes from the list of ideas obtained in phase one. During this phase of the analytic process the data is organized in meaningful groups.

Phase 3 starts with sorting the coded data into themes, and collating all coded data extracts under relevant themes. A thematic map can be used at this stage to identify the relationship between codes, themes, and levels of themes. Phase 4 involves reviewing and refining identified themes, as well as recoding to provide clear patterns, and establish the validity of themes in the data set.

Phase 5 is referred to as the stage of defining and naming themes. It begins with the confirmation of a suitable thematic map. The researcher then identifies what each theme means and the area of data it captures. Collated data is re-examined, and each theme or sub-theme organized into clear and internally consistent reports with narrative. The written detailed analysis should reveal the "story" each theme tells, and how the theme fits into the broader "story" about the data in relation to the research question.

Phase 6 represents the final stage of thematic data analysis. It begins with a set of defined themes, and involves the final analysis. Phase 6 ends with reporting the content and themes in the data. The final report should be a concise, clear, and logical narrative account which convinces the reader of the validity of the analysis and reveals the story being told about the data.

In keeping with these steps, the data analysis process for the current study required active listening to the participants' reports of their breastfeeding experience. The interview data were then transcribed verbatim. The text interview data were read several times in order to become familiar with the data. This allowed me to immerse within the data and obtained a deep understanding of the meaning each participant ascribed to the experience.

I initiated a detailed analysis using the NVivo Version 11 computer software to code the data. Coding is the practice of organizing and segmenting the text data into categories (Creswell, 2009). I imported each interview transcript into the NVivo computer software, auto-coding, and storing it. The coding process provided essential themes for analysis. I identified common words, experiences, and phrases and used them

to create the themes and subthemes. These themes captured the meaning of the participants' breastfeeding experiences.

The NVivo computer software allows qualitative researchers to organize and manage data to easily visualize themes and their relationships. NVivo qualitative computer software can be used to break down and code the responses from the open-ended interview questions (QSR International Inc., 2011). Completion of the qualitative data analysis process is confirmed when new themes no longer emerged, which indicated that saturation has been met. I confirmed the validity of the data analysis process through member checking. Member checking is a technique to establish the credibility of the study's findings by providing the completed analysis to each participant and inviting each participant to give their feedback on the interpretations that encompass the completed analysis. This also offered an opportunity to receive additional information that would otherwise be missed had the technique not been employed.

Issues of Trustworthiness

Validity and reliability are concepts used in both quantitative and qualitative studies. However, the terms do not have the same meaning in qualitative studies as they do in quantitative studies (Crosby et al., 2006). Validity in qualitative research equates to checking for accuracy of the findings, while reliability suggests consistency in approach among different researchers and studies (Trochim, 2006). Validity in interpretative research is an issue of trustworthiness or quality of the research. Qualitative researchers can achieve trustworthiness through credibility, transferability, dependability, and confirmability (Trochin, 2006).

Credibility

Credibility is the qualitative research equivalent for internal validity in quantitative studies, which allows a qualitative researcher to be confident in the truth of the study's truth. Techniques such as triangulation, prolonged engagement, and member-checking establish a study's credibility. There are four types of triangulation, methodological triangulation, triangulation of sources, analyst triangulation, and theoretical triangulation. Methodological triangulation establishes the consistency of the findings by using multiple different data collection methods (Lincoln & Guba, 1985). Triangulation of sources establishes the consistency of the findings by comparing different data sources while using the same data collection method (Lincoln & Guba, 1985). Analyst triangulation uses multiple analysts to review the findings in order to highlight any selective perceptions or blind spots that may exist in analysis (Lincoln & Guba, 1985). Theoretical triangulation employs multiple theoretical perspectives in order to examine the data and aids the interpretation of the data (Lincoln & Guba, 1985). Due to the nature of this study, I utilized triangulation of sources by comparing each participant in order to establish or verify emerging categories and subsequently themes.

Prolonged engagement is ideal when a qualitative researcher is able to spend a sufficient time with the group under study in order to understand the social setting or phenomenon under study (Lincoln & Guba, 1985). Inherent to this technique is building rapport and trust between participants and the researcher, which aids when co-constructing meaning throughout the data collection process. Member-checking is when participants are presented with the interpretations and analytic categories that were developed from the participants' data, and invited to make corrections and provide

feedback concerning the accuracy of the account. This provided an opportunity for additional information to be presented that otherwise would not be elicited.

Transferability

Transferability is equivalent to the concept of external validity in quantitative research; it is the ability to transfer the study findings to other settings (Trochim, 2006). The aim in qualitative research is not to generalize findings to individuals and places other than those being studied (Trochim, 2006), but to provide enough information to show that the findings of this study could apply to contexts and circumstances similar to this. A qualitative researcher can do this by employing thick description as a technique to ensure that transferability is established (Lincoln & Guba, 1985). Thick description is when a phenomenon is explained in sufficient detail in order to demonstrate that the conclusions and results can be understood to an extent that a second researcher can make conclusions about the transferability to other social settings.

Dependability

Dependability is the qualitative equivalent of the quantitative concept of reliability. In qualitative research, it is a measure of ensuring that the study results remain stable over time (Trochim, 2006). I ensured dependability of the current study findings through the following procedures:

1. Assessing the interview transcripts for errors during transcription;
2. Documenting the research process in detail to facilitate replication; and
3. Soliciting participants' review for comparative interpretation of the data by another person.

Confirmability

Confirmability is the process of establishing the value of the data in qualitative research or verifying the outcome with others (Trochim, 2006). Strategies to improve confirmability of the current study included reporting the findings accurately. Confirmability increases when researchers completely disclose their personal interests and biases related to the study. Provision of thick, in-depth reports of the participants' views supported the interpretation of the study and enhanced confirmability of the findings. Member checking of the study also confirmed the accuracy and credibility of the study findings.

Ethical Procedures

Respect for human rights, beneficence, and justice are key ethical principles required to protect research participants (Crosby et al., 2006). Respect for human rights includes providing participants with the right to voluntarily join or leave the study at any time. Respect for human rights embraces other conditions such as maintaining the privacy of participants. Beneficence is the assurance the study will not cause harm to participants, and the principle of justice supports the fair treatment of all participants (Crosby, 2007; Patton, 2002). Adherence to IRB and federal regulations research standards are necessary to protect human subjects. In conforming to these principles, I obtained IRB approval from Walden University (IRB Approval No. 02-10-17-0176020) and written approval from the community partner prior to communicating with the participants. The purpose and processes involved in the current study were fully described and explained to the participants during the invitation to participate phase. I

explained matters related to confidentiality, informed consent, interview questions and strategies at the onset.

The consent form was written at a reading level appropriate for the participants. The form contained information related to the expertise of the researcher, purpose of the study, sample population, research process, study timeframe, possible benefits and risks, how the study would be used, assurance of confidentiality, the right to participate or withdraw from the study, and contact person information. Signing of the consent guaranteed the participants read and understood the research process, as well as their rights, and were willing to participate (Crosby et al., 2006). I began data collection after receiving the signed informed consent.

Researchers are morally obligated to manage research data safely (Crosby et al., 2006). This includes maintaining confidentiality, as well as carefully monitoring and storing data to protect the identity of human subjects. I did not use names during the data collection and analysis process to ensure anonymity of participants. I securely stored interview notes and transcripts on my personal computer, with added security provided by Norton Internet data protection and antivirus software. A private password, inaccessible to others, protected the data. I also securely locked audio-recordings in a vault with a password-enabled code accessible only to me. I obtained a signed confidentiality agreement from the peer reviewer. I will securely store all data related to the current study for 5 years from the collection date as per Walden University policy. On completion of the 5 year period, I will delete all data from the computer hard drive, software, and audio-recorder. I will share the results of the study with the participants and other interested healthcare professionals.

Summary

In Chapter 3, I presented the research design for the current qualitative phenomenological study. The chapter also contained the research design and rationale; role of the researcher; and a discussion of the methodology such as participant selection, instrumentation, procedures for recruitment, participation and data collection, as well as data analysis. Chapter 3 also included a discussion on issues of trustworthiness and ethical procedures in qualitative research. Chapter 4 will contain an in-depth report of the current study findings. The key areas I will discuss in the chapter will include demographics, data collection, data analysis, interview findings, results, evidence of trustworthiness, and a detailed summary.

Chapter 4: Results

Introduction

My aim in conducting this qualitative phenomenological research was to explore 10 first-time African American mothers' experiences and perceptions about breastfeeding while seeking breastfeeding support. Creswell (2007), stated that a sample size of five to 25 individuals is appropriate for qualitative phenomenological studies. A suitable sample is necessary since the sample size and sampling strategy are influenced by the unit of analysis, the study purpose, data requirement, and available resources (Patton, 2002). My selected sample for this study was appropriate to provide adequate in-depth information and fulfill the study purpose (see Onwuegbuzie & Leech, 2007).

Therefore, the single research question that I developed to guide this study focused on first-time African American mothers' perception and experience of breastfeeding support. The research question guided my exploration of the mothers' personal meaning of breastfeeding support and revealed new information about the ways breastfeeding support is perceived by first-time African American mothers. The research question was: What are first-time African American mothers' perceptions and experiences of breastfeeding support? This chapter will include my summary of the interview findings of the 10 participants recruited through advertisement on the BMBFA Facebook page. The chapter will also contain information about the participants' demographics details, data collection procedures, data analysis, results, evidence of trustworthiness, and a detailed summary.

Demographics

The participants answered a series of demographic questions regarding their breastfeeding experiences. The results are reported in Table 1.

Table 1

Demographic Information From Interview Introduction Questions

Demographic	*n*	%
Age		
18-27	4	40
28-37	5	50
38+	1	10
Marital status		
Single	6	60
Married	3	30
Divorced	1	10
Hospital delivery		
No	0	-
Yes	10	100
Delivery time		
Before 37 weeks	0	-
After 37 weeks	10	100
Planned to breastfeed		
No	0	-
Yes	10	100
Who influenced decision		
Partner	1	10
Family member	4	40
Healthcare professional	2	20
Self	1	10
No definitive answer	2	20
When prepped to breastfeed		
Before pregnancy	5	50
During pregnancy	4	40
After delivery	1	10
Preparation method		
Audio visual	2	20
Classes	5	50

(table continues)

Demographic	*n*	%
Other	1	10
All of the above	1	10
None	1	10
Intended breastfeeding duration		
Less than 6 weeks	0	-
Between 3mo. and 6mo.	0	-
Over 6 mo.	10	100
Actual breastfeeding duration		
Less than 6 weeks	2	20
Between 3mo. and 6mo.	3	30
Over 6 mo.	5	50
When started breastfeeding		
Immediately	4	40
Less than an hour	1	10
Later than 1 hr.	5	50
Room with baby		
No	2	20
Yes	8	80
Feeding method		
Breast only	6	60
Breast and formula	4	40
Received assistance		
No	0	-
Yes	10	100
Positive experience		
No	2	20
Yes	8	80

Most of the participants reported positive experiences with breastfeeding and roomed with their child after birth. All of the participants received assistance with breastfeeding in the hospital. All participants intended to breastfeed for over 6 months, though only half of the participants reached that mark. The other half breast fed for less than 6 weeks to 6 months. Only one participant did no preparation for breastfeeding before birth and a significant number of participants took a class on breastfeeding. Almost half of the

participants were influenced to breastfeed by a family member. More than half of the participants were married, and a great majority were between the ages of 18–37.

Participant Recruitment

I recruited the participants for this study through advertisements on the Facebook page of the BMBFA. I allowed participants to contact me if they were interested, rather than making initial contact with them, which may have been considered intrusive. No contact was made with participants prior to obtaining IRB approval. I used the purposeful criterion sampling to recruit 10 first-time African American mothers 18 years and older who responded to the advertisement with interest and delivered term infants requiring only well-newborn care. Participants were recruited over a 3-week period between February and March 2017. Ten first-time African American mothers responded by e-mail within the first week of me advertising the study and confirmed their interest and eligibility to participate in the study. However, two of these eligible participants did not respond to subsequent e-mail communications or proceed with signing the consent form. Recruitment of participants continued into the third week until 10 eligible participants confirmed interest and provided written consent to participate in the study.

The study population consisted of women who had uncomplicated vaginal deliveries of term infants and who intended to breastfeed. Mothers who were not able to initiate breastfeeding early, who had previous live births, and mental health issues were not eligible to participate in the current study. Only English speaking mothers were allowed to participate so as to eliminate language translation issues. This homogenous population was relevant for the purpose of the study which was to explore the perceptions of African American mothers with no prior breastfeeding experience. I screened

interested participants upon initial contact to ascertain whether they met these criteria and asked to provide confirmed interest and sign the informed consent form to participate.

Data Collection

I recruited participants for this study using the BMBFA's Facebook page. An advertisement on the Facebook page was used to announce the study and invite first-time African American mothers to participate (see Appendix E). This advertisement contained the purpose of the research, the role of the participant, as well as the inclusion criteria and my contact information for those who were interested. I then asked interested potential participants to respond by e-mail to my personal e-mail address.

When interested parties contacted me, I reviewed the purpose, objectives, time commitment for telephone interviews, and data collection process for the study with the prospective participants. I then selected participants according to the order of e-mail responses received confirming their interest and eligibility. Recruitment continued until I obtained 10 participants. A second e-mail with the consent form was sent to each of the 10 eligible participants to be read, dated, signed, and returned to my e-mail address prior to any form of data collection. After obtaining the signed consent to participate, I sent a follow-up e-mail, requesting a convenient date and time to conduct the telephone interview. The e-mail correspondence was confidential and adhered to all ethical principles of research as outlined in the IRB form. The data collection process included a series of related activities which were created to obtain relevant information to answer the research questions (see Crosby et al., 2006; Patton, 2002).

I recorded the data using digital audio-recording. Data collection was conducted through telephone interviews over a 2-week period. Each interview lasted approximately

30 minutes or until adequate and quality information was obtained. Interviews did not exceed 60 minutes in totality. The interview started with questions inquiring about demographic data such as age, race/ethnicity, parity/number of children, marital status and spoken language (see Appendix D). I used open-ended questions to determine breastfeeding intention, initiation and duration, current breastfeeding status, and perceptions of breastfeeding experience (see Appendix C). The interview protocol used for each participant included assignment of a number to ensure anonymity and confidentiality. I then secured the data in a confidential folder on my personal password protected computer, located in my home office, which only I had the ability to access.

I conducted the interviews within the first 6 to 7 months after delivery to minimize bias due to retrospective reflection and also to increase the retention rate. According to Hassan (2005), recall information depends on memory which can be unreliable and result in difficulty remembering events that occurred in the past. Scientific evidence also confirms that individuals may not be able to recall 20% of important information from an event after 1 year from its occurrence (Hassan, 2005). The interviews took place at a time and date convenient to the participants. This was necessary as the comfort and privacy of participants was essential when discussing personal experiences (see Suzuki et al., 2007), such as breastfeeding. Participants obtained a copy of the transcribed interview if they so desired and were informed that the study, without their identity, would be published on completion.

Data Analysis

Data analysis in qualitative research closely relates to the data collection process and may not be easily distinguished (Patton, 2002). The research questions and

interpretation developed during data collection serve as the key sources in organizing qualitative data analysis (Creswell, 2009; Patton, 2002). Braun and Clarke's (2006) thematic data analysis is commonly used in qualitative research to identify, analyze, report patterns/themes within data, and interpret essential characteristics of the research topic. This method of thematic analysis can be applied irrespective of the theoretical and epistemological approach used in the research (Braun & Clarke, 2006).

I used Braun and Clarke's (2006) thematic data analysis to (a) provide a report of the participants' breastfeeding experiences and perceptions, (b) examine the effects of social interactions on their breastfeeding decisions, and (c) identify how the participants ascribed meanings to their experiences and how healthcare providers influenced those meanings. The thematic analysis provided flexibility which was useful in generating rich, detailed, and complex data. Thematic data analysis began during the data collection stage when patterns and areas of interest started emerging. This analytic process was recursive, developed over time, and involved the following six phases:

During Phase 1, I read and reread the data several times to identify meanings and patterns, as well as become familiar with the data. My transcription of verbal data was an interpretive act which increased my familiarity with the data. During this process, I took notes and made observations about each interview.

Phase 2 involved generating initial codes from the list of ideas obtained in Phase 1. During this phase of the analytic process, I organized the data in meaningful groups. I created a total of 19 codes. These codes are located in Table 2.

Table 2
Original Codes

Original Codes	
People who encouraged breast feeding	Group support
Breastfeeding is best	Support from lactation consultants
Formula is not good	OBGYN
Personal research about breastfeeding	Pediatrician
Breastfeeding groups	Enjoyment of breast feeding
Lactation consultant	Want more information
Research	Challenges with breastfeeding
Nurse support	

Phase 3 began with sorting the coded data into themes and collating all data extracts under relevant themes. I sorted the codes into like groups until no further reduction in data was possible. A total of five themes emerged during this process. I will list and define the themes in the results section later in this chapter. Phase 4 involved reviewing and refining identified themes, and recoding to provide clear patterns and establish the validity of themes in the data set. Once this process was complete, I noted no changes in the theme alignment.

Phase 5 was the stage of defining and naming themes. I identified what each theme meant and the area of data that it captured. Collated data were reexamined and each theme or subtheme was organized into a clear and internally consistent report with a narrative. Phase 6 represented the final stage of thematic data analysis. It began with a set of defined themes and involved the final analysis. Phase 6 ended with my reporting of the content and themes in the data in the results section of this chapter. The themes will be reported accompanied by supporting excerpts from the data.

In keeping with these steps, the data analysis process for my study required active listening to the participants' reports of their breastfeeding experience. I transcribed the

interview data verbatim. The text interview data were read several times in order to become familiar with the data. This allowed me to immerse within the data and obtained a deep understanding of the meaning each participant ascribed to the experience.

I initiated a detailed analysis using the NVivo Version 11 computer software to code the data. I imported each interview transcript into the NVivo computer software, auto-coding, and storing it. The coding process provided essential themes for analysis. I identified common words, experiences, and phrases and used them to create the themes and subthemes. These themes captured the meaning of the participants' breastfeeding experiences.

The NVivo computer software allows qualitative researchers to organize and manage data to easily visualize themes and their relationships. NVivo qualitative computer software can be used to break down and code the responses from the open-ended interview questions (QSR International Inc., 2011). Completion of the qualitative data analysis process was confirmed when new themes no longer emerged, which indicated that saturation has been met. I confirmed the validity of the data analysis process through member checking.

Issues of Trustworthiness

Credibility

Credibility is the qualitative research equivalent for internal validity in quantitative studies, which allows a qualitative researcher to be confident in the truth of the study's truth. Due to the nature of this study, I utilized triangulation of sources by comparing each participant in order to establish or verify emerging categories and subsequently themes. Prolonged engagement is ideal when a qualitative researcher is

able to spend a sufficient time with the group under study in order to understand the social setting or phenomenon under study (Lincoln & Guba, 1985). Inherent to this technique is building rapport and trust between participants and the researcher, which aids when coconstructing meaning throughout the data collection process. I made sure all participants were comfortable during the interview process and spent time probing responses and encouraging participants to share information. Participants were presented with the interpretations and analytic categories that were developed from the participants' data, and invited to make corrections and provide feedback concerning the accuracy of the account.

Transferability

Transferability is equivalent to the concept of external validity in quantitative research; it is the ability to transfer the study findings to other settings (Trochim, 2006). I used thick description to explain the phenomenon in sufficient detail in order to demonstrate that the conclusions and results can be understood to an extent that a second researcher can make conclusions about the transferability to other social settings. In addition detailed demographic information was collected to enable others to visualize and understand the participants who offered the data used in this study.

Dependability

Dependability is the qualitative equivalent of the quantitative concept of reliability. In qualitative research, it is a measure of ensuring that the study results remain stable over time (Trochim, 2006). I ensured dependability of the current study findings through the following procedures:

1. Assessing the interview transcripts for errors during transcription;

2. Documenting the research process in detail to facilitate replication; and
3. Soliciting member checks for comparative interpretation of the data by another person.

Confirmability

Confirmability is the process of establishing the value of the data in qualitative research or verifying the outcome with others (Trochim, 2006). Strategies to improve confirmability of the current study included reporting the findings accurately. Provision of thick, in-depth reports of the participants' views supported the interpretation of the study and enhanced confirmability of the findings. Member checking also confirmed the accuracy and credibility of the study findings.

Results

The data that were gathered from the participants were analyzed and resulted in the creation of five themes. The themes were titled: support from professionals, breast feeding support, reasons for choosing to breastfeed, experiences in getting breast feeding support, , and overall experiences breastfeeding. The themes are reported with supporting excerpts from the participant interview.

Support from Professionals

The experiences described in this theme were more mixed. Lack of support reported was mainly in their relationships with their OBGYN physicians. Pediatricians were described as helpful as well as nurses.

Participant 1 had some challenges when trying to breastfeed her child. She had great difficulties and eventually switched to using a bottle. She initially blamed herself. She spoke about her experience and said:

> I probably would have had a better experience if I would have known that her tongue wasn't long enough. That's why she wasn't getting on. Instead of trying to make her get on when she couldn't and getting frustrated with it. The pediatrician, she helped me a lot.

She did not know that her child had an issue that would impede her ability to breastfeed. It was not until she spoke with her pediatrician that she understood why breastfeeding was ineffective. She went on to describe her emotions and said:

> If they would just would have told me that her tongue was tied and it needed to clipped and it wouldn't have been so stressful and thinking that I failed at trying to breastfeed when it wasn't me that wasn't doing it right. It was just the situation.

While she was please to know she had not "failed," she was upset that the information had not been proffered. Participant 1 felt that she spent a good deal of time blaming herself rather than understanding it was the circumstance that was challenging.

Participant 10 had very limited interaction with her OBGYN and said, "actually that doctor was the first day, the delivery day was the first time I met that person. I didn't have much interaction. I don't even think we discussed breastfeeding." She did indicate that she received support and information from her pediatrician, but said that, "I don't think I saw my OBGYN after." She went on to say, "I would say there was definitely less support. It's [breastfeeding] not something that was a topic of discussion."

Participant 10 also felt that she did not receive a lot of support from the lactation consultant. She said:

> Honestly, I think I saw the lactation consultant once or twice after my son was delivered. That was it. I would say there wasn't too much follow up to check and

> see how it was going. Maybe I saw them within the first month, but then after that, there was no contact.

She found the follow up to be brief and not helpful. She felt that she should have been offered more support and wished that she had been able to learn more about breastfeeding form professionals who were supposed to be aiding her. Participant 4 also felt as if she did not receive the support she needed. Before the birth of her child she felt as if every professional was providing her support and encouraging breastfeeding as best practice. However, after the child was born her experience changed. She said:

> She just wasn't patient with me. I understand that they have many that they have to tend to, but as a first time mom, I felt like it should have been where we could have had more one on one and maybe later on after she showed me the one time, they should come back in the next hour or next day to see, "Is everything going before you leave? Do you have any questions about breastfeeding?" I think that would have been more helpful than what I experienced.

She wanted more individualized support from the professionals around her. She was a first-time mother and very unsure of herself. She wished that people had checked on her more often to make sure she understood what she was doing and to see if she had further questions.

Participant 3 also believed that more support should have been offered to her after the birth of her child. Although she reported that people were encouraging she said:

> It just was a, basically, just told me it, you know, good job, keep it going, don't be discouraged if I start to dry up, or anything. It wasn't ... There wasn't a lot of

> support. I don't think it was on purpose that they just didn't say a lot. They were really happy that I did it, and encouraged to keep going.

While she appreciated the encouragement she received, she would have preferred to get knowledge and support. She wanted more information than she was receiving and wished that there had been more structure.

Participant 2 was one of the participants who was satisfied with the support she received. She found the professionals around her to be very responsive and said:

> The support that I got, I think it was good that they were there and ready to help just in case you need them. I like that about it, that they were available and ready to help. I had difficulty with the format that they wanted me to use to breastfeed, so that was difficult for me, but otherwise everything was great. They were really helpful. They were available. If you call for someone, they would be there. I think, in terms of that aspect, that was good.

Although she also faced challenges in adjusting to breastfeeding, she was able to access the support she needed. She understood it was a learning process, but was more confident in herself because of the support she received.

Breast Feeding Support

This theme was used to explore the list of programs and supports used by the participants when seeking support for breastfeeding. These supports included breastfeeding groups, hospital support, lactation consultant, classes, as well as, research on their own.

Several of the participants worked with WIC after they returned home from the hospital. They found these services to be very helpful. Participant 9 felt she was able to

get a great deal of support because in her state, “everywhere you went it [breastfeeding] was being talked about.” She went on to speak about her experience with WIC in detail and said:

> They have a WIC program where they had someone, who if you're breastfeeding, they'll assist and see if they can come to your house, assist you. They call to see whether or not you're having any issues. They give you documents and leaflets that you could read in case you're having difficulty. They'll also show you different ways to hold the baby just in case you're not comfortable in one position. That it's important for you to get rest while you're breastfeeding. Sometimes it's gonna take longer time for a child to latch on so you just have to be patient. The baby's learning to suckle just like you're learning to feed.

She felt extremely supported and credited this level of support for her success. The help she received and the education provided helped her be patient with the process and patient with herself. She described it as a learning process and indicating that it took time to adjust.

Participant 10 delivered her baby at Kaiser and also had a positive experience in finding support after her child was born. She spoke about her experience and said:

> I went to Kaiser and I was surprised by how supportive they are. They advocate for breastfeeding actively. They had a lot of information on the benefits and also very supportive in terms of being able to call and talk to someone and go in. It was definitely a good experience going through Kaiser.

Not only was she able to access written materials that she found helpful, Participant 10 was able to connect with professionals who could offer teaching and support. In addition,

Kaiser was able to help her understand any benefits that she could receive and were forthcoming with information.

Participant 5 was fortunate in her experience as well. She was able to connect with a support system before during and after giving birth. She said:

> I think I had a really good hospital. I took a breastfeeding class which was actually the over-seven session class on just childcare and labor and how all that works, so our last meeting was just pure breastfeeding, and it was taught by a doula and a mother of eight, so I really trusted her expertise, and then when I finally did deliver the baby it was great that the lactation consultant actually helped deliver him, so I already had a bit of a relationship with her. She just kind of helped with the logistics and really showing me if he was on right or not, and it helped with my confidence having her right in the hospital with me.

She was able to connect with a professional who taught her about labor, delivery, and breastfeeding before her delivery. Since her teacher was also her doula, she was there during her delivery. She continued to provide support and encouragement after the birth. This relationship increased her confidence and helped her be successful.

Reasons for Choosing to Breastfeed

This theme contained information from the participants about the factors that influenced their decision to breastfeed. All participants had data which was included in this theme. The participants listed the following influences: (a) the people they knew who encouraged them, (b) belief it was better for the child/more healthy, (c) did not like the idea of formula and, (d) personal research and study.

The participants spoke about being influenced by people who they knew. Participant 10 spoke about her experiences and stated, "I had a lot of support from family in terms of their ideas of raising a child being in line with my views." She had a clear picture of how she wished her child to be raised in relation to her personal ideas and values. She indicated that, "I had a lot of support from family in terms of their ideas of raising a child being in line with my views." Participant 8 said she was influenced by "friends and family." She reported that, "They told me lots of the benefits." Participant 8 stated that the physician also agreed and that the doctor, "told me more about the benefits that happen with the child in the long run."

Participant 3 indicated she was influenced by her partner and his family. She said, "his family were, just all breastfed. My family never breastfed." She reported speaking at length with her partner and his family as the first step in her decision to breastfeed her child. For Participant 7, breastfeeding seemed to be the natural option. She stated, "My mother breastfed me and other family members I know breastfed their babies as well, and from that and other knowledge that I knew from breastfeeding, I decided that it would be best." Some of the participants engaged in personal research and studies about the benefits associated with breastfeeding. Participant 5 spoke about her experience and stated:

> As I progressed in my pregnancy I read a lot of articles and I had friends that breastfed that shared information with me, so I know that for example breastmilk carries antibodies if you're sick to help your child build up their immune system.

She spent time doing research in order to better understand how breastfeeding would be helpful for her child. Participant 4 also spoke about spending time "doing research."

Participant 3 spoke about her experiences and said she was, “researching, and going to classes, I took that knowledge, and I thought it was the best option for my child.” All of these participants spent time using the resources they could access to learn about breastfeeding and associated benefits. Once they did their research, they were convinced that breastfeeding was the best option for their children’s health and wellbeing.

Their experiences in studying about breastfeeding and talking with others about the benefits of the practice led the participants to believe that breastfeeding would provide many benefits for their child. Participant 1 stated she chose breastfeeding because, “it was supposed to be healthy for the baby and to get some bonding time with the baby.” She felt breastfeeding would help her bond with her child and also offer health benefits. Participant 5 spoke about her opinion and said, “I know that for example breastmilk carries antibodies if you're sick to help your child build up their immune system.” She wanted her child to reap all the benefits of breastfeeding and felt it was the best option. Participant 5 agreed and said, “the fact that it was the most nutritious way to be fed, helped me make the decision.”

For some of the participants breastfeeding fit best into their lifestyle and beliefs. Participant 9 said, “being vegan I honestly don't believe in formula. I think it's introduction to junk food. I'm healthy eating.” Participant 10 agreed and spoke at length. She remarked:

> I would start by saying I definitely believe in living a natural healthy life. I live a very healthy lifestyle so I feel like as a mother, that provided a good way to provide nutrients to our children. I think that's just the best way. That was number one.

They had chosen a specific lifestyle and felt that breastfeeding best supported that choice. For these participants, giving their child a healthy start to life was essential. They believed that breastfeeding enabled them to do so.

Many of the participants did not have a high opinion of formula. They felt that it was not a healthy choice to make. Participant 10 stated:

> Also understanding that formula, while it is necessary for [some] situations, if I'm able to breastfeed, why would I give something that isn't natural, [to my child] or I could potentially overfeed them. . . formula. For babies and obesity and [formula feeding are connected] for example.

She was concerned that formula, while necessary in some situations was not the optimal choice. She worried about long term effects and stated that she wanted to give her child a healthy start to life. Participant 5 agreed and spoke at some length. She said:

> It's [breastfeeding] also free whereas formula another expense. . . I know that for example breastmilk carries antibodies if you're sick to help your child build up their immune system. What else, and I also don't know what's in formula so I'd rather do something more natural. I think that's big for me, just being natural and not giving my child any synthetic hormones or any cow's milk or stuff like that at this age.

For many of the participants in the study, giving their child a health start to life was of primary importance. They worried about what was in formula and the effects of feeding a child formula if it was not necessary.

Some participants had more negative experiences. Participant 4 had great difficulties with breast feeding and indicated it was a negative experience. She said:

> I didn't like it because they only stayed in the room for a short period of time. To me, once she saw that he latched on, she left. The way she showed me was incorrect. That's why I was only able to breastfeed him for the two weeks because I started cracking and peeing and bleeding. It was very uncomfortable afterwards.

Participant 4 felt that she did not receive the support and help she needed to be successful. Breastfeeding was challenging because she was unsure of herself and she was suffering great physical discomfort. She went on to state:

> When I finally went to my doctor, I think it was before the 6 weeks, she was saying I shouldn't have cracked as much as I did. My nipples shouldn't have been as cracked and feeling like it was. He was latching on wrong. I knew that every time he latched on, it was very uncomfortable for me. I knew you could have discomfort, but not the way I was having it.

Participant 4 did not report reaching out and asking for help from others. She was unsure of what she should be doing, and the lack of support around her made it challenging for her to continue breastfeeding.

Experiences Getting Breast Feeding Support

This theme was used to explore the search for support and their experiences with support immediately after the birth of their child. The participants had good experiences finding support. They learned from the experiences – most often the support they spoke about was from nurses, groups and lactation consultants.

Many participants spoke about working with lactation consultants. Participant 1 indicated that although her physician was not helpful, she did get some limited support from hospital staff. She said:

> She just came in and just helped put the baby on and left and then I was having a hard time getting her to get on, and really didn't get my questions answered that I was looking for and just wish it would have been more time instead of just a rush in and out.

She felt rushed and that she lacked support. She was not sure where to get the help and knowledge she needed.

Participant 9 had a very positive experience and spoke at length about the people and policies that helped her. She stated:

> I think I had a pretty good service provider who from the get-go talked about this. Where I was there was a lactation specialist who did educational sessions. It was accessible for me, it wasn't hard. The state I live in, they do have a breastfeeding policy in place that you get a card where you could actually walk around with. I was humbled by my job where it's a part of our policies and procedures where you're given time to go pump milk when you need to and you can do this up to the child is three years old. It's been good.

From the very beginning, she believed that she received the highest level of support. She was the recipient of aid from her provider, a lactation consultant and others. She was supported in public and at work. She felt that she was surrounded by many factors that enabled her success.

Participant 6 received information and support from her physician and the internet. She spoke about her experience with her physician and stated:

> When I initially got pregnant and continuously going to my appointments at the doctor, later on in my pregnancies, close to birth is that the doctor would give us, well give me and my fiancé, give us options as to what we could do or the outlets that we could reach out to, to receive advice for breastfeeding. One of which was the breastfeeding class that I attended. It was okay.

Her fiancée was included in this process and was actively involved. She felt the knowledge she received was helpful and was pleased to receive information about available local resources. Because of this, she attended a breastfeeding class. She did not provide much information about the class itself other than to state that, "it was okay." She found breastfeeding to be a 'great experience."

Participant 7 was another participant who received some support when she decided to breastfeed her child. She stated:

> The way they taught me how to hold the baby to breastfeed, I don't think that was good for me. At first I had difficulties in latching, and I got frustrated with that method because the baby was not latching onto the breast. Somehow I felt like if I wasn't doing it properly, I was failing. After going home and my mother showing me how to do it, which was a different way than she did it, which was holding the baby like you would normally hold a baby, and let the baby latch on to the breast, that's when it became easier to me, because then I realized that this whole football and holding wasn't working, but just holding the baby normal, and having the baby latch onto the breast, that worked perfect for me. I guess just the

> way they went about teaching me how to let the baby latch onto the breast, or the way you should hold a baby, that was difficult for me.

She felt the support she received was okay but believed she could have "received a little more support." What she was taught in the hospital was not effective. She was initially frustrated and unsure. When she returned home she was able to speak with her mother, who provided the most effective support that she had received, which enabled her to be successful.

Overall Experiences

This theme focused on the overall comments women made about breastfeeding. Most women in the study deeply enjoyed the breastfeeding experience. Struggled with the experience and persevered. Others dealt with family opposition. Overall the participants in this study felt breastfeeding was very important and worth the struggles they faced.

Participant 10 wanted to make sure that fist time mothers really understood the importance of breastfeeding. She indicated that she had to do a great deal of self-education. Participant 10 said:

> I definitely think it's so important for first time moms, all across the board to be aware of the benefits. I had to do a lot of research on my own to understand why breast milk is so beneficial for babies, especially even after six months after one year. I think there's not enough information out there that's readily available on how your milk changes as your child grows. All the different components that are amazing for them that are so beneficial and protective.

She was knowledgeable because she made a concerted effort to learn more about breastfeeding on her own. The resources and information she wanted was not easily available. Participant 10 believed that if more women could easily access the information she had to search for, breastfeeding rates would increase. She was especially critical about the fact that information about how breast milk changes as the child ages was not available.

Participant 5 remembered some struggles she underwent when she was attempting to breastfeed for the first time. She reported about her struggles and said:

> I was struggling with my right side, like finding a comfortable way to hold him so we tried different positions, and she helped find a position that was easier for him to latch on, and then she also told me that sometimes if they're not, like you can lead a horse to water, but you can't make him drink, so sometimes you could do everything right. If the baby is not hungry or not in the mood to latch at that time, there's really nothing you can do but just try again in a few minutes

It very important for her to know that it could be challenging to breastfeed a baby. Getting information from a professional helped her to realize that she could do everything correctly and her child could still refuse to eat. It helped her acknowledge that her infant had thoughts, feelings and moods. Sometimes, she said, "the baby is not hungry." She learned it was important to be patient and be willing to try again and again.

Participant 3 faced some challenges in the beginning of her experience. She was new to breastfeeding and did not have anyone in her family who was familiar with the experience. She stated:

> I think it was, in the beginning, it was a very rough experience. One thing, as I mentioned before, I didn't have any family who breastfed. Coming from an African-American family, a lot of us don't breastfeed. A lot of times I was lost, just wasn't sure what to do, or who to call, and who to depend on. My family were ashamed. They didn't see the positive in it. Sometimes they'd make me go in other rooms, and hide me doing it.

Not only did she struggle with the act of breastfeeding, she also had to deal with her families' perceptions of breastfeeding. They regarded breastfeeding as something shameful and made her leave family gatherings to breastfeed. She had to fight against their perceptions and felt as if she had no support. She described feeling "lost" with no one to depend on. She went on to say:

> It wasn't until I thought to myself that I was doing something positive, that I decided not to hide my shame for breastfeeding my daughter. Once I stopped doing it, it allowed my family to see that I was doing it. I wasn't going to be discouraged from it, although they wanted me to do other things. It just kept me more motivated just to keep doing it. I think everyone should breastfeed their children.

Participant 3 had to take control of her own viewpoint about her breastfeeding and embrace the reason she was doing it before she could work with her family and make them understand. She felt it was an experience they did not understand because breast feeding was not common among the African American families she and her family knew. Once she reached a sense of comfort with the practice, she could advocate for herself and educate her family.

Participant 7 believed that breastfeeding was very important and felt that, “we should do more to encourage people to breastfeed, because like I said, a lot of people get discouraged.” She worried that people were told to breastfeed but then not offered the support and encouragement they needed to be successful. She spoke about her experience and statements she heard from others and stated:

> I think in the beginning they feel like, you know, they're saying that their baby won't latch on, or their baby won't eat, or the baby will go hungry, and those are all things that you see in newborn babies. Especially for me, my daughter wouldn't, she wouldn't latch on at first and she didn't want to eat all the time, and that's because they're, you know, they're still babies so they're still adjusting.

Participant 7, more than any other participant, expressed the idea that breastfeeding is not some innate skill that all women possess. The process was unique to each child-mother pair, and often a great deal of support and information was essential. She stated:

> I think people give up too soon, so if we could do more to encourage other mothers to keep on going and not give up at first, then I think there would be a lot more people that decide to breastfeed.”

Participant 7 went on to speak about her friends and their desire to ability to breast feed and said:

> Even now, I don't have, know, or have a lot of friends that choose to breastfeed. They did do breastfeeding at first, but then they just gave up because it was too hard to work around their schedules, or just they wanted to get back to their normal daily routine, but I think overall it's more beneficial for your baby, and it is challenging, but the important part is it's for your baby.

She believed that breastfeeding could be very difficult. There were many challenges and sacrifices involved. Participant 7 thought if women had better support and education more women would continue to breastfeed.

Participant 2 breastfeed for a little less than 6 months. She felt it was a positive decision and wanted to give her child a good start in life. She was not totally happy with her experience and said:

> My baby stopped breastfeeding at about 5 months and some weeks. I wish that she had continued up until age one. What I didn't realize was that it was changes I get in the taste of the breast milk because of hormones changing, and after I stopped breastfeeding and I spoke to a doctor about it, then the doctor explained to me that that's what was happening and I should have kept at it and the baby would have started to breastfeed again. I felt a little defeated in that sense, like I didn't get enough support so that maybe the baby will stop breastfeeding, but continue and the baby will start again. That was a little bit disappointing.

Because she did not have the education, support and knowledge that she wanted, she felt that she had discontinued breastfeeding too quickly. She indicated that if she understood what was happening with her body she could have persevered and continued to breastfeed.

Participant 6 had a deeply enjoyable experience breastfeeding her child she felt it had been very important and was proud of her ability to care for her child. She said:

> Actually, my daughter is still breastfeeding. . . I hope to stop in a matter of 2 months, because I've researched that by 18 months your baby should start making their own antibodies so they won't necessarily need to have to have a need to

> breastfeed. Hopefully, that will go away once I start to ween her off, but my overall experiences have, I would say it's been a very positive, demanding, but it's been a great experience. I can never say anything negative about it. I love the connection that I have with my daughter, because I've breastfed her from the beginning.

She did not have anything negative to say about breastfeeding and felt very accomplished. For Participant 6, being able to provide for her daughter strengthened their bond and enabled her to make sure her child would be healthy and protected from illness. She indicated that breastfeeding was demanding and at times challenging, but overall, she felt positive about the experience.

Summary

The participants in this study spoke about the act of breastfeeding. Most of them found it to be a rewarding experience. They educated themselves, attended classes and worked with professionals to learn about the practice. Some participants were not able to breastfeed and had a challenging time. The majority enjoyed breastfeeding in spite of struggles they faced. Overall, the women felt it was important to breastfeed for their children’s health and wellbeing. Their main area of contention was a lack of adequate support from professionals after they gave birth. All of the participants were spoken to about the importance of breastfeeding before giving birth, but the follow through afterwards seemed to be problematic for many of them.

In this chapter, I described the results of this study. The chapter included a report of demographics, participant selection, and data collection. The chapter also included a report of the data analysis process and the results. In Chapter 5, I will discuss the results,

implications for professional practice, areas for further research, and any limitations of the study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative phenomenological study was to explore a purposeful sample of 10 first-time African American mothers' experiences and perceptions about breastfeeding support received from healthcare providers. The study participants were English-speaking mothers who delivered term infants who required only well-newborn care. I recruited the participants through advertisement on the BMBFA Facebook page.

In Chapter 5, I will present the conclusions I drew from the in-depth interviews of first-time African American mothers' breastfeeding experiences. The results of the study revealed descriptions of the participants' experiences and helped to validate the level of support first-time African American mothers received from healthcare providers while seeking breastfeeding support. The findings of this study also provided information to assist healthcare providers to better understand the experiences and meanings first-time African American mothers ascribed to their breastfeeding support experiences. Such understanding could help health care providers address the mothers' concerns and experiences more effectively. The research question I developed for this study guided my exploration of the phenomenon and examination of the gap in the literature. The chapter will also contain my interpretation of the findings, the limitations of the study, my recommendations for future research and practice, the implications for social change, and a conclusion/summary of the main points of the study.

Interpretation of Findings

In this section, I will provide a description of the themes that emerged from the participants' interview responses. Ten first-time African American mothers responded to my semistructured, open-ended interview questions about their breastfeeding intention, initiation and duration, current breastfeeding status, and perceptions of their breastfeeding experiences. Several themes emerged that supported my assumptions in this study as well as corroborated theories I found in my review of the literature.

Theme 1: Support from Professionals

My findings from this study substantiated information from other studies related to the importance of adequate breastfeeding support interventions from healthcare providers. These included studies evaluating the impact of the BFHI, ACA, WIC, and healthcare providers' breastfeeding behaviors. In these studies, breastfeeding mothers identified emotional, informational, and tangible support as necessary interventions for healthcare providers when promoting breastfeeding (Drago et al., 2010; Kramer et al., 2001; U.S. Department of Health and Human Services, 2013). Researchers also revealed that a significant number of Americans seek support from healthcare providers because of their perception that healthcare providers are capable of influencing mothers' breastfeeding decisions (U.S. Department of Health and Human Services, 2013).

The experiences described by the participants in this theme varied. This variation in mothers' perceptions and experiences with breastfeeding support aligns with findings from previous studies (Cross-Barnet et al., 2012; Jessri et al., 2013; Kaufman et al., 2009; Lewallen et al., 2010; MacLean, 2011; Rossman & Ayoola, 2012; Schmied et al., 2011; Simpson, 2012). Participants identified the support they received from healthcare

providers in different behaviors displayed by physicians, nurses, midwives, and lactation consultant. Mothers mainly reported a lack of support in their relationships with their obstetrician. However, participants agreed that pediatricians and nurses were helpful.

Because early initiation of breastfeeding and proper position and latching of the infant are essential to successful breastfeeding, mothers perceived the presence and support of healthcare providers especially during the first feeds as great support. The literature also contained past studies that established an association between successful breastfeeding and supportive attitudes from healthcare providers (Hong et al., 2003). Taveras et al. (2004) agreed that early initiation of breastfeeding and adequate breastfeeding support from health care providers positively influence mothers' breastfeeding decisions.

Emotional support was also a key factor in the mothers' breastfeeding experience and was described by one mother as healthcare providers being happy that she was breastfeeding and encouraging her to keep going. Healthcare providers who demonstrated concern by being available to assist with breastfeeding were appreciated. Another participant recalled that it was great to have the nurse and lactation consultant available to help with latching the baby to the breast. Provision of a breast pump and contact information for assistance with breastfeeding after discharge from hospital were also considered to be supportive behaviors by healthcare providers.

On the other hand, despite preparing for breastfeeding during pregnancy, more than 50% of the participants reported that their breastfeeding experience could have been better if physicians, nurses, lactations consultants, and midwives offered adequate information, options, and support to overcome difficulties with breastfeeding. The

perception of these mothers was that healthcare providers, such as lactation consultants, did not provide relevant breastfeeding education, guidance, assistance with latching, and follow-up checks to ensure breastfeeding success. Previous researchers confirmed that healthcare providers who did not support breastfeeding were considered to be negative influences in the mother's breastfeeding experience (Cottrell & Detman, 2013; Drago et al., 2010; Philipp et al., 2001; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013; WIC, n.d). Therefore, participants indicated a need for healthcare providers to have individualized breastfeeding sessions with first-time mothers as well as maintain contact with mothers after discharge. Individualized breastfeeding support activities and provision of accurate, practical breastfeeding information were reported in prior studies as key factors which facilitated success in breastfeeding (Drago et al., 2010; Schmied et al., 2011).

Theme 2: Breast Feeding Support

Participants from this study indicated that they sought breastfeeding support from online breastfeeding groups, hospital support groups, lactation consultants, and breastfeeding classes. These participants confirmed that support from online breastfeeding groups, the WIC program, and family members and a desire for a healthy lifestyle were significant motivators in their decision to breastfeed. This information aligns with findings from previous studies by Declercq et al. (2009), Drago et al. (2010), and Romano (2007). Breastfeeding support groups create environments for mothers to access professional breastfeeding support and overcome breastfeeding barriers. In a prior study, Mickens (2009) emphasized the role of breastfeeding support groups in increasing breastfeeding initiation and continuation rates. In describing the importance of the

breastfeeding support group, one participant stated that the online support group was very helpful.

Theme 3: Reasons for Choosing to Breastfeed

Participants in this study were aware of the health benefits of breastfeeding, and therefore, intended to breastfeed for at least 6 months. One mother stated:

> I definitely think it's so important for first-time moms, all across the board to be aware of the benefits. I had to do a lot of research on my own to understand why breast milk is so beneficial for babies, especially even after six months and after one year. All the different components that are amazing for them are so beneficial and protective. (Participant 8)

The participants further listed social networks, cultural beliefs, dislike of formula feeding, and personal research as factors which influenced their decision to continue breastfeeding. This theme aligned with previous studies conducted by Gross (2013) and Simpson (2010), which noted cultural practices and family support as significant factors in sustaining breastfeeding. Of particular interest is the personal account of one mother who recalled that the support she received from her family contributed to her success with breastfeeding for over 6 months. Another participant reported that personal determination helped her to continue breastfeeding despite a lack of support from family members.

Theme 4: Experiences in Getting Breastfeeding Support

The participants reported that their experiences seeking breastfeeding support were positive and informative. Their encounters were with nurses, groups, and lactation consultants. The literature confirms that support for breastfeeding is highly

recommended and necessary in achieving positive breastfeeding outcomes (Perrine et al., 2012; U.S. Department of Health and Human Services, 2013). Provision of accurate breastfeeding information during pregnancy has been cited in previous studies as a way to empower mothers to breastfeed (Drago et al., 2010; Schmied et al., 2011). Participants who received breastfeeding assistance in the form of audio-visual material and assistance with proper breastfeeding technique were more likely to breastfeed for more than 6 months. All the participants in this study confirmed that breastfeeding support classes were readily available during pregnancy. However, some mothers felt that healthcare providers were not very supportive after delivery. Participants also considered the failure to provide breastfeeding education or follow-up checks after the first month a lack of anticipatory guidance.

Theme 5: Overall Experiences

Most of the participants in this study enjoyed their breastfeeding experience but wished physicians would focus more on breastfeeding and providing adequate information. Breastfeeding mothers desire to know and prepare for changes associated with breastfeeding. One mother who intended to breastfeed for at least a year but stopped breastfeeding before 6 months stated, “I didn’t realize the change in the taste of the breast milk because of hormones changes” (Participant 2). This mother also reported that she felt defeated and would have continued breastfeeding if healthcare professionals educated her about what to expect. Participants also recalled that there is no emphasis on breastfeeding after 6 months. Nutrition education is more geared at formula feeding and introducing solid food. One mother felt that the pediatrician’s primary concern was about vaccination rather than breastfeeding. It is necessary to address these nonsupportive

behaviors identified by participants because of the important role healthcare providers play in increasing mothers' breastfeeding confidence. One mother asserted that "if we do more to encourage other mothers to keep on going and not give up at first, then I think there would be a lot more people who decide to breastfeed" (Participant 7). In the same way, some healthcare providers failed to inform mothers of anatomical issues such as a tied tongue which prevented the infant from latching and breastfeeding successfully. Such ineffective communication by healthcare providers contributed to feelings of frustration, stress, and failure among mothers who intended to breastfeed. One participant claimed that:

> If they would just have told me that her tongue was tied and it needed to be clipped, it wouldn't have been so stressful and thinking that I failed at trying to breastfeed when it wasn't me that wasn't doing it right. It was just the situation. (Participant 2)

The literature shows an association between clear communication and breastfeeding success (Cottrell & Detman, 2013; Hong et al., 2003).

The findings also validated the conceptual and theoretical frameworks that I used in this study. I was able to generate themes and essential points by incorporating the phenomenological research strategy, the social constructivist philosophical framework, and the breastfeeding self-efficacy theory. The themes in this study reflected those of the conceptual and theoretical frameworks because as individuals interact in social settings they develop personal feelings about their experiences. These experiences can also help to foster self-efficacy.

For example, I used the phenomenological research strategy to guide the research process and understand the lived breastfeeding experiences of the participants. Phenomenology is the practice of revealing individuals' interpretation of an experience (Higgs et al., 2012; Kafle, 2011). Through interaction with the participants, I generated rich textual data, which subsequently provided clarity regarding the participants' breastfeeding accounts. Several participants reported that they perceived health care providers to be inconsistent in offering breastfeeding support. Some mothers felt like the physician and lactation consultants were in a hurry and did not spend enough time educating them about breastfeeding or assisting with proper position and latching techniques. In one account, a mother reported that she received little help from her physician who told her not to worry, just keep trying, and the baby will latch.

Similarly, I applied the concepts of the social constructivist philosophical framework to understand how first-time African American mothers construct meaning from their breastfeeding experiences. The social constructivist researchers believe that as individuals interact, they develop personal meanings related to their experiences (Research Methodology, 2014; Robert Wood Johnson Foundation, 2008). Application of the social constructivist theory was evident in this study as the participants' complex views emerged and provided an understanding of the personal meanings first-time African American mothers ascribe to their breastfeeding experiences. For instance, one participant described her breastfeeding experience as being tough during the initial phase. She felt that negative perceptions about breastfeeding within her African American culture contributed to her initial shame about breastfeeding. However, with

determination and motivation, she developed a positive attitude which helped her to achieve her breastfeeding goals.

The breastfeeding self-efficacy theory which was developed by Dennis in 1999 to enhance breastfeeding confidence and support strategies was also used to inform this research. The breastfeeding self-efficacy theory was used to explain how a mother's belief in her ability to breastfeed her baby influenced her decision to breastfeed and deal with breastfeeding challenges (Dennis, 1999; Dennis & Faux, 1999; Eidman, 2011; Phillips, 2010). Emerging themes from the current study revealed that adequate breastfeeding support from healthcare providers helped to enhance participants' self-efficacy and breastfeeding outcomes. Participants who attended breastfeeding classes and had direct supervision with positioning and latching the infant to the breast felt that this type of support increased their self-confidence about breastfeeding. Undoubtedly, adequate breastfeeding support from healthcare providers can positively impact the mother's breastfeeding experience. This study is the first to focus on first-time African American mothers' perceptions about breastfeeding support. Therefore, the results from this study contributed to a wide knowledge base and research related to perceptions of breastfeeding support. The current study provided the groundwork to examine further why breastfeeding rates are low among African American mothers.

Limitations of the Study

The main limitation related to this study was inherent in its phenomenological qualitative research design. Due to the phenomenological research strategy employed in this study, a small, purposeful sample was recruited. Although the sample was appropriate to provide adequate in-depth information and fulfill the study purpose (see

Onwuegbuzie & Leech, 2007), the lack of random sampling technique prevents generalization to other populations. This study was also limited in scope to first-time African American mothers who had uncomplicated vaginal deliveries. This limitation must be considered when applying these findings to other ethnic groups and mothers with previous breastfeeding history. Also, my role as a labor and delivery nurse and the principal data collection and analysis person may have presented a potential bias. To overcome this limitation, I openly disclosed my personal interests and biases related to breastfeeding, as well as actively listened and transcribed the participants' experiences verbatim to avoid influencing the data collection and analysis process. Despite these limitations, this study provides an in-depth account of first-time African American mothers' perceptions and experiences of breastfeeding support received from healthcare providers.

Recommendations

In this phenomenological qualitative study, I used a sample of 10 participants. One recommendation is that a quantitative study using a larger sample could be conducted to determine the impact of the ACA on breastfeeding outcomes. This approach is necessary since a major goal of the ACA is to provide adequate professional breastfeeding support and thereby equalize breastfeeding opportunities and choices for new mothers (Drago et al., 2010). For example, researchers could recruit participants from breastfeeding support groups such as the La Leche League International to provide a larger and more diverse sample. It is also important for researchers to further explore the concerns highlighted by the mothers in this study. A chief concern was the absence

of follow-up care to ensure that mothers were overcoming breastfeeding difficulties and increasing their confidence about breastfeeding. One participant stated:

> Honestly, I think I saw the lactation consultant once or twice after my son was delivered. That was it. I would say there wasn't too much follow up to check and see how it was going. Maybe I saw them within the first month, but then after that, there was no contact (Participant 10).

First-time mothers who do not have adequate breastfeeding support are less likely to be confident about breastfeeding. According to one participant, her initial attempt to breastfeed was difficult. She associated this with being the first person to breastfeed in her family and not having adequate breastfeeding support because a lot of African American mothers did not breastfeed.

In the same way, the breastfeeding self-efficacy theory validated the importance of self-confidence in a mother’s decision to breastfeed and deal with breastfeeding challenges (Dennis, 1999; Dennis & Faux, 1999; Eidman, 2011; Phillips, 2010). A key component of the breastfeeding self-efficacy theory is performance accomplishment which individuals achieve through self-confidence. For example, a mother who is confident about breastfeeding is more likely to overcome breastfeeding challenges. The literature also confirmed a strong correlation between breastfeeding self-efficacy and a mothers’ ability to successfully breastfeed (Dennis, 1999; Eidman, 2011). Therefore, a large-scale study related to the impact of breastfeeding support offered by healthcare providers on breastfeeding outcomes would be socially and academically meaningful.

The current study findings also unveiled other areas related to breastfeeding support which requires further research. Information obtained from participants revealed

concerns about inadequate breastfeeding education, anticipatory guidance, patient-centered breastfeeding interventions, and follow-up support. Future research to determine the impact of these factors on breastfeeding continuation and success would provide further insights regarding low breastfeeding rates and ways to attain the Healthy People 2020 breastfeeding goals. Since participants also reported a need for more information related to sustaining breastfeeding after 6 months, future research could be conducted to understand outpatient office practices and promote breastfeeding continuation education after discharge from the hospital.

In Chapter 2, I discussed the importance of verbal persuasion or valid assessment and praise from healthcare providers in increasing mothers' self-confidence related to breastfeeding. Healthcare providers significantly influence mothers' breastfeeding decisions. Physicians, nurses, midwives, lactation consultants, nutritionists, and all levels of healthcare providers working in maternity centers are trained to provide evidence-based breastfeeding support strategies (U.S. Department of Health and Human Services, 2013). The participants in this study also confirmed the value of healthcare providers in promoting breastfeeding success. Therefore, the final recommendation is for healthcare providers to develop strategies that address mothers concerns and promote breastfeeding. A culturally sensitive breastfeeding model program which incorporates ongoing breast-feeding education, rooming-in practices, early initiation, anticipatory guidance, self-efficacy, and appropriate follow up care could increase breastfeeding rates among African American women.

Implications

Breastfeeding is promoted as an effective public health strategy. However, mothers' perceptions and experiences related to breastfeeding support received from healthcare providers vary (Schmied et al., 2011). The significance of these views was highlighted in the participants' reports of their breastfeeding experiences. Evidently, mothers desire emotional, informational, and tangible support from healthcare providers as this type of assistance helps in acquiring a sense of acceptance, validation, and support. For instance, some participants in the current study reported that healthcare providers did not provide adequate breastfeeding education, assistance, and follow-up checks to ensure a positive breastfeeding experience and outcome. Besides, research has also shown that breastfeeding rates are lower among African-American mothers than Hispanic and Caucasian mothers (CDC, 2013, 2014; National Conference of State Legislatures, 2011).

Therefore, early initiation of breastfeeding support from healthcare providers at the time of birth, throughout hospitalization, and after discharge would be an indication of social change. Such ongoing support would facilitate social change as first-time African American mothers would be educated and supported to start breastfeeding within the first hour after birth as well as maintain breastfeeding for at least the first 6 months of the infant's life. Awareness of breastfeeding support strategies and the healthcare providers' role in promoting breastfeeding can assist first-time African American mothers to effectively utilize breastfeeding support services and enhance their self-efficacy related to breastfeeding.

The information discerned from this study may also contribute to positive social change as an understanding of the perceptions of first-time African American mothers about breastfeeding support can provide clarity regarding the low breastfeeding rates among African American mothers. I intend to participate in employee development seminars and professional conferences at local hospitals and public health departments to disseminate the study findings to healthcare providers. The findings from the current study can be integrated in breastfeeding promotion programs and seminars to increase awareness about the lived breastfeeding experiences of the study participants. Understanding of the experiences and meanings the participants ascribed to their breastfeeding support experiences may assist healthcare providers to direct evidence-based and culturally competent breastfeeding support strategies more effectively to address the mothers' concerns and experiences. This approach could further empower first-time African American mothers to overcome barriers hindering positive breastfeeding experiences. As such, enabling these mothers can help to reduce disparities in breastfeeding as it may encourage more first-time African American mothers to breastfeed. By disseminating my research to different categories of healthcare providers I will bring greater awareness to needs of first-time African American mothers and advocate for ongoing, patient centered breastfeeding support from healthcare providers. Social change is inevitable when healthcare providers are cognizant of the mothers' needs, and when new mothers feel supported in fulfilling their desire to breastfeed.

Conclusion

This qualitative phenomenological study was conducted to explore 10 first-time African American mothers' experiences and perceptions of breastfeeding support

received from healthcare providers. This study was the first to focus on any particular ethnicity of first-time mothers' perceptions about breastfeeding support received from healthcare providers. I examined the participants' views about behaviors displayed by physicians, nurses, midwives, and lactation consultants while seeking breastfeeding support. Findings from the study provided information about how first-time African American mothers identified supportive and nonsupportive breastfeeding behaviors and how these behaviors influenced their breastfeeding decisions. This study contributed to the literature by providing additional information to guide the development of culturally competent evidence-based breastfeeding support strategies which could assist in the attainment of the Healthy People 2020 breastfeeding goals.

The study findings also validated the phenomenological research strategy, the social constructivist philosophical framework, and the breastfeeding self-efficacy theoretical framework by providing understanding about the lived experiences of first-time African American mothers and insight about how the study participants construct meanings to their experiences as well as develop self-confidence related to breastfeeding. The mothers in the study agreed that support from healthcare providers with initiating breastfeeding immediately after delivery, and providing assistance with proper position and latching of the infant especially during the first feeds significantly helped to increase their self-confidence. Such self-confidence along with ongoing breastfeeding education and follow-up checks provided opportunities for mothers to successfully breastfeed their infants for at least the first 6 months of life.

Breastfeeding protects against diseases as well as provide better growth and development outcomes for infants (AAP, 2003; Ip et al., 2007; U.S. Department of

Health and Human Services; 2013; WHO, 2003). In the same way, breastfeeding provides numerous maternal benefits such as reduced risk for postpartum hemorrhage and obesity (AAP, 2005; Coalition for Improving Maternity Services, 2009; Ip et al., 2007; Schwarz et al., 2009; Taylor et al., 2006). Breastfeeding is also a cost-effective measure that provides financial benefits for families, communities and the wider society (Center of Advancing Health, 2014; Gartner et al., 2005). Considering the benefits, breastfeeding advocates, recommended breastfeeding as the best feeding choice for the first 6 months of an infant's life, followed by continued supplemental breastfeeding for at least 12 months (CDC, 2013; Eidelman et al., 2012; Hauck et al., 2011). Support for breastfeeding is, therefore, vital.

To provide effective breastfeeding support strategies, healthcare providers are trained to develop relevant skills and knowledge to support breastfeeding (Baby-Friendly USA, 2012; Saadeh & Casanovas, 2009; U.S. Department of Health and Human Services, 2013; VanDevanter et al., 2014). The implications of this study are not only limited to educating mothers and healthcare providers about effective breastfeeding support strategies but have the potential to impact the field of public health. By providing in-depth accounts to guide the development of effective, culturally competent evidence-based breastfeeding support guidelines more first-time African American mothers may be encouraged to breastfeed and attain the Healthy People 2020 breastfeeding goals. Through exploration of the lived breastfeeding experiences and perceptions of 10 first-time African American mothers I developed a better understanding of the barriers these mothers encountered while seeking breastfeeding support. The information provided by the participants clearly described supportive and nonsupportive

breastfeeding behaviors displayed by healthcare providers and as perceived by the mothers. The study participants identified breastfeeding education as well as tangible and emotional support as necessary strategies for healthcare providers when offering breastfeeding support. Five themes were elicited from the study.

The mothers in the study also articulated their knowledge of the benefits of breastfeeding and openly expressed a desire to successfully breastfeed their infants. However, despite their intentions, participants reported difficulties with breastfeeding which they thought could have been alleviated with adequate and continuing support from physicians, nurses, lactations consultants, and midwives. These mothers stated that healthcare providers such as lactation consultants did not provide appropriate breastfeeding education, anticipatory guidance, assistance with latching, and follow-up checks to ensure breastfeeding success. Participants also suggested that it was crucial for healthcare providers to have individualized breastfeeding sessions with first-time mothers as well as provide follow-up care and breastfeeding education after discharge. Findings from the current study also indicated a need for physicians to inform mothers of anatomical issues such as a tied tongue to minimize feelings of frustration, stress, and failure among mothers when infants have difficulties latching due to anatomical issues.

Although the benefits of breastfeeding are known, and several breastfeeding support strategies have been identified, the actual breastfeeding rates are significantly less than the Healthy People 2020 goals (CDC, 2014; Drago et al., 2010; Eidelman et al., 2012; National Conference of State Legislatures, 2011; Renfrew, 2012). The difference in the actual breastfeeding rates and support services calls for better understanding of mothers' perceptions of breastfeeding support, and targeted interventions to enhance

support for breastfeeding (CDC, 2013; Drago et al., 2010; Perrine et al., 2012; Saadeh & Casanovas, 2009; U.S. Breastfeeding Committee, 2013; U.S. Department of Health and Human Services, 2011, 2013). First-time African American mothers in the study described the barriers which hindered their breastfeeding experiences as well as the supportive strategies from healthcare providers which enhanced their self-efficacy and breastfeeding success. The current low breastfeeding rate among African American mothers confirms a need for efficient and targeted breastfeeding support strategies. Healthcare providers and breastfeeding mothers must, therefore, work together to promote breastfeeding continuation as an essential public health behavior.

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Appendix A: Ten Steps to Successful Breastfeeding

The following represents the Baby Friendly Hospital Initiative *Tens Steps to Successful Breastfeeding* (Baby- Friendly, 2012).

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breast-milk, unless medically indicated.
7. Practice rooming in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth.

Source: Baby- Friendly (2012).

Baby- Friendly USA. (2012). Baby-friendly hospital initiative. Retrieved from https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative

Appendix B: Invitation to Participate in Study

FIRST-TIME AFRICAN AMERICAN MOTHERS

Deborah Jarrett, Researcher and Doctoral Candidate at Walden University

I am doing a research to assess mothers' view of breastfeeding support from healthcare providers. The risk of this study is similar to discomfort you might encounter in everyday situations where you have answering questions during a conversation. Your help can lead to proper support strategies to help improve breastfeeding rates. This is important since breastfeeding provides several benefits to mother and infant.

If you are 18 or older, I would be grateful for your participation in this Study.

If you are interested, please send a note to the researcher, **Deborah Jarrett** via e-mail to confirm your interest to participate.

Participation is voluntary and you may withdraw at any time.

Participants will receive a Consent Form as an e-mail attachment.

Participation is voluntary, and you may stop at any time.

All volunteers will scan, sign and send the Consent to Participate Form via e-mail to

An e-mail confirming receipt of the signed Consent to Participate Form will then be sent to all volunteers.

All participants will be asked to take part in an audiotaped telephone interview lasting approximately 60 minutes, and consisting of five open-ended questions.

Interviews will be conducted at your convenience.

At the end of the interview, participants will receive a $20 Walmart gift card to compensate for your time.

You will also be asked to review the results upon completion of the analysis. This is expected to take approximately 15-30 minutes, and you have the right to refuse.
The results of the study may be published. However, no names or personal information will be used in the study or shared. All information will be kept confidential and disposed of after 5 years.

Sincerely,

Deborah Jarrett

Doctoral Candidate

Walden University

Appendix C: Interview Protocol

Interview Guide: A Phenomenological Study Exploring First-Time African American Mothers' Experiences and Perceptions About Breastfeeding Support.

Time:

Date:

Place:

Participant Code:

Information for Participants: The purpose of this study is to understand first-time African American mothers' experiences and perceptions about breastfeeding support received from healthcare providers. Your information will be kept confidential. No names or identifiers will be used, and all information will be stored securely. Access to data can only be obtained by me using a private password. One-to-one telephone interview will be conducted for approximately 60 minutes. Telephone interviews will be audiotaped, but you will be advised before the tape is turned on. The information will then be analyzed for emerging themes in the results. The results of the study may be published, but private information will not be disclosed. All data will be deleted after 5 years according to Walden University research protocol.

Please remember that you can refuse to respond to questions and you may end the interview any time.

Are you still willing to participate in this interview?

Do you have any questions?

Question 1: What situations influenced your decision to breastfeed your baby?

Question 2: What is your perception of the breastfeeding support services?

Question 3: Describe your experiences seeking breastfeeding support.

Question 4: Tell me about your perception of the breastfeeding support you received from your physician, nurse, or lactation consultant.

Question 5: Is there anything else you would like to mention at this time?

Potential probing questions:

I'm not quite sure I understand you. Could you please tell me more about. . .

What makes you feel that way?

I'm not certain what you mean by. . . Could you give me some examples?

You mentioned. . . What stands out in your mind about that?

Could you tell me more about your thinking on that?

This is what I thought I heard. . . Did I understand you correctly?

Appendix D: Demographic Survey

1. How old are you?
    a. 18–27 years old _______
    b. 28-37 years old ________
    c. 38 years and older _______
2. What is your marital status?
    a. Single ________
    b. Married ________
    c. Divorced ________
3. Did you deliver your baby in the hospital?
    a. Yes ____________
    b. No______________
4. When did you deliver your baby?
    a. Before 37 weeks of pregnancy __________
    b. After 37 weeks of pregnancy ____________
5. Did you plan to breastfeed?
    a. Yes ____________
    b. No______________
6. Who influenced your decision to breastfeeding?
    a. Partner ________________________
    b. Friend__________________________
    c. Family member _________________
    d. Social network__________________
    e. Healthcare professional ___________
7. At what stage did you prepare to breastfeed?
    a. Before pregnancy ______________
    b. During pregnancy ______________
    c. After delivery _________________
8. What preparation did you make for breastfeeding?
    a. Use audio-visual breastfeeding material__________
    b. Attended breastfeeding classes _________________
    c. Other ______________________________________
9. How long did you intend to breastfeed your baby?
    a. less than 6 weeks___________________
    b. 6 weeks to 3 months ________________
    c. 3 months–6 months ________________
    d. Over 6 months ______________________
10. How long did you breastfeed your baby?

a. less than 6 weeks____________________
b. 6 weeks to 3 months _________________
c. 3 months–6 months _________________
d. Over 6 months _______________________

11. How soon after delivery did you start breastfeeding?
a. immediately _________________________
b. less than one hour ______________________
c. Later than one hour______________________

12. Did you room-in with your baby in the hospital?
a. Yes ______________________
b. No _______________________

13. What feeding method did you use?
a. Breast only _______________________
b. Breast and formula _________________

14. Did you receive assistance from your physician, nurse or lactation consultant?
a. Yes____________________
b. No _____________________

15. How did your physician, nurse or lactation consultant assist?
a. Provide educational material ___________________________
b. Assist with latching ____________________________________
c. Provide breast pump ____________________________________
d. Assist in overcoming breastfeeding difficulties _________________

16. Has your breastfeeding experience been positive?
a. Yes _________________
b. No __________________

Thank you for participating in this survey!

Appendix E: Recruitment Flyer