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Breastfeeding Among African American Women in Minneapolis

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DEDICATION

This work is dedicated to God: To him be the glory for great things he has done!

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Abstract

The health benefits of breastfeeding for mothers and infants are widely recognized and because of this, breastfeeding should be considered the preferred choice of infant feeding for all women. Its relevance as a disease prevention and health promotion tool should not be underestimated for any population. However, the breastfeeding rates for African American women remain well below the *Healthy People 2020* goals.

The purpose of this project was to determine why breastfeeding rates are low in the African American community through exploring the barriers for African American women to breastfeeding. Through this research, appropriate interventions were developed and implemented to improve breastfeeding initiation, duration, and exclusivity rates in this population. Ten African American women of reproductive age, who had one live birth, reside in Minneapolis, and were either currently breastfeeding or had previously breastfed, were interviewed for this project.

This research used a qualitative, descriptive phenomenological approach to develop a deeper understanding of breastfeeding experiences of African American women. Data were analyzed and categorized into descriptive themes, using the participants' own words to provide a unique insight into the barriers for breastfeeding success. From this analysis, implications for practice were identified.

Chapter 1

Breastfeeding offers many wonderful health benefits to both mother and infant. Health professionals in the United States recommend that infants be exclusively breastfed for the first six months of life and then breastfed in combination with complementary foods for at least the first year (Li, Rock, & Grummer-Strawn, 2007). The literature states clearly that despite the many benefits of breastfeeding, breastfeeding rates in the United States are lower than in most nations; the rates also vary by socio-demographic factors, with Non-Hispanic African Americans and other socioeconomically disadvantaged groups having the lowest breastfeeding rates (Li et al., 2007). There is a working assumption among health care professionals that African American women do not want to breastfeed and that they do not know how beneficial it is for their infants. However, there are very few published studies on African American women's perspective of breastfeeding. The stories of these women provide a unique perspective into why their rates are low and how they decide whether or not to breastfeed. The purpose of this project is to determine why breastfeeding rates are low in the African American community. This project explores the barriers that prevent women from breastfeeding or from even thinking about breastfeeding. Recommendations are proposed to improve breastfeeding initiation, duration, and exclusivity rates in this population.

Background and Significance

The Healthy People 2010 breastfeeding initiative was developed to eliminate racial disparities in health with the goal of having 75% of mothers breastfeeding after birth, 50% at six months, and 25% at one year. According to the most recent statistics released by the Centers for Disease Control and Prevention (CDC, 2010), 75% of U.S. women initiated breastfeeding, 43% breastfed for six months, and 22% for one year. African American women showed the greatest

improvements of any population group over two years, with 61% initiating breastfeeding, 29% breastfeeding to six months, but only 13% breastfeeding for one year (Lewallen & Street, 2010).

According to the Centers for Disease Control (2010), in the state of Minnesota 81.9% of all women initiate breastfeeding and 51.7% remain breastfeeding for six months, but by twelve months only 26.6% are still breastfeeding. Unfortunately, this data set does not provide information on African American women at this time.

According to the Academy of Breastfeeding Medicine, the *Healthy People 2020* goals make breastfeeding a public health priority (Rubinger, 2010). The goals set targets for initiation and continuation of breastfeeding, including support to address maternity care and workplace barriers, which historically have negatively impacted breastfeeding success. The Academy of Breastfeeding Medicine aims to increase rates to 82% for those who have ever breastfed, 61% breastfeeding at six months and 34% at one year. Exclusive breastfeeding goals are set for 44% at three months and 24% at six months (Rubinger, 2010).

According to Mohrbacher and Kendall-Tackett (2005), the negative health outcomes associated with non-human milk and the list of health problems associated with formula continues to grow. Scientific knowledge continues to support that for a baby's immune system to be fully activated, human milk's living antibodies are needed for at least the first twelve months of life. In fact, breastfeeding is the biological norm for mothers and babies. The significant benefits of breastfeeding are widely recognized. Human milk not only contains a balance of nutrients that matches infant requirements for growth and development, but also an abundance of immunological agents that protect infants against infectious diseases. According to the World Health Organization (2010), scientific evidence shows that because breastfeeding provides a very broad multi-factorial anti-inflammatory defense for infants, it can be described as

a natural immunization that decreases the rate of childhood illnesses and gastrointestinal problems. It reduces the risk of SIDS, which is a cause of infant mortality, and this protection continues as long as the infant is breastfed.

Moreover, having been breastfed decreases childhood illnesses, obesity, breast and ovarian cancer rates, and chronic diseases, such as hypertension, diabetes, and cardiovascular diseases, which are common in the African American community (Barber, 2005). Therefore, according to Barber (2005), it is absolutely necessary for African Americans to recognize that affordable and attainable health begins with breastfeeding.

Problem Statement

African Americans continue to have one of the highest infant mortality rates (defined as the rate of infant death during the first year of life per 1,000 live births) in the state of Minnesota. According to the *Populations of Color in Minnesota Health Status Report* by the Minnesota Department of Health, despite a decline in infant mortality rates among African Americans from 16.5 to 9.4 during 2002-2006, their infant mortality is still more than two times higher than Whites (MDH, 2009).

For many years, the operating theory in the health field has been that the high incidence of infant deaths among African Americans is attributed to higher teen pregnancy rates, single motherhood, lower education levels, poverty, and, most recently, genetic causes. However, when all these factors are controlled, infant mortality still remains high, so it is important to further explore the relationship between infant mortality and infant feeding (Joint Center, 2007).

Principles of Social Justice

Social justice issues related to infant feeding are not new. The researcher's ethical position stems from principles of justice that promote human rights. The American Nurses Association (ANA) (2001) interprets the call to work for social justice as,

> Through support of and participation in community organizations and groups, the nurse assists in efforts to educate the public, facilitates informed choice, identifies conditions and circumstances that contribute to illness, injury and disease, fosters healthy lifestyles, and participates in institutional and legislative efforts to promote health and meet national health objectives. (p.24)

Therefore, according to the ANA (2001), nurses are called to participate in the work for social justice and should be participating in disease prevention and health promotion efforts locally and nationally. The promotion of breastfeeding reflects this ethical premise of social justice.

According to the ANA (2001), *Code of Ethics for Nurses,* nursing "extends supportive care to the family and significant others. Nursing care is directed toward meeting the comprehensive needs of patients and their families across the continuum of care" (p. 7). This ethical principle of social justice is embraced in the nurse's role and responsibility of providing breastfeeding education and support to women and their families, while sustaining women's right to breastfeed and maintaining their dignity while doing so.

The need for dignity relates to the societal impact of sexualizing the breast and its effect on breastfeeding; such dignity is central to the protection of the health of children and families. In the United States, our modern American society pays great attention to the sexual and aesthetic function of women's breasts, which may make some people perceive that breastfeeding should be hidden from the public. However, the human female breasts are not only sexual organs but also are physiologically designed for the function of milk production in order to feed children (Riordan, 2005). Because public beliefs and social and cultural norms influence women's choice regarding breastfeeding, women often choose not to breastfeed, which can contribute to poor breast health and diminished overall health for both mother and baby. Therefore, it is important

to educate our society at large that breastfeeding is a normal, desirable, and achievable activity for women of all cultures and socioeconomic levels (Li et al., 2007).

Furthermore, "the nurse has a responsibility to be aware not only of specific health needs of individual patients but also of broader health concerns, such as world hunger, environmental pollution, lack of access to health care, violation of human rights, and inequitable distribution of nursing and health care resources"(ANA, 2001, p. 23). Therefore, the ethical and social justice principle of solidarity is also applicable to breastfeeding because of the role it plays in affecting social determinants of health, such as poverty and world hunger. This principle calls us to work toward world peace, global development, protection of the environment, and international human rights. As a result, breastfeeding promotion in the U.S. during the ever-pending threat of natural disasters is an excellent disaster preparedness tool as well as a tool to decrease pollution and to address poverty during these tough economic times.

Since hunger is a major issue of poverty and in the event of a major disaster in which clean water is unavailable, a woman who breastfeeds can provide food security for her infant. According to Lawrence (2007),

> The report of the Dutch famine in World War II is one of the most unique human experiments in history. It demonstrated that women could lactate after delivering an infant during famine. The infants were born about a pound lighter at birth, but the milk was adequate, again because the lactating breast is so efficient. (p. 194)

In studies of healthcare expenditures in the United States, health maintenance organizations have documented between $300- $400 dollars a year is saved per child when they are breastfed (Lawrence, 2007). As Mohrbacher and Kendall-Tackett (2005) point out, breastfeeding can impact a family's financial health. In the U.S., formula costs a minimum of

$1200 during a baby's first year. And, depending on the type used and what a baby can tolerate, it could cost twice that amount. This estimate does not include the cost of feeding equipment and extra healthcare costs, as babies on non-human milk tend to be sick more often and more severely. Therefore, in the effort to eradicate poverty one small step would be to ensure that every newborn is breastfed (Lawrence, 2007).

The activist and physician Paul Farmer (2005) asserts that we must think globally and act locally. Working on a global and local level solidifies the thought that something as simple as how we feed our babies can make a significant impact in the arena of social justice. Liberation theology drives a bi-directional analysis that first, seeks the root causes of the problem and second, elicits the experiences and views of the persons affected in order to incorporate their view into all observations, judgments, and actions. A tenet of liberation theology is historical accuracy and another tenet is those who are suffering should be allowed to speak out about the reality of their lives. It doesn't mean that those who suffer have a monopoly on the truth, but it means that in order for the truth to emerge it must be in tune with the experience of those who are undergoing the suffering (Farmer, 2005). This principle of social justice drives this research project.

Chapter 2

Theoretical Framework

Research has shown that women approach breastfeeding within a specific social, cultural, political, and historical context. Leininger's culture care theory stresses the importance of seeking knowledge of diverse cultures as a basis for providing culturally competent care (Cricco-Lizza, 2004). This theory provides the context for examining the lived experiences of breastfeeding for African American women within a cultural context. Cultural empowerment takes into account the knowledge, attitudes, and beliefs of a population at both the micro (individual, family, and community/grassroots) and macro (national and international power and politics) levels. Thus, the decision-making must be situated within its proper political, historical and cultural context (Airhihenbuwa, 1995). The population being targeted should be included in the process of developing appropriate interventions that address their cultural needs. Both cultural care and cultural empowerment demonstrate a strong case for the inclusion of culture in research. Also, nursing theory is important. Nursing theorizing; which is the reasoning processes involved in constructing a framework, is needed for research that contributes to the scientific progress of the discipline. Therefore, the theoretical knowledge gained through research can be translated into action that can transform care.

Margaret Newman's (1994, 2008) unitary approach provides the nursing theoretical foundation for a conversation about breastfeeding in the African American community in Minneapolis. Pregnancy and birth certainly represents a changing environment that is life altering and can be quite stressful. Allowing a woman to share her story using the unitary approach can help direct an individualized approach by viewing the pattern of the whole. It involves letting the women have the space to discuss their problems and to find their own

solutions so that pattern recognition and meaning may occur. Through this process we can clarify myths and obtain accurate information regarding the factors that influence African American women's decision to initiate and succeed in breastfeeding. This process also helps to develop culturally appropriate interventions that can increase breastfeeding rates in this population.

Literature Review

Overview

Although public health agencies conduct national surveys for breastfeeding data, they fail to perform annual monitoring. In fact, breastfeeding statistics were not available until the early 1900s. Even then, the studies focused on infant mortality rates and not on breastfeeding. However, one study in 1912 found that 54.8% of Black mothers breastfed their babies, 25.5% of Black mothers breastfed and supplemented, and 19.7% of Black mothers did not breastfeed (Barber, 2005).

There are very few published studies on women's perception of breastfeeding. Those studies that have been done are predominantly quantitative studies of attitude based on initiation of breastfeeding and provide little data on in-depth knowledge to illuminate women's real experiences (Spencer, 2008). In the literature there is little data about the issue from women who have experienced breastfeeding and this omission seems significant. In order to promote breastfeeding successfully and target resources appropriately, it is vital to gain an understanding of the factors influencing decision-making (Spencer, 2008).

Benefits

There is ample evidence of the numerous benefits of breastfeeding. Human milk is uniquely matched for the needs of the human infant and in a recent article on breastfeeding benefits, the World Health Organization (WHO) (2010) explained the benefits of breastfeeding, describing breast milk as the ideal food for newborns and infants. It not only provides nutrients for healthy development but contains numerous antibodies that confer protection from a number of common childhood illnesses (WHO, 2010).

Unfortunately, many new mothers either will never breastfeed or will discontinue prematurely. Black women and women from socioeconomically disadvantaged groups are less likely to breastfeed than others. Many factors influence whether a woman chooses to initiate or continue breastfeeding (Hill, Arnett, & Mauk, 2008). However, despite the variety of factors offered to explain the low rates of breastfeeding among African American women, researchers' acknowledge that breastfeeding is an intense and a profoundly human experience that positively influences women's perceptions of themselves as women and mothers. In order to research what is assumed to be a socio-cultural activity, it is necessary to explore the meanings, values, and beliefs held by those who experience directly the phenomena of breastfeeding (Spencer, 2008). The evidence of racial/ethnic disparities in breastfeeding supports the need for research that identifies social, cultural, and psychological factors that can be targeted for interventions with African American women (Li et. al., 2005).

Low Birth Weight and Infant Mortality

Breastfeeding is a public health issue for African Americans and its promotion is imperative for decreasing infant mortality rates in this population. According to Stuebe (2009) formula feeding is associated with 1.3 fold higher risk of infant mortality in the United States when compared with breastfeeding. The World Health Organization (2010) estimates that

annually the lives of 1.5 million children under the age of five years old would be saved if women breastfed their infants exclusively for the first six months of life and continued with complementary food up to the age of two.

Breast milk is supported in the literature as the ultimate source of nutrition for infants, and despite the known maternal and infant benefits of breastfeeding, African American women breastfeed at a lower rate than any other ethnic group in the U.S. Their associated low birth weight and high infant mortality rate has brought national awareness to this infant health disparity and the benefits of breast milk for this population (Robinson, & VandeVusse, 2009).

Cultural and Ethnic Influence

In a recent a qualitative study on breastfeeding conducted by the Minnesota Department of Health (MDH) and Amherst Wilder Foundation (2010), the researchers did not include African American women as a population for participation in the study. According to MDH this decision was made based on the researchers desire to study women who were believed to be underrepresented in the current literature (personal communication with MDH, October 25, 2010). However, this conclusion was erroneous. No data exist on breastfeeding rates of African American women in Minnesota. The majority of literature that is available on African American women is based on Women Infant and Children (WIC) research, which is over 10 years old. Many previous breastfeeding studies report clearly that WIC presented a breastfeeding barrier because the majority of Black women were more likely to receive advice on bottle feeding and less likely to receive breastfeeding advice from WIC nutrition counselors (Beal, Kuhlthau, & Perrin, 2003).

Unfortunately, the majority of previous studies have used combined race samples to examine issues associated with African American women and breastfeeding, making it difficult

to isolate cultural influences. Several authors characterize women who breastfeed as being married and older in age, and having higher educational levels and incomes than women who don't breastfeed (Brownell, Hutton, Hartman, & Dabrow, 2002). However, ethnicity was found to be more important than any other demographic factor in determining breastfeeding rates among Black women. Ethnicity means more than just biological definition but is inclusive of a shared social and cultural heritage passed down through successive generations (Ludington-Hoe, McDonald, & Satyshur, 2002). Therefore, there is a need to examine cultural influences on breastfeeding. Comparing Black women among themselves across social class backgrounds will yield better understanding about how culture may contribute to breastfeeding disparities (Lewallen & Street, 2010). The reasons for decreased breastfeeding rates in this population are far more complex than has been typically believed, and this complexity includes Black women's unique and distinct cultural and historical legacy in the United States.

Historical Legacy

There may be many factors that could contribute to the possibility that breastfeeding is no longer viewed positively in the African American community, and is often considered substandard to formula. Perhaps the reason for this thinking is rooted in slavery and poverty. During slavery, African American women were expected to breastfeed not only their own young, but also the infants of the White overseers and owners. If a White woman had problems breastfeeding or did not want to breastfeed, a wet nurse was secured. African American women who breastfed others' infants were better fed and received better treatment than other enslaved women, indicating a higher status for wet nurses. However, when privileged women enlisted wet nurses, the practice resulted in the infants of wet nurses getting insufficient care and inferior food, yielding high infant mortality. In addition, during the Great Depression and World War II,

many mothers breastfed their infants because they could not afford to buy formula. Consequently, breastfeeding has become associated with slavery and poverty (Ludington-Hoe, McDonald, & Satyshur, 2002).

Unfortunately, African American mothers face a particular legacy of embodied exploitation in which their sexuality and reproduction were not within their control. The exploitation and demonization of their character and bodies as women and mothers, and their lack of privacy may have contributed to their desire to escape the external controls and judgments placed on their bodies, leading them to reject the "animal-like" aspects of breastfeeding (Blum, 1999). Both slavery and the eugenics movement in the U.S. linked the animality of breastfeeding to Black females and the purity of womanhood to White women. In the slave system, this link was direct. Not only did the southern White woman push sex out of her life as a shameful thing, but she also gave her children to "Black mammies" to suckle and nurture because, according to the myth of sacred White womanhood, the White woman was above doing such "nasty" things (Blum, 1999).

Black women suffered the heavy emotional, physical, and psychological effects of giving birth under siege to their slave masters and then breastfeeding their own children while having to breastfeed the children of their slave master and mistress. Additionally, by moving the birthing process from midwives in the home to the hospital and physicians, and mass producing formula, society redefined the practice of breastfeeding. These changes have greatly affected breastfeeding rates among Black women (Barber, 2005).

There is no doubt that African American mothers' experiences are reflected through the distinct historical lens of slavery and racial hatred, which casts particular meanings on their bodies. Black women have represented the most essentialized "other" of all groups to White

Americans, and Black women's sexual and reproductive bodies have been cast as dangerous and impossible to rehabilitate (Blum, 1999). Given all the external monitoring of their bodies during pregnancy, could it be that African American women simply desire to have their bodies back to themselves? (Blum, 1999). Breastfeeding is both a biological and socially constructed phenomena and in recognizing this ontological perspective, cultural and historical perspectives of the person are required (Spencer, 2008).

Cultural Beliefs

Comprehending cultural beliefs is important to understanding feeding patterns and the decision-making process involved. These patterns often include the extremely early introduction of complementary fluids and foods. The influence of family and other cultural concepts may be barriers to breastfeeding, such as not wanting the baby to become "too attached" or not wanting to "spoil" the infant. The mother may also have the fear of becoming too attached to her child. As reported in a study on infant feeding, one participant stated,

> I don't want to be in love with my child. I mean I want to love it to the fullest but I don't want to be in love with my baby…What if something happens to the baby or something like that and you're in love with this child? I think that's what happened with my mother; when my brother died I think she was in love with him and she died of depression. (Cricco-Lizza, 2004, p. 1205)

Another cultural concept reflected in the literature is the strong belief that children need to be independent at very young ages. For African American women, the challenges of their daily lives meant that they might not always be available to protect their children from everyday dangers. Therefore, children were socialized to face a tough world early and independence is

viewed as a survival mechanism. Early independence is considered a positive attribute because they are able to do things for themselves (Cricco-Lizza, 2004).

Barriers to Breastfeeding

Most African American women do not know anyone who has breastfed, therefore, beliefs or anticipation about the pain involved is a common barrier depicted in the literature. Most women believe that pain is inevitable and that it would last until they wean (Bentley, Lee, & Jensen, 2003). Other studies have identified the importance of maternal confidence and women's concerns about breastfeeding in public. Their beliefs that breasts are sexual overlap with their concerns about breastfeeding (Bentley et al., 2003). In another study, mothers identified cultural images of the sexualized breast as a barrier to breastfeeding, particularly in the presence of extended family members. They reported feeling pressured to leave the room to feed their babies even in their own homes (Grassley & Eschiti, 2008).

Return to Work

There are many factors that influence breastfeeding rates in the United States. A common factor cited is that women have to return to inhospitable work environments after giving birth. One out of three women will return to work within three months of giving birth and two out of three women will return to work within six months of giving birth. However, African American women are returning to work even sooner, within six or fewer weeks postpartum. They often have to return to work sooner than White women (Galson, 2008) , which is one of the major reasons they stop breastfeeding so early (Barber, 2005). Poor Black women often work in low income, non-salaried jobs, such as, in fast-food restaurants, retail stores, or other blue collar jobs. They are usually paid hourly wages with less control over their schedules. This type of work influences their breastfeeding continuation rates because they may not be covered by the Family

and Medical Leave Act (FMLA) provisions. Moreover, if they are on public assistance they are often required to return to work sooner and work longer hours, which is not optimal for breastfeeding. Therefore, decreased breastfeeding rates are a documented negative outcome of welfare reform (Hurst, 2007).

Low income women returning to work face barriers to breastfeeding, including restricted schedules, inadequate break time, and insufficient privacy for pumping. Among women who returned to school, the absence of available on-site childcare was also a major issue (Taveras, Capra, & Braveman, 2003).

A study done by The Society for Human Resource Management indicated that only 25% of employers reported providing on-site lactation support or accommodations for breastfeeding. The need for worksite lactation programs to support women in the workplace has received a lot of recent attention due to the passage of the workplace breastfeeding support provision in the Patient Protection and Affordable Care Act (USBC, 2010).

Currently, the Office on Women's Health and the U.S. Department of Health and Human Services are working to encourage the elimination of workplace barriers to breastfeeding by conveying the message to the business industry that accommodating breastfeeding is good business practice. They explain how the health benefits of breastfeeding for mother and baby, can translate into reduced overall costs to employers by lowering health care costs, decreasing absenteeism, enhancing productivity, improving employee satisfaction, and improving their corporate image (Galson, 2008). They demonstrate how offering time and space for breastfeeding is not complicated. As with other work-site issues, by clarifying mutual time, setting up a location in which to pump or express the breast milk, ensuring employer-employee

communication, making child care available on site or nearby, and allowing supportive schedules, breastfeeding can continue seamlessly (Galson, 2008).

Many employers are beginning to understand that it is feasible for women to breastfeed in their work environments and should be allowed to participate in the work place in a manner reflecting their responsibilities and dignity. All persons have a right to productive work, to fair wages, to private property, and to economic initiative. And, the economy should exist to serve people, not the other way around (ANA, 2001). According to the Academy of Breastfeeding Medicine (2010), the need for accommodating workplaces for nursing women is such an important issue that the new Healthy People 2020 goals set out to increase the number of work places that support working mothers in expressing milk or breastfeeding their infants during the work day from 25% to 38%.

Influence of Healthcare

The literature points out that another barrier influencing U.S. breastfeeding rates is where women give birth. The cultural shifts of African American women having hospital-based births, hospitals promoting bottle-feeding, corporations mass marketing formula, and economic and social structure forces changing the family structure from two-parent to single-parent families may imply that breastfeeding has lost its importance to African Americans (Umar, 2004). Because of these cultural shifts, African American women receive less breastfeeding education and support from health care providers.

In addition, current U.S. maternity practices (e.g., separating infants from mothers at birth during a time when the infant is most receptive to breastfeeding; and, women undergoing epidurals, inductions, and cesarean sections) greatly impact breastfeeding initiation and duration as well as infant health outcomes. The hospital is an important institution to focus on since most

African American babies are born there, yet it is only one institution among many that must support breastfeeding if our society is to create healthy futures for families (Dorfman & Gehlert, 2008). However, the fact that healthcare providers (midwives, physicians, and nurses) set the tone in our society and have significant influence on a woman's decision to breastfeed cannot be ignored.

Healthcare Providers

One study indicated that many African American women reported that no health care provider substantially discussed breastfeeding with them during pregnancy. When breastfeeding was mentioned it usually occurred late in the pregnancy or during labor and was limited to asking which method of feeding the woman had chosen (Lewallen & Street, 2010).

However, the literature suggests that the decision to breastfeed happens early in pregnancy. The quality of breastfeeding information given to mothers and the advice of the health professional can greatly influence the mothers' decision on whether or not to breastfeed. Various surveys have shown that many health care providers involved in breastfeeding education and support gave incorrect information and had negative attitudes toward breastfeeding, and/or did not provide sufficient information to be able to help mothers (Clifford & McIntryre, 2008).

According to a study of patient perception, clinicians' opinions directly correlated with breastfeeding duration. Breastfeeding prevalence increased to 70% when women thought their providers supported breastfeeding versus 54% when they thought they did not. Multiple studies provide evidence that formula feeding is associated with increased risks for infants and mothers and that by supporting breastfeeding as the normative way to feed an infant, the health care provider can play a powerful role in improving health outcomes (Stuebe, 2009). Therefore, the prenatal messages providers give to their patients are significant to breastfeeding initiation rates,

and mothers are 40% less likely to discontinue breastfeeding early in the postpartum period if their clinician encourages them to continue (Beal, Kuhlthau, & Perrin, 2003).

Social Support

Another study discussed how the role of social relationships and support from others affect a mother's continuation of breastfeeding (Johnston & Esposito, 2007). Supportive relationships can entail social and professional relationships. Social support contributes to effective coping and sufficient self-care. The World Health Organization recognizes that social support provides emotional and practical resources, has a protective factor on health (Noel-Weiss & Hébert, 2004), and affects initiation and duration rates for breastfeeding. African American women want their family members to acknowledge breastfeeding as important and desirable, and to affirm rather than criticize or question their decision to breastfeed (Grassley & Eschiti, 2008). For African American women, this social support can affect their confidence in their breastfeeding ability.

In one study, African American women's lack of maternal confidence was a factor reported to predict early weaning and was closely related to the perception of having inadequate milk supply to meet their infants needs (McCarter-Spaulding & Gore, 2008). Unfortunately, the advice they receive from family members and friends may reflect cultural beliefs and infant feeding practices that do not support breastfeeding. As stated in one study, what makes it so frustrating is that at their weakest moment they are getting the worse information, and that can tear them down very quickly and lead to early weaning (Grassley & Eschiti, 2008). Yet, appropriate professional support can compensate for this influence and facilitate initiation and continuation of breastfeeding.

Finally, Black women who have few breastfeeding role models encounter many beliefs that discourage breastfeeding, so it is understandable that breastfeeding may not initially be perceived as practical. However, to achieve the breastfeeding goals of *Healthy People 2020* in this target population and to support breastfeeding for all women, there must be a cultural shift and change in structure at all levels in our society (Bentley et al., 2003). Therefore, according to the Academy of Breastfeeding Medicine (2010), we need changes that enable the health care system, employers, and the general public to work together to empower and support all mothers in achieving the best breastfeeding goals possible.

Chapter 3

Methodology

Qualitative research is an appropriate mode of enquiry when researchers wish to study the understanding and motivation of phenomena. It provides a means of capturing the context of specific situations, by focusing on the human beings within their social and cultural context, and the focus of this phenomenological approach generally is to describe accurately the lived experiences of people (Spencer, 2008). Because social and cultural norms help guide African American women's decisions on breastfeeding, it is important to understand what these norms are in order to develop appropriate strategies for promoting and supporting breastfeeding in this population (Li et al., 2007). Therefore, this study was not limited to recent or current breastfeeding participants. The reason for no time limit was to include mothers who had an opportunity for reflection on their birthing and postpartum experience.

The aim of this project is to explore the factors influencing African American women's desire or lack of desire to breastfeed. Qualitative interviews were completed with African American women who have had one live birth, have never breastfed, have previously breastfed, or are currently breastfeeding. The data collected from the interviews provide important information for developing a culturally appropriate intervention to increase breastfeeding rates in this population.

Pre-Project Phase

To obtain background data on the proposed research topic, a presentation on African American women's breast health was done for lactation specialists in Minneapolis at the Hennepin County Breastfeeding Coalition. Questions were posed to the experts in the field attending the meeting to identify the issues affecting breastfeeding rates in this population. The

goal was to obtain information that would be helpful with the development of research questions for this project.

The following questions were asked:

1. Why are the breastfeeding rates low in the African American community?
2. What are the barriers for African American women breastfeeding or even thinking about breastfeeding?
3. What can we do to promote breastfeeding in the African American community?

The responses to these questions were summarized and reported back to the lactation specialists at the next coalition meeting (Appendix B).

Next, the questions for the participant interviews were developed. The interview guide questions were adapted from validated questions by Wambach and Cohen (2009) and revised from the information gleaned from the background data information obtained from the lactation specialist. The resulting qualitative survey tool (Appendix C) was developed to conduct individual interviews to answer the same three overarching questions noted above. Once the interview guide was completed, a research project time line was done. See Appendix A for details of the complete timeline.

Recruitment

The participants were African American women 18-35 years old, who have had at least one live birth and have never breastfed, have previously breastfed, or are currently breastfeeding, and reside in Minneapolis. They were recruited by using a flyer (Appendix D), which was distributed to churches, clinics, and other community agencies. When the potential participants were contacted, a phone script was used to give the potential participants a brief summary of the purpose of the research. Then a mutually agreed upon appointment time was established (Appendix E). Most interviews took place in the participants' homes. At the time of the

interview, the project purpose was described and consent forms were reviewed and signed. Upon obtaining signed consent, all participants were given a copy of the consent form for their own records (Appendix F). The participants were reminded that their participation was voluntary and they could decide not to participate at any time. It was expected that the initial interview would take about 1-1 1/2 hours and a follow-up thirty-minute interview could be required to ensure accuracy of information. All participants were informed that the interviews were audio taped and transcribed without any identifying data, including socio-demographic information, and they would receive a $25 gift card for participating in the research after the interviews were completed.

Interview Phase

The first interview took approximately 1.5 hours and during the interview reflective listening prompts were used, such as, "Can you tell me more about that? "You talked about…" or "Anything else you would like to add?" These prompts were used for clarification and to encourage each participant to share her views. A follow-up call was made after reviewing the participant transcript. If during the follow-up call the participant wanted to add more information, another interview took place to ensure that the participant's intended response was fully captured. The second interview lasted approximately 30 minutes. During the second interview, the participant was asked to review and clarify the information provided during the first interview. The participants received a $25 gift card for participating in the research after the interviews were complete.

Ten in-depth interviews were conducted to collect qualitative data on the cultural beliefs and norms regarding breastfeeding among Black women. All interviews were audio taped and then sent to a transcriptionist without any identifying data, including socio-demographic

information. All interviews were transcribed word for word by the transcriptionist and returned to the researcher for data analysis.

Ethical Considerations

Benefits and risks.

The ethical principal of beneficence that insures a person is treated in an ethical manner not only respects her decision and protects her from harm, but also makes efforts to secure her wellbeing is suitable for breastfeeding (Washington, 2006). This principle goes beyond the act of kindness or charity to include not doing harm, and maximizing possible benefits and minimizing possible harms. This principle lends itself not only to breastfeeding education and promotion, but to research itself. The Hippocratic maxim "do not harm" has long been a fundamental principle of medical ethics. However, Claude Bernard extended it to the realm of research, saying that one should not injure one person regardless of the benefits that might come to others (Washington, 2006). According to the Belmont report all research by human subjects should be preceded by a careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interests of the subject must always prevail over the interests of science and society (Washington, 2006).

In this research project beneficence was upheld because there was minimal risk in participating, and the research methodology caused minimal risk to participants. Probing for personal or sensitive information in interviews was the only potential risk and the researcher took reasonable steps to minimize the risks. Talking about pregnancy and mothering experiences can be pleasurable, unless painful memories occur due to some form of birth trauma. The right of the research subjects to safeguard their integrity must always be respected (Washington, 2006). As a result, participants were allowed to stop the interview and chose when and if they wanted to

resume. As a certified nurse midwife and an international board certified lactation consultant, the researcher felt comfortable addressing participants' issues and was able to refer them to appropriate resources, if necessary.

Actually, to not do this research was the greater ethical dilemma because the benefits could be substantial. There are no known culturally specific resources for African American breastfeeding women in Minneapolis. Thus, the data collected from this study could lead to new community resources, such as support groups, peer education, and increased community outreach for this population. From the development of additional supportive resources for African American women, the rate of breastfeeding among this population could increase over the next decade in Minneapolis.

Participant selection.

The principle of Justice gives rise to moral requirements that there be fair procedures and outcomes in the selection of research participants (Washington, 2006). In this study participants were recruited from the community of north Minneapolis by using fliers that were distributed to churches, clinics, and other community agencies. Consequently, to maintain boundaries between professional practice and research, no patients of the researcher were included in this study.

Social justice requires that a distinction be drawn between classes of subjects who ought and ought not participate in research, such as vulnerable adults or children (Washington, 2006). The criteria for participant selection in this research project reflected this principle because only African American women of reproductive age, between the ages of 18 and 35, who have had one live birth and have never breastfed, have previously breastfed, or are currently breastfeeding, and reside in Minneapolis were allowed to participate.

Information.

Most codes of research establish that specific items for disclosure are intended to assure that subjects are given sufficient information. When participants contacted the investigator, they were given a verbal summary of the research purpose and process, and they made an appointment for an interview. Prior to the start of every interview, the investigator described the research process thoroughly. Next, informed consent was explained and obtained (Appendix F), Participants were reminded that all information would be kept confidential. Participants were reminded that being in the research was voluntary; they could decide not to participate at any time. The expected length of the initial interview was about 1.5 hours and a follow-up thirty-minute interview was added, if necessary, to ensure accurate information. The participants were informed that all interviews would be audio taped. In addition, the participants learned that they would receive a $25 gift card for participating in the research after completing the interview process.

Informed consent.

According to the Nuremburg code in the Belmont report, the voluntary consent of the human subject is absolutely essential. Therefore, when obtaining informed consent for any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits, and potential hazards of the study and the discomfort it may entail. He or she should be informed that he/she has liberty to abstain from participation in the study and he/she may withdraw his/her consent to participate at anytime. This should be included in obtaining informed consent that should be obtained in writing (Washington, 2006).

In this study before the scheduled interview began the informed consent form was discussed, as indicated in the information section above. The participants were also informed that

the study was being conducted within the graduate nursing department of St. Catherine University. The descriptive narrative design would allow the researcher to learn from participants' experiences and to assist in developing a deeper understanding of breastfeeding practices among African American women in Minneapolis. The interested women were also informed that their decision to participate would not affect any relationship with St. Catherine University or with the researcher's employer in any way. Moreover, participants were told that all information would be documented without their names or identifying information, and that audiotapes will be secured in a locked cabinet and destroyed after data were transcribed.

All participants received a copy of the consent form that also served as a research information sheet for them to read and consider before they actually agreed to participate. Participants also got the opportunity to ask questions prior to signing the consent form. Ultimately, their signature on the informed consent form indicated that they understood the expectations of participating in this project.

Confidentiality.

According to the Belmont Report, every precaution should be taken to respect the privacy of the participants and to minimize the impact on the participants. Furthermore, in publication of the results, the researcher is obligated to preserve the accuracy of the results (Washington, 2006) and to maintain confidentiality of the participants. In this study, the consent forms with participants' names were placed in sealed envelopes and kept in a locked file cabinet that only the researcher had access to. The consent forms were kept separate from the tapes and transcribed data. Names or identifying information the participants offered during the interview were deleted from the transcriptions and audio taped interviews. The audiotapes were locked in a file cabinet that only the researcher had access to. The consent forms were kept separate from

the other research material and consent forms. All information that could identify a participant was removed from the final written transcript. Only transcripts without identifying information were kept for analysis. After the research paper is completed the audiotapes will be destroyed. The consent forms will be kept in a locked cabinet and destroyed after three years. No confidential information will be included in any publications or presentations of data.

Assurances

This research has met the requirements and has been approved for the use of Human Subjects by the University of St. Catherine's Institutional Review Board (IRB). However, it was subject to continuing review and approval by the committee. The researcher complied with all requests from the IRB to report on the status of the study and maintained records of the research according to IRB guidelines. If these conditions were not met, approval of this research would have been suspended.

Chapter 4

Data Analysis

This research is a qualitative descriptive study designed to learn from participants' experiences and to assist in developing a deeper understanding about breastfeeding practices among African American women in Minneapolis. Descriptive phenomenology requires the researcher to become totally immersed in the phenomenon being investigated. This process helps to avoid criticism or personal bias, and enables the researcher to stay focused on the research subject itself (Speziale & Carpenter, 2002). In this study, data collection occurred through individual semi-structured interviews of 10 African American women of reproductive age (18-35), who had one live birth, had never breastfed, were currently breastfeeding, or had previously breastfed, and live in Minneapolis.

The data were analyzed using the Dahlberg, Drew and Nystrom (2001) phenomenological analysis process of whole-unit-whole. This process involved probing through the data to search for common themes or essences and establishing patterns of relationships shared by particular phenomena (Speziale & Carpenter, 2002). This was accomplished by initially reading through the entire transcript to obtain a sense of the whole and to determine the overall meaning of the entire transcript. The summary of the whole was noted directly on the transcript.

Then the transcripts were reviewed again for identification of meaning units and supportive quotes in individual interviews. The themes were noted in the margins next to the correlating highlighted quotes in the transcript. In describing the findings, the meaning units were classified into twelve main descriptive themes and six subthemes, using the words of the participants. Then, the transcriptions were reviewed again to ensure that the true essence and meaning were reflected in the reporting of the data by the researcher and that the most significant

findings were highlighted. After reviewing transcripts, the participants were contacted to offer an opportunity for them to add any additional information after the "whole" and prevailing themes were discussed with them. However, only one participant desired to add anything. She stated. "I didn't think they expected me, or rather someone who had depression, to breastfeed. I actually weaned myself from medication during pregnancy to breastfeed because they don't really know the risk for sure, and I found other ways to manage my depression." However, she declined an additional interview and only desired to add that one comment. Then, again the researcher reviewed the interview transcripts while listening to the tapes to ensure their accuracy. The text of each transcript was analyzed for themes, using the content analysis method. Then the transcripts were categorized into themes that were integrated into categories and transferable to the findings of the literature. Using the participants own words the data were summarized into these descriptive themes that provided insight on developing breastfeeding interventions that can be utilized by this population. Then the descriptive themes were written in narrative format and presented as a final report. The outcomes were used to provide recommendations to promote this method of infant feeding in this population.

Participants

The 10 participants ranged in age from 18-31. All were single and never married except one participant, who was divorced. Educational levels varied from high school completion to four years of college. Six out of ten had completed at least two years of college. Nine out of ten had single, full-term births, and two had at least one premature infant. Eight had given birth to more than one child. Two were cigarette smokers. All considered themselves low income. Nine out of ten returned to work or school after delivery. One participant was currently breastfeeding,

one chose not to breastfeed, and eight had previously breastfed. One of the breastfeeding mothers was only able to pump due to having a premature infant. Breastfeeding initiation rate was 90% with a duration rate of three weeks to two years; the average was six months.

Chapter 5

Presentation and Discussion of Findings

All breastfeeding materials, regardless of their source, have at least one significant thing in common: They exist against a backdrop of ideas and assumptions that people already hold about breastfeeding, as well as powerful cultural expectations about its place in society (Dorfman & Gehlert, 2010). However, contextual information is needed to fully understand how factors influencing breastfeeding initiation and continuation operate in the lives of women in the community to comprehensively identify key influences on breastfeeding and describe their context. No facts or statistics can replicate the lived experience of a mother who breastfeeds. When adding mothers' voices to the story, it allows their successes or difficulties with breastfeeding to be understood in relation to society's successes or failures in supporting breastfeeding, rather than outcomes solely attributable to that individual mom (Flower, Willoughby, Cadigan, Perrin, & Randolph, 2008).

Therefore, the words of the mothers are used in discussing the findings as an example of the power of data being expressed in the words of those involved in the research process. It allows for the true articulation of the phenomenon being studied. It eliminates the artificial, prevents the researcher's voice from only being heard, and maintains the ethical integrity of the knowledge gained from the research process. The participants' own words are used to discuss the following themes: motherhood, breastfeeding is natural, lack of knowledge, bonding, relationships, transition to motherhood, barriers to breastfeeding, early discontinuation, breastfeeding education, lack of positive images, body image, fear, and sexuality.

In discussing the findings, the terms participant and mother are used interchangeably. In addition, the terms African American and Black are used interchangeably for the sake of simplicity.

Motherhood

This ideal of motherhood is one of the prevailing themes from this research that the participants expressed. Many of the women felt it was their duty to breastfeed and they were very proud of doing it, as one mother stated, "Being pregnant and feeling like I have my child growing inside of me, why would I not give her what's already there? You know I just needed to do it." Another mother said,

> I just feel like it is what I'm suppose to be doing as a mom. I felt like I was really protecting her and that I just felt, I don't know, I always thought as a woman and as a mom that the best thing you could do is breastfeed. And since I was able to do that even if I wasn't able to do other things that I always thought, I should be able to do or be where I was at as a mom or when I got pregnant that I had that covered.

As stated in the literature, it's difficult to think or talk about breastfeeding without cueing images of a woman and a baby. And it's nearly impossible to settle on those images in a neutral way, without connecting them to other concepts or making judgments. Those connections are what cause us to see the woman not just as a woman but as mother. And that mother is not just a mother; she is a caregiver. She is responsible for ensuring the health and well being of the baby. Why? Because that's what our culture tells us "good mothers" do. (Dorfman & Gehlert, 2010, p.6)

Breastfeeding is natural.

There appeared to be a strong connection between the concept of, "natural" and being a good mother**.** For some of the mothers interviewed breastfeeding was considered as what you "naturally" do as a good mother. Even though, many of them were unsure about what to expect with breastfeeding and how to actually do it. It is often described as "natural' but is also a skill that has to be learned by the mother and newborn. Yet, some of the other mothers refer to "natural" as being chemically free.

As one mother stated,

> I just felt it was more natural and I read up on it a lot. I read on the internet how it builds up their immune system, they will have less ear infections, and it was just something that I always decided that I would do once I became a mother.

Another mother said,

> It was already something that I had wanted to do. Well I know from research that it is most natural, I mean better for…healthy for the baby and me and I just want what is most healthy for my baby and me. I am just glad that I am able to do things the natural way cause that is the way I am living is like the most natural way.

Another mother also discussed the issue of natural versus chemical,

> Formula is a chemical …that they are trying to do to try to have it like breast, but it can't because breast milk is natural and if God didn't want us to breastfeed, he wouldn't have given us milk to breastfeed our child with and actually you are suppose to breastfed until your child is five years old but you know, ha, ha, ha. Like me I breastfed my oldest until she was two and that is only because you know she got to embarrassing me but, you

> know, that is ok. I did it for a long time anyway. But, I loved it. I liked it. It is cheaper, it is healthier, and it is more comfortable for the baby's body

Lack of knowledge.

The participants expressed concerns about their lack of knowledge regarding motherhood and parenting**.** One mother said,

> I am not going in the clinic and say, 'you know, I don't know anything about having a baby because the first thing you want to do is know.' African Americans don't want to ask questions because they don't want to feel lower or they don't want to feel like they don't' know.

Many women expressed the need for more information about parenting and breastfeeding, including the hazards of using formula, but they were too embarrassed to admit the need (Umar, 2004). As one mother stated,

> So we will sit and suffer …you don't open your mouth, because you think you are [suppose] to know. Whether you been a mother or [are] a new mother, you don't know and I was once told by my grandmother that it takes a village to raise a child.

The literature suggests that without education, mothers tend to be unfamiliar with the physiology of breastfeeding. They may be unaware of their bodies' ability to rebuild or to maintain milk by increasing feeding time or don't know how to manage other basic breastfeeding problems. If there are no helpful role models or knowledgeable professionals to educate the mother, she usually decides to use formula instead of breast milk (Hurst, 2007). In a similar light, one mother noted,

> If you are a mother and you're not educated then you are passing that on to the next generation. Because we are generations and if you don't get an education, then how could you expect your child or your child's child to have education?

The literature confirms that we must educate every generation as they come along and make breastfeeding a "cool thing" to do (Umar, 2004).

Bonding

The participants also had thoughts regarding the positive influence of breastfeeding, such as the bonding that occurs between mother and child. One mother said,

> It builds a stronger bond with me and my kids; it really did that you know… it was a good experience for me. If I could go back and do it all again I would still do it. If I had more kids I would still breastfeed and this time I would go well beyond six months.

Another mother agreed:

> … It helps that child, you develop more close with that child, you know, that child is close to you, you know, I mean, it knows you and I was told by a person that breastfed that you know, that they are closer to their mother. They become mother babies.

Many participants also noticed that there was a visible difference between breast- and formula-fed children. According to one mother,

> Seeing mothers that had formula fed their babies and they would like put them in a car seat, or put them down on the couch, and prop them up with a bottle and, I am like, that is not bonding with your child, you know, so I wanted to bond with my baby.

Another participant voiced a similar thought:

> Well for instance like they are not too over protective of them. Like they let them go and do whatever they want as toddlers, you know, like they don't' want them

> near them, you know like, they could be asking them a question or saying mommy I need this, mommy I need that and the mother's are ignoring them. You know, cursing at them and stuff like that, rather than attending to their needs. I mean people say I spoil my kids, but I think it had something to do with breastfeeding because I had built that bond with them and they always want to be underneath me too like that.

Relationships.

While most of the mothers described breastfeeding as a positive way to bond with their babies, the participants honestly discussed the adverse impact of breastfeeding on their intimate relationships. One mother admitted,

> Sometimes when you are pregnant with your baby and you don't have a bond with that father you decide not to have a bond with the baby as well. I have seen that with women and that is the reason why they bottle feed them, push them over in a car seat somewhere and prop a bottle in their mouth even at one week old…you don't have a bond with the father, you are mad at the father so you want to be mad at the baby next and so you are not going to have that bond with your child.

The literature states clearly that partner support is an important factor for continuing to breastfeed. Unfortunately, social support for breastfeeding comes primarily from other women (McCarter-Spaulding & Gore, 2009). The lack of support from partners indicates a need to increase the male role and knowledge about breastfeeding. Participant responses correlated with the literature that describes a lack of support from partners and families as a major deterrent to breastfeeding for African American women (Umar, 2004).

Transition to motherhood.

Some women also spoke of having to make the difficult adjustment to motherhood, noting how breastfeeding intensified the adjustment. As one participant pointed out:

> I think Black women don't want to take out the time and don't have the patience for breastfeeding. They're just use to convenience, and they just want what is most convenient and it takes up too much time, some people are use to clubbing or hanging out with friends and stuff and they probably feel like they want to have as much time to do what they were use to doing before they got pregnant. Now, that time has to be taken up to breastfed and I know I don't want to do that, if I know I can just give her the bottle.

Another woman mentioned that the young age of many mothers makes transitioning to motherhood hard, too:

> You know, I think breastfeeding rates are low because of teen parents, not to say that all African American females are teen moms, but the majority of them are, and they don't breastfeed because they don't want to. I don't think that some of the teen mothers have the connection like other mothers do, where they know breastfeeding is right and stuff.

However, another participant stated:

> When you are first having a baby you should always have time set aside for that baby. For all my future babies I know that anything else can wait. Breastfeeding my baby is more important than anything, so I am just going to keep that in my head and it is more important, and it is more important, than anything else can wait.

This mother indicated having learned the requirements of motherhood from her previous breastfeeding experience and articulated an understanding and ability to transition into that new role.

Barriers to Breastfeeding

According to the literature there are many barriers to women breastfeeding in our society and some of the most common themes besides return to work issues are: self efficacy, cultural factors, social life, and inconsistent information being given to new mothers.

Self-efficacy.

Research states that self-efficacy is a concept that is part of the social cognitive theory. Although similar to confidence, which refers to the strength of a belief, self-efficacy includes both the strength of the belief and the affirmation of the capability to perform a specific task. Efficacy beliefs are formed based on how well one perceives that one can perform the tasks necessary to meet a specific goal (McCarter-Spaulding & Gore, 2009). One participant spoke of the difficulty of doing the task of breastfeeding:

> I think really the barriers are probably women feeling like, Oh I don't have the time, I can't dedicate myself to that or just even if it is just women that are always on the go and not really wanting to.

Several of the mothers suggested that breastfeeding was considered too time consuming. Using the self-efficacy theory to analyze this problem, it could be stated that the mother doesn't believe she can organize and carry out the actions necessary to breastfeed (McCarter-Spaulding & Gore, 2009). According to one mother,

> That is pretty much it, my work concerns, going to school, always being busy, you know, I just can't really just stop what I'm doing instead I could just give him a bottle and you know he will be alright.

One participant argued, though:

> A lot of them don't have the time; they say , 'I don't have time to be doing that'. That is what they always say, 'I don't have the time for that. I don't have time to breastfeed; I don't have time to be doing that. That just takes too much time'. I think mothers be moving way too fast. You know they forget that babies are not dolls. That you have to tend to them and I think this [is] because of the lack of education.

Many of the mothers put a great emphasis on time as a barrier, which translated into concerns about their lack of freedom, their confidence, and their ability to breastfeed.

Several mothers spoke of the myth about breast size determining one's ability to breastfeed. This myth can affect women's confidence in their ability to feed their infant. A woman understanding that breast size does not indicate milk supply is an important factor related to self-efficacy (confidence). One woman explained how the myth affected her:

> I didn't have bigger breasts like everybody else, so I just thought that they wouldn't latch on and I tried it with my daughter. I didn't try it with my last son, but I tried with my daughter and she wouldn't latch on, either.

Another woman also thought her breasts were too small: "I am a small person so I thought you know I didn't have enough breasts to give the milk and that probably was a concern for me, but other than that nothing else."

Cultural factors.

Breastfeeding is a cultural practice that takes place within the context of an extended family. Consequently, the advice given and concerns expressed among the family may reflect cultural beliefs and infant feeding practices that do not protect breastfeeding practices (Grassley & Eschiti, 2008). This situation results in a lack of familial support for many women. One mother noted this barrier: "Family and their partners, I think if the family is not supportive, that is a big thing. It's just easier to take the bottle and formula has all kinds of good stuff in it. And then, partners feel we won't be able to have sex, if you are breastfeeding."

The literature showed that women who did not receive support from their social environment reported that they didn't view breastfeeding as positive, leading to their using formula and cereal supplementation instead of breastfeeding (McCarter-Spaulding & Gore, 2009).

Social life.

The participants also expressed that the restrictions on social life was a barrier to breastfeeding for younger women**.** One mother stated, "I think another big factor is a lot of people use drugs now days or they drink and they don't want to give that up." Another mother stated,

> When I was 25, you know, I would go out and all my friends would be drinking and I know that, I knew that when I got home my daughter would be waking up around that time for a 2 a.m. feeding. Just knowing how I wanted a drink and couldn't drink and seeing everybody drink. That was really hard for me especially since I had been pregnant

> for nine months and then I was breastfeeding for another year. So, it was really like two years before I had a drink and that was hard.

Another mother reported that she was given outdated information regarding social alcohol use and cigarette smoking,

> A friend of mind stated that because I smoke cigarettes that it was not good to breastfeed and later when I did go to the clinic I did find that out. They would rather, if you smoke cigarettes, consume drinks of any form of alcohol beverages or medication, not to breastfeed…because I was a smoker and I didn't want to be transferring that to my child. So, you know it just made me stop.

Healthcare providers giving outdated information to participants negatively impacted their breastfeeding experience. As another mother stated, "The doctor who I was talking to strongly encouraged me to quit (breastfeeding). You know if you smoke cigarettes they said it was not healthy."

Early Discontinuation

Besides social drug use, early discontinuation of breastfeeding was often due to either return to work problems or pain. One mother expressed her lack of knowledge about latch (applying an infant to the breast) as a factor contributing to her early discontinuation of breastfeeding. She stated,

> The only reason I didn't finish [breastfeeding] them is because my breasts were getting tender and stuff, and I didn't know it was actually the way it was supposed to be, to put on the breast, and I didn't know that until I had my fourth child.

Another mother said,

> I didn't know that you had to have, like, the whole breast part in their mouth … until my second baby which was five years after I had my first one, like she made my nipples crack and bleed and stuff, so I had to stop breastfeeding her.

Another reason for early discontinuation rates, as seen in the literature, was the mother's lack of knowledge about weaning and initiating complementary foods. According to one participant, "I do feel like once your child gets to a certain age that you should stop, like around six months. I feel like breastfeeding should stop cause that's the time when they start getting cereals and foods and stuff." Another mother stated,

> Don't go too long on the breast milk because I know some kids who breastfed their whole one year and you don't have a chance to get your son on a sippy cup because you are so focused on breastfeeding. He doesn't have to be on the titty for so long.

Many women also considered the WIC- provided formula as a barrier that contributed to early discontinuation. According to one participant, "I think they pick formula because it is given. It's given; that is an easy way out because it is available." Therefore, one mother explained that her doctor talking to her prior to receiving WIC formula influenced her to breastfeed:

> I think my OB doctor influenced me cause he was telling me stuff like, you know, just breastfeed, it gets easier. WIC was giving me formula, but it is like for my son, for him to be healthy, I have to give him my nutrients, my breast milk, before I give him formula. I have to give him something from me.

The lack of access to pumps was another barrier that contributed to early discontinuation for mothers. Several reported the problem of not having money to pay for breast pumps, not knowing that pumps were covered by their insurance, or being given a hand (manual) pump when in fact they needed an electric pump. As one mother stated,

> I needed to get a breast pump and when I attempted to buy one from Target or someplace like that. They were ranging from $89 to $250 dollar. I didn't know if my insurance would cover breast pump. I never thought about it and when it was time to get one I would just get confused like how do I get this and I didn't have the resources at the time to know that I could get one with my insurance.

The literature supports this notion of early discontinuation of breastfeeding being related to African American mothers receiving inadequate education regarding breastfeeding itself, inadequate information on obtaining supplies and inadequate information regarding community resources available to help them with basic breastfeeding dilemmas (Hurst, 2007).

Inconsistent information.

Another mother stated,

> When I got to the hospital, they told me this is how you do it. They told me to hold my breast, put the baby's head right there, make sure the baby latches and once they latch on let them eat and then every 10-15 minutes change and feed the baby every 2-1/2 hours.

This is an example of outdated information that healthcare providers give to mothers, often causing confusion. In the literature, conflicting advice was a common complaint from postpartum mothers and this advice often had a detrimental effect on the mother's breastfeeding

duration rate. Inconsistent advice was mostly associated with inaccurate information and an authoritarian way of communication that could worsen the effect of the inconsistencies (Clifford & McIntyre, 2008).

Nurses, however, were usually found to be the most helpful if they provided help. One mother stated,

> They were telling me in the hospital, the nurse, that I am feeding my baby too much. But, you know you are not really feeding them that much in the beginning so yeah that is what I didn't like and that's what I found difficult especially when they told me I was feeding my baby too much.

Their concerns regarding health providers not being knowledgeable enough to help women correlates well with the literature's discussion on health care provider's impact on breastfeeding success. Yet, when discussing what type of help they had or would have liked, many of the mothers felt that lactation consultants were the most healthful providers. One participant said,

> I had a couple of consultants come in and explain to me about it and they told me how to latch on. How to have her latch on and basically showed me the ways of breastfeeding that will make it more comfortable for me and baby.

Another mother stated, "A lactation consultant was able to give me some pointers on how to make breastfeeding easier." Another woman agreed:

> A lactation consultant told me at the WIC office to have skin to skin contact for stimulation and her to get the message, I guess, in her body to want to be able to suck. So that worked and I was glad for that.

It was clear that those who received education and/or support from a lactation consultant received more consistent, helpful information that was applicable to their breastfeeding concern. In one study, women who were given a chance to ask a lactation counselor questions about breastfeeding were more likely to exclusively breastfeed than those receiving standard education (Archabald, Lundsberg, Triche, Norwitz & Illuzzi, 2011).

Return to work issues.

The negative impact of work on breastfeeding continuation and duration rates is well documented in the literature. These studies conclude that women who are employed are not as likely to breastfeed as unemployed women primarily because of constraints and job requirements (Forste, Renata, Weiss, Jessica, & Lippincott, 2001).

> One mother voiced the time restraints regarding working and breastfeeding:
> Especially when you know you have to set time aside at work, maybe somebody wants to breastfeed and they work at for example at a fast-food place and they feel like well I really don't have anywhere to go [breastfeed], you know, so maybe those type of issues may be barriers.

As one mother pointed out,

> Work and school, they don't really have private places where you can do it so I had to pump when I was there and they don't have anywhere besides the bathroom which is still hard because I had to plug it in to pump and that's what made me stop.

Another participant had a similar experience:

> As far as work, at first it was hard to find a room to breastfeed. You know and I had read somewhere don't go in the bathroom, you know, because of germs and I

> ended up in one of the offices where you know they were used for meetings I just started going in there, you know, I would take my breaks. In the morning, you know, I would pump in the morning and would be on my first 15 minute break and then pump during my second 15 minute break in the afternoon and just go in one of those rooms and mainly just, finding somewhere to go pump because not a lot of places have somewhere you know, you can go and pump.

One mother voiced a complaint regarding time constraints when pumping at work:

> I would pump in the morning, my first break or if I didn't pump on my first break, by time lunch time came. One boob or the other would start to get engorged and I knew I had to go pump…by being back at work I wasn't producing, you know, as much milk because I was away from them and so I would have to use my breaks to try and pump.

Another mother said that the need to maintain her employment was more important for her family than continuing to breastfeed*:*

> I'm a single mother and I work you know and I work a lot and I figure that you know if I had to get called off of work that is making it inconvenient for me while I am trying to make ends meet for my child, and so I rather put him on the bottle than to just keep on getting called off of work if they won't take the bottle.

Another participant voiced a similar concern:

> Well right now I am in college for a health information technician. So I am trying to pursue a career in the medical field and I always had a job so I couldn't take the time to do it. But, also I use to work in a daycare and it is like kind of hard for mothers to go to work and then have to keep on coming back and forth to like breastfeed cause sometimes

> they won't take the bottle. They are so use to the breasts so they won't take the bottle. I had kids that I had to really take care of that won't take the bottle so I had to call the moms from work to come back and breastfeed their child.

Breastfeeding Education

Breastfeeding education is key to promoting breastfeeding in this population. Many of the mothers talked about their lack of knowledge regarding breastfeeding and the lack of educational resources available for them. One stated,

> Education on breastfeeding, I don't feel like if we did have a lot of resources we don't [know]. We are not aware of it and a lot of classes we do not go to while we are pregnant, and we just don't have a lot of guidance in our actual home."

When asked about receiving breastfeeding education prenatally, one mother stated, "No, I just decided to do it on my own. No there was no one there to help me with it."

Many of the mothers' voiced a need for a more personal educational experience with individualized attention, as one mother described, "One to one education because, of course, we say we understand when we don't' have a clue in this world what you are talking about but, we refuse to be embarrassed in front of the next person." When asked what would be helpful, one mother emphasized prenatal education and stated,

> During your pregnancy, you know people should come out and actually sit there with you, one on one to help you breastfeed and even after you have your you know having somebody actually there with you making sure your doing good on your breastfeeding.

Women preferred to get a demonstration along with verbal instructions, such as having the health provider patiently watch them feed their baby (Clifford & McIntrye, 2008).

One study indicates that, many health care providers do not routinely address women's concerns about breastfeeding. Meaningful discussions with patients about breastfeeding are essential, not only to possibly increase breastfeeding rates but to strengthen the provider-patient relationship and support mothers' breastfeeding goals (Archabald, Lundsberg, Triche, Norwitz & Illuzzi, 2011).

Many of the mothers in the study wanted additional information but felt it was not available. One mother stated,

> They don't have people that come out and speak to you much about it. You have people that come into the room and offer, you know like ask you 'do you want to breastfeed 'and if you say, 'no' then they don't talk to you anymore about it.

They desire classes with hands on training, as these two mothers said, "A class that I could come to that would help me out with breastfeeding skills." And "Demonstration would be helpful."

According to Umar (2004), most Black women decide to breastfeed late in their pregnancy and, therefore, received limited, if any, breastfeeding education. For those who do receive education, most often it is inaccurate and, according to the literature, this is due to a lack of cultural competence among medical staff. This lack of competence affects their ability to provide culturally sensitive education that is current and reliable (Umar, 2004).

One mother suggested that more education on the harmfulness of formula was needed because many people are not aware. She said,

> Formula…that is all chemicals. You are giving your baby nothing but chemicals in their body. They can say oh, compared to breastfeeding they got BPH or whatever the heck that thing is that they have in formula but it's not actually it. It is a chemical that they are trying to do to try and to have it like a breast but can't because breast milk is natural.

She stressed a lack of knowledge regarding nutrition and breastfeeding in general in the Black community as a contributing factor. The literature states that to accurately promote breastfeeding, practitioners should not only discuss the benefits and advantages of breastfeeding, but also the costs and risks of infant formula (Hill, Arnett, & Mauk, 2008).

Lack of Positive Images

Seeing few models of Black women breastfeeding their infants directly influences Black women's attitudes about breastfeeding. According to the literature, there are few culturally sensitive images of African American women breastfeeding, so breastfeeding role models have not been available to African American women (Ludington-Hoe, McDonald, & Satyshur, 2002).

All of the participants interviewed for this study noted the absence of African American breastfeeding mother role models. One mother stated,

> I don't think enough Black people breastfeed. My friends are predominantly Black and they all had children they didn't breastfeed and every time I went to the doctor; I felt like I was seeing a White woman breastfeed or somebody else breastfeed and I felt like, I can do this too. You know, am I going to be the only one doing this . . .

Another mother agreed, "I think that it's helpful for women to just hear from other family members and just other people in general what their experience was like." One mother refused to allow her lack of images to prevent her from breastfeeding. She stated**,**

> No, none of my friends have really talked about it. They all had children before me. One of them had a negative experience, but I always figured I am going to try to breastfeed, even if I didn't have any images.

Body Image

A mother's personal beliefs, way of being, and view of herself (body image) in the world are central components of breastfeeding success. One mother stated**,**

> I don't think a lot of women feel comfortable enough with their body too, you know, to breastfeed or feel like I need to preserve my breast just for aesthetic reasons you know. Some women are vain enough or just that's more important to them, you know.

Regarding body image another mother stated,

> Now I have body image issues cause my breast were a double B before I had my child and now they are like A . . . And they droop, and sag and so that is the negative effect of breastfeeding for me.

Another mother discussed the breast changes that occurred while breastfeeding. She stated**,**

> One thing I will say is that they are not the same. They kind of deflate and shrink. You don't have the breasts that you had before. But, at the same time I don't have any regrets. I did it for a good reason and my kids are healthy.

Poor body image can be directly connected to anxiety and comfort with breastfeeding especially in public places. In a national survey, women reported that their personal discomfort with breastfeeding was a barrier. Those who reported embarrassment about breastfeeding weaned 10 weeks earlier than those who were not embarrassed (Johnston & Esposito, 2007).

Fear

Similar to other studies, the negative aspects of breastfeeding that the participants mentioned included embarrassment, pain, and breast damage, and even "unnaturalness" of an infant suckling their breast. But, in this study "fear" was the emotion most women often expressed. Many of them explained how they had received many negative messages about

breastfeeding that contributed to their fear, "I've heard so many negative stories and people haven't had a good time with it."

One mother spoke of her negative experience**,**

> For me it was because it hurts. It was the pain. But come to find out . . . one of my girlfriends said that after six weeks it would go away as my body heals. It was because they were full, you know; your breast be [are] sore throughout your pregnancy.

Yet, one participant's experience differed, as she pointed out:

> I think the things that prevent them from breastfeeding is the fact that a lot of people tell you it hurts. A lot of times when I was telling people that I was going to breastfeed, they were always like no you don't want to do that because it is going to hurt you. It's going to hurt you. Then in reality when you actually do it, it doesn't hurt …you know it really doesn't hurt. It just gives you kind of like a stinging feeling. I think what prevented females from breastfeeding is the fact that they were told it would hurt.

Another woman agreed: "That's my biggest fear breastfeeding. I am scared of it. I think I'm going to get sick. I think my breasts are going to bleed and crack." As found in the literature, these ungrounded fears exist for most African American women, even when they have never been exposed to anyone breastfeeding.

Another mother spoke of other women's fear, "I think some women are scared, scared of it. I know that a lot of women have said, 'do you breastfeed in public? You pull out your breast and breastfeed?'" This fear exists even though laws have been passed protecting a mother's right to breastfeed in most public places.

Sexuality.

Some of the participants associated their fear with being sexually aroused by breastfeeding. One mother explained,

> How could your baby suck your breast when your man sucks your breast? And, I'm like that is a totally different feeling. It's totally different, I mean, nothing like it what-so-ever, and I think that's probably another reason why we are scared to breastfeed is because you don't want it to feel like a man, and it doesn't, you know. It is a completely different feeling and actually after a while [with] breastfeeding you have no more sensation at all in your breasts in your nipple. It like, completely goes away. I don't know for how long but you have no feeling like that anymore, so your man can try to play with your breast after your baby just got done breastfeeding, and you are not going to have no feeling anyway.

But one mother emphasized the healthy aspect of breastfeeding**,** minimizing the sexual aspect:

> I don't know. I think breast are mostly associated with sex. Most people feel and may feel uncomfortable about it. That's truthfully what kind of made me uncomfortable at first, but you know I put that out of my head, and I just was thinking that this is most healthy for baby and me. So, you know that outweighs all the other negative stuff about breastfeeding.

Younger mothers strongly associate their breasts with their sexuality. One participant discussed her experience with attempting to encourage teen moms to breastfeed. She stated, "They say things like, my man loves my breast and I am not going . . . I would feel weird giving

my baby the breast and knowing that my man is taking the breast, and wouldn't the milk come out then?" Studies have demonstrated that such sexual perceptions may influence women's choice to breastfeed. Most women still must adjust to the notion of the nurturing breast rather than sexual breast (Hurst, 2007).

Conclusion

A myth is a powerful message that explains and legitimizes a belief about a particular situation. This study dispelled two common myths often believed in the medical community. One, African American women do not desire to breastfeed. Two, they are unaware of the health benefits of breastfeeding. However, many of the mothers interviewed were very knowledgeable about the health benefits of breastfeeding. In fact, many of them talked about researching the topic themselves. Several expressed strong opinions about recommending that all women should breastfeed. Several women were very strong advocates for breastfeeding. Unfortunately, they did not have the same knowledge regarding the harmfulness of formula. This correlates with the new recommendations of shifting public health messages from the benefits of breastfeeding to the harmfulness of formula.

Many of the mothers expressed a desire to breastfeed their babies even when they had no personal examples or experience with breastfeeding. They expressed a strong desire for more education and help to breastfeed. They felt more support was needed to increase their confidence in their ability to breastfeed. They felt it was very significant that they saw more images of themselves breastfeeding in the media. One mother stated, "We actually need to start advocating doing commercials and instead of bottle feeding having breastfeeding."

Regarding education for mothers living in the community, one woman said,

> We actually need to start going out and showing them it is ok to breastfeed and walk around without a blanket thrown over baby's face and over our breasts. Walk around in public breastfeeding and be more visible because we need to start making a statement and a stand.

Regarding the need for educational materials in their community, they stated that it was very important that someone who looked like them provided them with education and support. They wanted someone to take the time to come to their homes and discuss the breastfeeding process with them. Additional strategies for promoting breastfeeding initiation and duration among African American women should consider the relevant cultural context and take a more directive and collaborative approach. These strategies should include resources to deal with lactation problems after women go home (Hill, Arnett, & Mauk, 2008).

As stated in the literature, when information is coming from another African American woman, it tends to help the mother, whether she's poor or affluent. Lactation consultants and peer counselors whom they can relate to (who look like them), and can teach them about breastfeeding one-on-one, tend to make a big difference (Umar, 2004). Many of the mothers stated that they desired support groups, one to one education, home visits, and follow-up calls. According to one participant, "I think there needs to be more one-on-one time with women who have children and who especially want to breastfeed, but don't know how to go about doing it…especially in the African American community."

Another significant factor is that many of the mothers were not given proper information or support from health care providers for breastfeeding. In fact, many were given incorrect information or received none at all, including information about resources and supplies. They

did not know how to properly latch their infant, access breast pumps, or get what else they may have needed to breastfeed successfully. Fortunately, those exposed to lactation consultants found them to be very helpful and considered them to be the most helpful of all the healthcare providers they saw. Otherwise, they relied on family and friends, whose limited knowledge often presented additional barriers. Yet, many tried and persevered despite these barriers—which is truly amazing!

Recommendations

These recommendations are in addition to the wonderful comments already provided by the women interviewed. First, African American women often receive delayed or no prenatal care due to a lack of money, insurance, or the ability to obtain a prenatal appointment. Breastfeeding decisions are usually made early in pregnancy and often within the first three months of pregnancy. Therefore, the elimination of this barrier is vital because it would allow for the initiation of breastfeeding education early in the pregnancy and during the full ten months of prenatal care.

There is a consensus in the literature that the African American father is the most influential person to the mother; so, it is imperative that men are educated about breastfeeding. In addition to the father of the baby, other family members and friends, including extended family, such as mothers and grandmothers, will require education in order to provide support and to prevent the misinformation and negative messages that often barrage African American women.

There is a need to increase the number of well-trained African American healthcare providers (midwives, nurses, and physicians), lactation consultants, and allied health

professionals, such as, community health workers, peer counselors, and educators. Due to their known lack of knowledge, all of them should be educated about breastfeeding. The education should be included in all formal medical and nursing training and should be taught as part of their formal educational curriculum. The breast should be considered an organ and taught like all other body systems. The promotion and management of breastfeeding should also be included in the training. This education should be extended to allied health training programs as well.

Breastfeeding education needs to be standardized, comprehensive, culturally appropriate, and inclusive of the harmfulness of formula, the anatomy and physiology of the breast and milk supply, latching, breastfeeding problem management, hand expression of milk, milk storage and pumping, impact on sexuality, complementary foods, and weaning. Comprehensive standardized education will increase the access of African American mothers to well-trained individuals who can offer accurate breastfeeding education and support in their own community. Outreach workers and home visitors are needed to provide individual breastfeeding education in the home upon hospital discharge to increase initiation and duration rates. Additional community resources are needed, such as classes, breastfeeding support groups, workplace lactation support, and the availability of culturally appropriate educational materials.

This additional education should be incorporated into all women's health programs, and healthcare courses in colleges and university. We even need to begin breastfeeding education in grade school, middle school, and high school as part of essential health curricula. Policies need to be implemented that promote funding for training and education at all levels of society, including supporting businesses in accommodating their breastfeeding employees.

Furthermore, an increase in media images of African American women breastfeeding and a decrease in formula advertising is needed. Public awareness campaigns using various forms of social media can be used to normalize breastfeeding and promote breastfeeding to the general public, while supporting women in breastfeeding publically. Additional public education through public awareness campaigns and workplace initiatives are necessary to help all women feel comfortable breastfeeding in public.

Sustained funding for these recommendations is needed to adequately provide the long-term support that is required to address this complex issue of low breastfeeding rates in the African American community.

In conclusion, breastfeeding has the potential to play a significant role in eliminating health disparities in the United States. But, the work must start with asking those most impacted by the issue what they believe would be useful, because it is the women's stories that provide a unique perspective into their decision making process for breastfeeding. It is when we enter into dialogue with women about what is meaningful in their experience, that we know where to focus our actions. In fact, a woman's concern about breastfeeding and the meaning she attaches to her breastfeeding experience is important to the rate of duration. Therefore, it is important to listen to all women's experience because when we show support for women, we ultimately become a society that supports breastfeeding, and a society that supports breastfeeding is an advocate for healthy families and promotes healthy communities.

Recommendations for the DNP.

This research provides significant information for improving patient outcomes in primary care clinics on breastfeeding initiation, duration and exclusivity rates in this population. It provides an opportunity for not only translating research into practice but for changing the

culture of a clinic environment where breastfeeding is the gold standard of prenatal care and is considered the norm. The findings from this study give a clear take home message that breastfeeding information needs to be provided for all women consistently, accurately, and early during prenatal care!

Doctor of Nursing Practice (DNP) prepares leaders to focus on the transformation of clinical services, which require clinicians who clearly understand the context of healthcare delivery and can translate newly discovered scientific knowledge into the provision of health care to diverse populations in the United States. DNP prepared nurses generate practice-based knowledge not only by evaluating existing clinical services, but also by developing new services based on the evidence. Therefore, DNP-prepared nurses play a major role in transforming systems of care, not just applying newly-gained knowledge (Vincent, Johnson, Velasquez, & Rigney, 2010).

Therefore, while conducting this research, the researcher was able to translate this new knowledge of African American women and breastfeeding into practice by transforming clinical services through the development and implementation of lactation services at the researchers' current clinical site. The researcher works in a community-based clinic that offered no distinct lactation services, yet it is located in an area with great health disparities and serves the underserved (uninsured and underinsured) in the inner city, where the majority of patients served are African Americans, actually, over 52%.

Although, the research project was purposely designed to be separate from the researchers' clinical practice for ethical purposes it allowed for the application of research findings to the care of patients in the real world in a clinically-feasible manner that contributed to quality improvement or may even generate new basic science or clinical services (Vincent et al.,

2010). This immediate application of the wisdom of women in the community combined with evidence from the literature clearly demonstrated filling the gap between research and practice, which is the role of a DNP-prepared nurse, so it is worth noting. But, this was just one study and there is clearly a need for additional qualitative DNP-lead comparative research on African American women and breastfeeding in the United States.

Nonetheless, through the translation into practice process it was found that having policies, practices, and support make the difference in helping women meet their breastfeeding goals. For the purpose of this paper the steps of the process for development, implementation, and evaluation have not been included. This is, however, consistent with Newman's theory and community-based action research—when the voices of the community are heard and honored, action ensues.

According to Barber (2005) the importance of breastfeeding for African American infants cannot be overemphasized because without the benefits of breastfeeding, they are twice as likely to die before their first birthday than White infants. This is also significant because African American children have a 20% higher occurrence of childhood obesity than White children. They have the highest rate of asthma, severe asthma, and mortality caused by asthma than any other racial group.

Breastfeeding is one of the few potentially modifiable factors that help prevent breast cancer. Breastfeeding's protective effect may be because it reduces the number of ovulations proportionally to breastfeeding duration and intensity, and maintains lower estrogen levels than if a woman was menstruating. African American women are 2.2 times more likely to die from breast cancer than White women. Breast cancer is the second leading cause of cancer deaths for African American women (Barber, 2005). For women who are at risk for breast cancer,

prolonged breastfeeding may at least delay its occurrence before menopause (Riordan, 2005). Consequently, the goal should be to get all African American women to breastfeed because the impact extends far beyond their own infants but into future generations (Ludington-Hoe, McDonald, & Satyshur, 2002).

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Appendix A: Timeline

Develop Power Point presentation and questions to obtain background data from lactation specialist by March 8, 2009.
Report back to lactation specialist background data summary by March 31, 2009.
Develop and submit qualitative survey tool for approval by May 1, 2009.
Complete IRB for submission by June 1, 2009.
Complete qualitative interviews by August 31, 2010.
Start Data analysis September 1, 2010.
Complete IRB renewal completion form by September 23, 2010.
Complete DNP Public Presentation November 5, 2010
Complete narrative of data analysis by December 1, 2010.
First draft of Systems Change Project (SCP) paper to advisor by December 17, 2010.
Second draft of SCP paper to advisor by January 23, 2011.
Complete SCP Paper by February 11, 2011.
Complete final revisions of SCP paper by March 15, 2011.
Complete Project Disquisition by March 30, 2011.

Appendix B: **Background Data Obtained from Hennepin County Lactation Specialists March 2009**

Why are the breastfeeding rates low in the African American community?

Absence of role models/peer support.
Uncertainty of what to expect, no real image of what it will be like—the "experience".
Lack of breastfeeding (BF) experience in the community.
Perception of BF as animalistic, low class, unprofessional etc…
Family and friend influences.
Lack of education about BF.
Body image issues.
It's not a cultural norm.
Health care providers don't fully understand the barriers to BF in the A.A. community and are therefore unable to address them.
The slavery experience.
Myths because of misunderstandings about the importance of BF.
Not enough support and encouragement from other Black women.
The tradition has been lost.
Disparity in BF education.
Young moms
See bottle feeding a lot.
Don't' understand how milk is made e.g. feel no milk.
Hungry baby "needs formula".

What are the barriers for African American women breastfeeding or even thinking about breastfeeding?

Not an expectation from childhood—family, friends, community.
Economic issues-needing to go back to work quickly, in the types of jobs without support and bargaining power.
Lack of knowledge about what's 'normal' esp. for duration of BF.
Lack of social support.
Teen mother's pressure from school, grandmothers etc…
Health care that assumes bottle feeding (also a class issue).

Self confidence.

Influential people think negatively of it.

It's not a cultural norm.
Most women around them aren't BF so they don't have examples of success.
Many become parents at a young age.
Economic considerations.
Work or school.
I don't feel there are barriers. I believe unawareness is the problem. If more support and education were given I believe BF would increase.
Generation who haven't BF.
Family structure.
Gaps in prenatal care.
Perception of problems e.g. lack of milk, return to work, and embarrassment.
Lack of images of women breastfeeding in real life and the media.

What can we do to promote breastfeeding in the African American community?

Identify motivators, exposure, incentives and community education.
Consistent health care messages (same as for any community).
Explain risks of formula. Explain Pro/Con of Formula versus BF.
Develop Role models-Identify community leaders to serve as role models.
Increase knowledge about BF.
Provide continuous, ongoing support systems throughout pregnancy, hospital, postpartum and peer support.
Better engage clients and address their barriers.
Create culturally specific groups.
Create support groups tailored toward A.A.'s.
Start talking to young girls and educate them on the importance of BF.
Focus outreach on BF to the community.
Educate on the benefits to mom's and babies, in a cultural setting/context and focus on what's important for each group.
Media.
Role models.

Lack of education prior to becoming pregnant in the schools and prenatally.
Encourage.

Teach how milk is made.
Continue having daycares in schools.

Appendix C: Interview Guide

Sociodemographic data

Marital status

Level of education

Age of Mother

Parity

Term birth?

Singleton birth?

Cigarette smoker?

Return to work *and/*or school?

Income status: Low-Middle-High? (self described)

This guide provides more probing questions to facilitate obtaining information regarding the following overarching questions:

Why do you think the breastfeeding rates are low in the African American community?

What factors influenced your choice to initiate or not initiate breastfeeding?

What are the barriers for women breastfeeding or even thinking about breastfeeding?

What would a successful model look like and what are the barriers?

Introductory questions:

How old are you?

Have you ever breastfed?

If so, how old were you at the time?

How long did you breast feed?

Did/Are you exclusively breastfeeding or supplementing with formula?

If still breastfeeding how long do you plan to breast feed?

Transition questions:

Tell me how you decided to or not to breastfeed?

What factors influenced your decision?

What are the best things about breastfeeding for you?

Who helped you with breastfeeding?

What types of help were useful? Why?

What difficulties and/or problems did you experience in breastfeeding in the hospital?

What difficulties and/or problems did you experience in breastfeeding after going home from the hospital?

What made it hard for you to continue breastfeeding?

If still breastfeeding, what has helped or kept you going in breastfeeding?

If weaned, what happened that lead to switching to the bottle?

If did not breastfeed:

What had you heard about breastfeeding that influenced your decision?

Did you breastfeed any of your other children?

What factors influenced your decision not to breastfeed?

What was a barrier to breastfeeding for you?

Did lack of support affect your decision?

Were there myths or other information that influenced your decision? If so what were they?

Were there any work or lifestyle issues that affected your decision?

Were there any personal issues that influenced your decision such as body image or other concerns?

Ending questions:

What type of help would you have liked to have had?

What type of resources do you think are needed?

If you were to help another woman get started and keep going with breastfeeding, what would you say, suggest, or do?

The interview guide questions were adapted from a validated study by Wambach & Cohen (2009). This qualitative survey tool was developed to conduct individual interviews to answer the same overarching questions used to obtain the background data.

Appendix D: Flyer

An Invitation to participate in Research on Breastfeeding in the African American Community

The researcher is LaVonne Moore, CNM, IBCLC, Doctor of Nursing Practice student at St. Catherine University

I am interviewing African American mothers between 18-35 years old who have never breastfed, have previously breastfed, or are currently breastfeeding to learn about their experiences.

I hope this information will help us to understand the factors influencing African American women's choice to breastfeed.

You will receive a $25 Cub Foods or Target gift certificate at the end of the interviews (initial interview 1-1 ½ hours with one or two 30 minute follow up interviews).To participate, call: LaVonne Moore at 612-850-0016

All information is confidential!

Appendix E: Phone Script

The purpose of this study is to describe the factors influencing African American women between 18 and 35 years old choice to breastfeed. If you decide to participate, you will be asked to describe your experience with breastfeeding during individual interviews with the researcher. The purpose of the interview is to understand what influenced your decision to breastfeed or not to breastfeed and what you found to be helpful during the process. The first interview will take approximately 1 – 1½ hours. A second interview will take place within two weeks after the first interview and last approximately 30 minutes. During the second interview you will be asked to review and clarify the information provided during the first interview. If during the second interview you feel you would like to add more information, another interview will take place to assure the researcher fully captured what you have told her. The decision whether to have an additional interview is yours. The interviews will be audio taped. A professional transcriptionist will transcribe the audiotapes. No identifying information will be included in the final transcript or in any reports or publications. The audiotapes will be destroyed at the conclusion of the research study. Participation is voluntary and you have the right to end the interview at anytime. You will be given a $25 gift certificate to **CUB** Foods or Target at the completion of your interview as a stipend for participating.

Appendix F: Consent Form

Breastfeeding among African American women in Minneapolis

INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating the breastfeeding experience of African American women in Minneapolis. The study is being conducted by LaVonne Moore , a nurse midwife and lactation consultant who is a Doctor of Nursing Practice student at **St. Catherine University.** The faculty advisor is **Roberta Hunt, PhD**. You were selected as a possible participant in this research because you are an African American mother between ages 18 and 35 who has never breastfed, has previously breastfed, or is currently breastfeeding. Please read this form and ask questions before you agree to participate in the study.

Background Information:

The purpose of this study is to describe the factors influencing African American women's choice to breastfeed. Between 5 to 20 women are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to describe your experience with breastfeeding during individual interviews with the researcher. The purpose of the interview is to understand what influenced your decision to breastfeed or not to breastfeed and what you found to be helpful during the process. The first interview will take approximately 1 – 1½ hours. A second interview will take place within two weeks after the first interview and last approximately 30 minutes. During the second interview you will be asked to review and clarify the information provided during the first interview. If during the second interview you feel you would like to add more information, another interview will take place to assure the researcher fully captured what you have told her. The decision whether to have an additional interview is yours. The interviews will be audiotaped.

A professional transcriptionist will transcribe the audiotapes. No identifying information will be included in the final transcript or in any reports or publications. The audiotapes will be destroyed at the conclusion of the research study.

Risks and Benefits of being in the study:

The study has minimal risks. For some people breastfeeding may be hard to talk about or may bring up uncomfortable feelings about their pregnancy or birth experience. However, the opportunity to

describe your experience may be a positive experience for you. The findings from this study will benefit African American women breastfeeding in Minneapolis as it provides information that could be helpful in the improvement of breastfeeding rates in the African American community. You will be given a $25 gift certificate to your choice of CUB Foods or Target in gratitude for your participation.

Confidentiality:

Your comments will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

The researchers will keep the audiotapes, transcriptions, and research results in a locked file cabinet that only the researcher will have access to while we work on this project. The researcher will finish analyzing the data by June, 2010. **I will then destroy all audiotapes, original reports and identifying information that can be linked back to you.**

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with **St. Catherine University** in any way. If you decide to participate, you are free to stop the interview at any time.

Contacts and questions:

If you have any questions, please feel free to contact LaVonne Moore at (612) 850-0016 or **Roberta Hunt, PhD** (the faculty advisor); at 651-690-6851. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact **John Schmitt, PT, PhD, Chair of St. Catherine University** Institutional Review Board, at (651) 690-6529.

This form serves as your information sheet and consent form and you will receive a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

_____

I consent to participate in the study and I agree to have my participation audiotaped.

_____

Signature of Participant Date

_____

Signature of Researcher Date