A Qualitative Analysis Of Facilitators And Barriers To Breastfeeding Among Black Mothers In The Greater New Haven Area

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A Qualitative Analysis of Facilitators and Barriers to Breastfeeding Among Black Mothers in the Greater New Haven Area

By Victoria Tran

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A Thesis Submitted to the
Yale University School of Public Health
In Partial Fulfillment of the Requirements for the
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Abstract

Objective: Racial and ethnic disparities in breastfeeding persist in Connecticut, with Black and African American mothers breastfeeding at the lowest rate. A qualitative study of Black mothers in the Greater New Haven Area was conducted to understand the barriers and facilitators to breastfeeding.

Methods: A qualitative design adapting the Barrier Analysis tool was used to conduct in-depth focus groups with Black mothers who did exclusively breastfeed for 3 months (EBF3) and Black mothers who did not exclusively breastfeed for 3 months (NEBF3). 3 focus groups were conducted with EBF3 participants and 3 focus groups were conducted with NEBF3 participants. Focus groups were recorded and transcripts were analyzed by a four-person research team.

Results: Barriers and facilitators were categorized based on the ecological model at the following levels: policy, cultural, institutional, interpersonal, and individual. The major barriers include lack of awareness and access to workplace policies, sexualization of breastfeeding, lack of publicly-accessible lactation spaces, cultural bias against breastfeeding, inaccessible lactation support, unhelpful breastfeeding support, lack of lactation supplies, discouragement from social networks, returning to work and having to make substantial lifestyle changes. The major facilitators include staying home from work, generational breastfeeding, and having a strong support network.

Conclusion: This study describes the additional barriers that Black mothers face when trying to breastfeed and the facilitators that can help mitigate difficulties. These findings help to contextualize racial and ethnic disparities in breastfeeding to inform public health practitioners in breastfeeding campaigns and program development.
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Introduction

Breastfeeding is widely regarded as the optimal form of nutrition for infant growth and development, and the benefits of breastmilk are well-documented. Some of the demonstrated health benefits for the infant include reducing the risk of asthma, obesity/overweight, hypertension, type 1 and type 2 diabetes, severe lower respiratory disease, acute otitis media, sudden infant death syndrome (SIDS), and gastrointestinal infections (CDC, 2020; Harder et al., 2005; Horta & Victora, 2013). There is also consistent evidence that longer breastfeeding duration is associated with improved cognitive development in children (Bernard et al., 2013; Kramer et al., 2008; Lee et al., 2016). For mothers, some of the benefits of breastfeeding include decreased risk of severe postpartum bleeding, breast and ovarian cancer, high blood pressure, and type 2 diabetes (AAP, 2021; CDC, 2020).

The American Academy of Pediatrics and the World Health Organization recommend exclusively breastfeeding for 6 months, with continuation of breastfeeding as complementary foods are introduced up to 1-2 years (Eidelman & Schanler, 2012; WHO, 2021a). Recognizing the importance of breastfeeding, support for breastfeeding through evidence-based policies and programs has increased, as evidenced by The Surgeon General’s Call to Action to Support Breastfeeding (Office of the Surgeon General (US), 2011). Additionally, targeted efforts such as the WHO and UNICEF’s Baby-Friendly Hospital Initiative and Ten Steps to Successful Breastfeeding have been instrumental in guiding facilities that provide maternal and newborn care to become more supportive of breastfeeding (WHO, 2021b; Wright, 2021). The Department of Health and Human Services (HHS) also launched the Healthy People Initiative which includes specific goals for breastfeeding duration and exclusivity (HHS, 2020).

Despite the many efforts over the last few decades aimed at improving breastfeeding outcomes, progress has been uneven across different racial groups. Data from the National Immunization Survey - Child (NIS-Child) of infants born in 2015 show a considerable difference in initiation, duration, and exclusivity of breastfeeding between Non-Hispanic white infants and Non-Hispanic Black infants (Beauregard, 2019). Among all infants surveyed, Black infants had a significantly lower rate of initiating
breastfeeding (69.4%) than white infants (85.9%), falling well below the Healthy People 2020 breastfeeding initiation goal of 81.9% (Beauregard, 2019; HHS, 2020). This is significant as breastfeeding initiation, particularly early initiation, can then influence exclusive breastfeeding rates (NEOVITA Study Group, 2016; Walsh et al., 2019; WHO, 2019). Black infants also had a substantially lower rate of any breastfeeding at 3 months (58.0%) than white infants (72.7%); in terms of exclusivity, Black infants had a lower rate of exclusive breastfeeding at 3 months (36.0%) than white infants (53.0%) (Beauregard, 2019).

Another study that looked at breastfeeding data from the National Immunization Survey-Child from 2009 to 2015 showed that despite seeing increases in breastfeeding rates among all racial/ethnic groups, Black infants saw a smaller percentage increase compared to white infants (Li et al., 2019). These racial/ethnic disparities in breastfeeding rates are also evident at the state level in Connecticut. According to data from the Connecticut Pregnancy Risk Assessment Monitoring System (PRAMS) in 2018, 76.2% of Non-Hispanic Black women were engaged in any breastfeeding at 4 weeks compared to 84.5% of Non-Hispanic white women, and 67.3% of Non-Hispanic Black women were engaged in any breastfeeding at 8 weeks compared to 74.3% of Non-Hispanic white women (CT DPH, 2018).

Although wide disparities exist in engaging in breastfeeding, research has shown that intentionality to breastfeed does not vary significantly by race or ethnicity. In a study of 2,070 women and children enrolled in the WIC program across 27 states, researchers found that 87.2% of Non-Hispanic Black moms had general breastfeeding intentions compared to 86.9% of Non-Hispanic white moms. 48.3% of Non-Hispanic Black moms intended to only breastfeed up to 1 month of age compared to 52.3% of Non-Hispanic white moms, and 40.9% of Non-Hispanic Black moms intended to only breastfeed at 3 months of age compared to 43.8% of Non-Hispanic white moms (Hamner et al., 2020). Noted similarities in intent but disparities in engagement suggests that there are barriers unique to Black mothers that are affecting their ability to meet their breastfeeding intentions. One significant barrier is employment. Black women are disproportionately over-represented in the service-sector industry, in which labor protections are weaker. Thus, they have less access to adequate maternity leave or lactation breaks during the workday (DeVane-Johnson et al., 2017). There is also evidence that Black women are less likely than
white women to report receiving breastfeeding advice or guidance from healthcare providers or counselors (Beal et al., 2003; Kulka et al., 2011). Further, Black women are disproportionately at risk of having poor birth outcomes such as preterm birth, which can make breastfeeding much more difficult (Crippa et al., 2019; Culhane & Goldenberg, 2011). Finally, Black women disproportionately experience structural racism and systemic discrimination, which contributes to inequities in stress and post traumatic stress disorder, leading to lower breastfeeding rates (Giscombé & Lobel, 2005; Seng et al., 2011; Taveras et al., 2003).

In order to truly understand the roots of these disparities and barriers, it is important to look at the history of breastfeeding within the Black and African American community and examine the influences of slavery and wet nursing. In times of slavery, Black women were forced into breastfeeding their slaveholder’s infants, a practice known as “wet-nursing,” in order to free white women from the “messier” parts of motherhood (Freeman, 2018; Johnson, 2018). This was at the expense of the health of their own children, who would perish due to the slaveholders not allowing Black mothers to breastfeed their own babies (West & Knight, 2017). Oftentimes, to ensure that Black mothers could not breastfeed their own babies, slaveholders would kidnap or take the babies away, leaving them with no choice but to breastfeed the slaveholder’s babies (Johnson, 2018; West & Knight, 2017). For Black women, breastfeeding then became a painful reminder of this period of exploitation.

In the 1920s, commercial formula from the company Mead Johnson came onto the market and was heavily promoted to an elite, white consumer base and branded as the epitome of sophistication (Freeman, 2018). In the 1940s, St. Louis Pet Milk formula company, recognizing the opportunity to expand their market audience to include Black women, bought the rights to “The Fultz Sisters,” the world’s first recorded identical quadruplets who were born to a Black-Cherokee mother (Freeman, 2019). The Fultz Sisters were delivered by Dr. Fred Klenner, a white doctor, who auctioned off the girls to the formula company to use in their advertising campaigns targeting Black women (Freeman, 2018, 2019). During this period of aggressive marketing of formula to Black women, positive images of Black women breastfeeding were non-existent. Instead, advertisements depicted Black women breastfeeding as
“primitive” and marketed formula-feeding as the answer to societal acceptance and upward mobility (Freeman, 2019). At the same time, stereotypes of the “Bad Black Mother” were emerging, catalyzed by the highly publicized tragic death of a Black infant from inadequate nutrition. This death was a result of a lack of counseling around breastfeeding from the hospital (Freeman, 2019). This led to formula companies adopting a new angle for their marketing: formula as the solution to being a “Bad Black Mother.” By this time, formula-feeding was falling out of favor for white women, as public health advocates started targeting white women for breastfeeding promotion after research demonstrated the benefits of breastfeeding (Freeman, 2018). The demonization of breastfeeding for Black women and the valorization of breastfeeding for white women, worked in tandem to contribute to disparities seen today.

To examine these disparities, our study explores the current barriers and facilitators to breastfeeding among Black and African American mothers in the Greater New Haven area. This study, carried out by myself and done with the support of the breastfeeding team at the Community Alliance for Research and Engagement (CARE), addresses two primary research questions. First, what are the barriers and facilitators to breastfeeding for Black mothers? Second, how, if at all, do these barriers and facilitators differ between Black mothers who were able to exclusively breastfeed for 3 months compared to Black mothers who were not able to exclusively breastfeed for 3 months? Altogether, this study sought to better understand the experiences of Black mothers in their breastfeeding decisions and journey, in the context of the Greater New Haven area. Ultimately, as we explored these questions, they were considered and contextualized in the difficult history of breastfeeding in the Black community in the United States.

**Methods**

*Overview*

This study used an adapted Barrier Analysis tool, a rapid assessment tool that is used to identify behavioral determinants associated with a particular behavior (Davis, 2004). The behavior examined was exclusive breastfeeding for 3 months. The purpose of a Barrier Analysis is to identify key barriers or facilitators and identify why recommended behaviors, such as breastfeeding, are adopted or not adopted. This method is based in two main theories of behavior change: the Health Belief Model, which focuses on
the reasons people may take action to prevent illness, and the Theory of Reasoned Action, which suggests that a person’s behavior is determined by the norms around them (Davis, 2004). We adapted the Barrier Analysis to evaluate the following determinants that influence breastfeeding: self-efficacy, social norms, positive consequences, negative consequences, access, susceptibility/risk, severity, action efficacy, divine will, policy, and culture (Kittle, 2013). To evaluate differences in how the determinants affected adoption of the behavior, participants were separated into those who exclusively breastfed for 3 months (EBF3), and those who did not exclusively breastfeed for 3 months (NEBF3). We adapted the Barrier Analysis tool, normally administered through surveys or individual interviews, to be used for focus groups and created separate interview guides for EBF3s and NEBF3s (Appendix 1) (Davis, 2004).

Participants and Eligibility

Participants were eligible to participate in the study if they met the following criteria: identified as a resident of the Greater New Haven Area, identified as Black, African-American, or Hispanic Black, gave birth within the last 18 months, and had an infant who was at least 3 months old. Recruitment was done by utilizing existing community partnerships, specifically through New Haven Healthy Start, in which outreach workers would send potential participants to our team for additional screening. Electronic flyers were also posted on CARE’s social media platforms and sent to other community partners for dissemination (Appendix 2). Participants were screened into their respective EBF3 and NEBF3 groups based on whether they exclusively breastfeed for the first 3 months of their infant’s life. Participants who exclusively breastfed their infant for the first 3 months without supplementation were classified as EBF3. Participants who breastfed during the first 3 months but supplemented with formula or other liquids or solids were classified as NEBF3 mothers. It is important to note that the majority of the participants classified as NEBF3 mothers had still breastfed or tried to breastfeed; the major difference between EBF3 and NEBF3 mothers was that NEBF3 mothers also supplemented or stopped early. We reached out to 59 potential participants, 50 participants responded and were screened. After screening, 39 participants met the eligibility criteria, 29 were scheduled and 7 participants did not show up. A total of 22 participants were enrolled in the study. Thirteen qualified as EBF3 mothers and 9 qualified as NEBF3 mothers.
Data Collection

Two members of the research team, a graduate research assistant and the Assistant Director of Health Equity Leadership Programs at CARE conducted a total of 6 focus groups with participants from the Greater New Haven area from January 2021 through March 2021. Verbal informed consent was obtained during the screening process after walking through an IRB-approved informed consent form. Due to restrictions from the COVID-19 pandemic, the focus groups were conducted over Zoom and audio-recorded. At the beginning of the focus group, the facilitator re-iterated the core principles from the informed consent and asked for verbal consent before starting the recording. Participants were asked questions related to the following determinants: self-efficacy, social norms, positive consequences, negative consequences, access, susceptibility/risk, severity, action efficacy, divine will, policy, and culture. Focus groups were approximately 90 minutes in length and each participant received a $40 VISA gift card as compensation for their time, regardless of level of participation. The audio-recordings were sent to a professional transcription service, Rev. Two team members worked to de-identify the transcripts to remove names, occupations, birth dates, countries of origin, and other identifying information. All study protocols, recruitment materials, interview guides, and team members were approved by Yale University IRB.

Data Analysis

De-identified transcripts were coded by a two to four-person research team in Dedoose, with the first EBF3 and NEBF3 transcripts being coded by all four members. A combination of inductive and deductive coding was used as we started with a priori parent codes based on the theory-derived determinants of the Barrier Analysis. The predetermined determinants of behavior change formed the overarching themes that we then inductively coded within, forming the child codes. Some parent codes were changed or combined based on the themes that emerged during the coding process. Researchers independently analyzed transcripts and then codes were compared to ensure consistent application of codes. Disagreements on codes or code applications were discussed until a consensus was reached.
Codebook development and refinement took place after every transcript during a meeting to adjudicate differences in code application.

The major barriers and facilitators were then identified by looking at the number of applications of the child codes and categorized based on the Ecological Model for Health Promotion developed by McLeroy, Bibeau, Steckler, and Ganz that built upon Bronfenbrenner’s multilevel framework of ecological influence (Bronfenbrenner, 1977; McLeroy et al., 1988). The McLeroy et al. model expands Bronfenbrenner’s model by including five levels of influence on health behavior and behavior change: intrapersonal/individual factors, interpersonal factors, institutional factors, community factors, and public policy (McLeroy et al., 1988).

Results

The main barriers and facilitators were grouped into the following levels of influence according to the Ecological Model: public and workplace policy, community and cultural, institutional, interpersonal and social networks, and individual.

Public and Workplace Policy

Breastfeeding-Friendly Policies as a Facilitator

Although most of the participants expressed that there was no influence from public policies and law, there were six participants who noted that there was at least some level of influence from breastfeeding-friendly or supportive laws. Two participants, one who was an EBF3 participant and one who was an NEBF3 participant, respectively, discussed the benefits that they experienced in their workplaces:

But there are laws that definitely support that [breastfeeding]. I know my girlfriend, I remember when she got pregnant years ago, we were both teaching, and she was breastfeeding, and she had a place to go and time to do all of that, so I think the laws definitely now support it. It's not looked at as bad as it used to. - Participant 013
I work at [redacted] and I think there are laws or policies in place about giving women spaces to breastfeed. And it just so happens that my office is very flexible in about that sort of stuff and helped that my boss had a baby at the same time. And so he was very understanding about anything. But I had an office that I could just go in and pump during the day. And I think having those spaces made it a lot easier for me. And I know that depending on where you work, the space that people allow for people to breastfeed, like I've heard of people having to go into like a closet or something like that to breastfeed. And I think that would probably make you a little, unless you were very determined, I could see how that would turn some people off. - Participant 023

The provision of breastfeeding policy within their workplaces seemed to have facilitated their ability to continue breastfeeding their infants even after returning to work. To illustrate the effect that going back to work can have on breastfeeding, another EBF3 participant expressed the importance of maternity leave provisions of the Family and Medical Leave Act (FMLA). This participant noted being home and being able to take maternity leave for 3 months was helpful in continuation of exclusive breastfeeding. This is especially important because, as previously mentioned, Black mothers are more likely to be working in the service industry where labor protections, such as maternity leave, are weaker. Having access to protected maternity leave can be an important facilitator to breastfeeding. For this participant, she did not want to have to worry about pumping at work, which shows that even breastfeeding-friendly policies in workplaces are not necessarily enough to accommodate mothers.

I know for Connecticut that they're just starting to get FMLA for maternity leave for a certain amount of time. So I know that like being home for three months, really helps being able to figure it out rather than worrying about pumping so that when you do go [back to work] and that does help. - Participant 004

Lack of Knowledge of and Access to Policies as a Barrier

As stated previously, most of the participants expressed no influence from any specific public policy in their decisions to breastfeed. When asked whether specific laws or policies made it more likely or easier for them to breastfeed their infants, participants overwhelmingly said no. In some instances, participants were unaware there were any laws around breastfeeding. The excerpt below comes from an NEBF3 participant, which further illustrates that policies may not be enough or may not have a critical
enough influence on mothers and their decisions to breastfeed. While having a breastfeeding-friendly environment and policy can be an important facilitator, it does not seem to be the sole influence.

"At my job, when I did go to work, there is a breastfeeding room, and they made it very comfortable for moms. They have a little fridge, a little sink there, a little sitting area. I even went in there before I was a resident. I was pregnant, and I just went in there just to chill for like 15 minutes, because I've got to put my feet up. It's real comfy. You get to put your feet up. You get to lay back. They made it really nice. But it's not like a requirement. It's just convenient." - Participant 015

As the participants noted above, they did not know of any laws in place that addressed breastfeeding.

[Facilitator]: Are there any laws or policies in place that make it more likely for people in your community to give only breast milk to their babies for the first three months?
[Participant 015]: I don't believe there is.
[Participant 016]: I would say not that I know of. Right.
[Participant 014]: I was about to say me either. I don't think so.

This group of participants were classified as NEBF3, which alludes to the possibility that if people were aware of their breastfeeding rights, such as in the workplace, they may have been able to initiate or continue breastfeeding. The previous participants noted that workplace policies, which are a result of state policies, were a factor in making breastfeeding and the decision to continue breastfeeding easier. Therefore, being unaware of these policies or not having access to them is a barrier to breastfeeding.

Community and Cultural Factors

Generational Breastfeeding as a Facilitator

Historically, Black women have been dehumanized for breastfeeding, so having positive role models in their community, especially family members and friends, can help to facilitate initiation of breastfeeding. We see from our focus group that an important facilitator to breastfeeding is having a generational tradition of breastfeeding within their community.

"For me it would be yes. Just hearing my mom say, told me, "I breastfed you." And my grandmother, "I breastfed her." You know what I mean? You can call it a tradition I guess, I don't know." - Participant 013
For me, baby father, my mom, my brother, everybody support me because all my family was breastfed. It was something passed down. - Participant 008

For these two EBF3 participants, breastfeeding was thought of by the people around them as the default, a theme which came up 18 times across focus groups. It was a generational practice to breastfeed. The more of a cultural norm that breastfeeding becomes, the more it becomes the standard in the community. Creating this culture is crucial in motivating mothers to breastfeed.

Religious Communities as a Facilitator

Another important cultural norm of breastfeeding can exist in religious communities as well. One EBF3 participant, also noted that her religious community of fellow Muslim women was instrumental in influencing her to breastfeed.

I would say the same thing. Being a Muslimah, there's a lot of, every Muslim of that I've seen so far has breastfed. And it's in our Quran, that it's a benefit for your children to be breastfed. They actually want you to breastfeed till like you're five years old. Like I said with me, a lot of Muslimas do it. I'm surrounded by Muslimas a lot. So that's the norm with us per se to my friends that are not Muslim, and they're looking at me like, first it was a shock of culture here in the Muslima. And then for me to be around them a lot, I see the difference between my non-Muslim friends and my Muslimas. So it's definitely normal with my same religion people compared to the non-[Muslims]. - Participant 001

As the participant noted, everyone around her in her religious community was breastfeeding and it was seen as the norm to do so. This demonstrates the powerful influence that cultural norms can have on a mother’s decision to breastfeed. If everyone around her is breastfeeding, it helps to normalize it and make it the default. In this specific case, her religious community was an important facilitator to motivate her to breastfeed. However, for the rest of the other participants, there was little influence from religion.

Formula-Feeding being a Cultural Norm as a Barrier

Unfortunately, some participants noted that breastfeeding is not necessarily the social norm for many mothers, especially those in communities of color. As one NEBF3 participant said:

I think that in the minority community it's like, "Girl, put that baby on some formula." You know? You hear that really quickly. Like, my whole family, nobody breastfed, or
This participant’s insight suggests that for many women of color, breastfeeding is not the default but rather, formula is the default practice, a theme that came up 13 times. The cultural and community values prioritized formula, as demonstrated by her statement that everyone around her thought she was “weird” for even wanting to try. She also noted that no one around her breastfed, alluding to the importance of having a cultural norm of breastfeeding. While not having this as the cultural norm can often be a barrier to breastfeeding, this participant still wanted to try, though she ultimately was unable to exclusively breastfeed for 3 months.

**Sexualization of Breastfeeding as a Barrier**

Black women in our study reported feeling stigmatization around breasts as primarily having a sexual and not a nurturing quality.

*But I think the stigma is still there. It's a really annoying one. And people talking about sexualizing breast and whatnot and you're like, but this is like actually what they're for. Men do sexualize it and they're like, oh, you need to cover up. But... you how are you sexualizing a child eating.* - **Participant 021**

*They're trying to say like your baby is sucking on your boob, and that's nasty, and making it sexual kind of thing. I've heard people talking about people flashing when you're breastfeeding in public.* - **Participant 020**

These participants, both NEBF3, experienced criticism for breastfeeding as it related to the sexualization of breasts. This cultural norm of breast sexualization has led to a stigma around breastfeeding as being a sexual act or something “nasty” that should not be done in public. This can be amplified for Black women, who have a history of being sexualized in popular media. As mentioned previously, breastfeeding for Black women throughout history has also been seen as “primitive.,” reflecting a strong colonial and neocolonial view. This is echoed by one EBF3 participant, who said:

*Just let me put it as, they'll see as if you're not civilized by breastfeeding the baby.* - **Participant 003**
This echoes a stereotype from the literature of Black women as uncivilized for engaging in a practice that white women have been lauded for. They may feel as if breastfeeding is not meant for them or they will be viewed a certain way if they do try breastfeeding, especially in public. Indeed, an EBF3 participant and an NEBF3 participant, respectively, noted that they experienced negative reactions or comments from people in public.

And at that time I didn't really have the cover over me. So I had no choice, but to feed her. So I'm feeding her and this guy looking like with a disgust on his face, like "Why is she have her breasts out and stuff like that? - Participant 002

It wasn't me, but I could factor in the judgment and stuff that people have out in public when you are breastfeeding and stuff. It's very, like I said, discouraging and stuff like that. Especially when females, we are covering up or... using the cover-ups and stuff, but it's still very discouraging of the faces and stuff people make. - Participant 020

When breastfeeding in public, even just seeing the faces of “disgust” or seeing the “judgement” on people’s faces can be discouraging for mothers. This can present a huge barrier for mothers who are just trying to feed their baby, but are being told repeatedly that there is something wrong with the way they are going about doing that. In addition to the faces people make, some participants experienced people approaching and confronting them in public:

I'm like, "You know what, if you have your baby, however you want to treat your child. That's your business. This is mine. And this is my baby. If I choose to give her formula, I can give her formula. If I choose to give her breast milk, I can give her breast milk. And this is what I choose to do." And she's like, "Oh, and so you just going to open your breasts." I'm like, "If you don't want to see it, then you leave. There's many seats over here." Because I didn't have any cover. Like the little towel I had covered the top of my chest. And she, like, "You have to have a cover. If you want to do this in public."
- Participant 005

This confrontation between an EBF3 participant, and another person further demonstrates the ways that sexualization of breastfeeding is part of our culture. Again, as we see from participants who mentioned judgement in public 21 times, this can have consequences for Black women and their comfort or safety with breastfeeding in public. This confrontation illustrates another interesting facet of the
sexualization or judgement of breastfeeding: the idea that women need to at least cover up if they want to breastfeed in public.

[Participant 006]: As long as you cover yourself, I don't see the problem. [Participant 007]: As long as you've got a covering - [Participant 006]: As long as you're not exposing your body in public, fine. You cover yourself, you feed your baby.

In this exchange between EBF3 participants, even though they are supportive of breastfeeding in public, this support comes with a caveat associated with modesty. It was noted 21 times by participants that they need to cover themselves up in public when breastfeeding so as to not expose themselves.

Me personally, I don't like seeing when moms do that, but I'm not going to go up to a mom and say, "Why are you doing that?" That's your business, you know? But I think you should cover yourself. That's more appropriate to be in the public.
- Participant 006

I'm a pretty strong believer in modesty while breastfeeding. But what you do publicly is totally your prerogative, just don't put a show on for people, because some women are guilty of doing that and if that's how they feel, then that's them. But I'm more of a modest person. I can care less on if you're breastfeeding a child and he's four, five, six years old, but just cover yourself up. - Participant 010

The two EBF3 participants above, reinforce the sexualization of breasts, especially when they talk about what is appropriate in public and how they feel some women put on a show for people when breastfeeding. This culture of modesty and the need for covering up can be a barrier for many women as it requires them to bring additional supplies, such as a blanket or towel, if they are planning to breastfeed in public, creating an additional barrier to breastfeeding. As discussed earlier, it can also be discouraging for mothers to see the negative reactions of people around them when they are simply trying to feed their babies. This could lead to many women feeling like they are unable to breastfeed in public or that they need somewhere more private to breastfeed.

Lack of Community Spaces for Breastfeeding as a Barrier

Oftentimes, private spaces are not necessarily available or accessible, posing another significant barrier to breastfeeding:
I had went somewhere before where there, I knew, it was a part of the bathroom. And where it was you could breastfeed there, a part of the bathroom. And I'm like, "Well, I specifically think we need our own space for that time where it's private areas.
- Participant 020

Private spaces in public areas are difficult to come by and women are often relegated to breastfeed in bathrooms, as this NEBF3 participant pointed out, demonstrating the need for more private lactation spaces that are accessible by the general public. The threat of “looks of disgust” and heated remarks by complete strangers can put women off breastfeeding in public, which can be a necessity for many. Thus, communities that don’t provide private spaces for women to breastfeed can contribute to a culture or environment that is hostile to breastfeeding.

Bias Against Breastfeeding in the United States as a Barrier

Interestingly, to elaborate on the importance of culture on breastfeeding, some participants who were immigrants to the United States mentioned the differences in norms around breastfeeding from their countries of origins and the norms in the United States.

From where I'm from, from [West African country], we don't even have cover. We just open up the breast. Oh baby, come and get it. We don't know anything about covering. Open it like that. The baby just breastfeed. When the baby finish, we'll put it back in. We don't have no cover. It's not that ... when you by, when you see people try to like cover it up. But the first time, everything just leave open. If they have twin, ... we just open all two. Like, "Take one, you take one.” - Participant 005

It is for me too. [Participant 5], I'm from [Caribbean island]. It is for me because in [Caribbean island], when people are ... well, before I migrated, in [Caribbean island], when people were breastfeeding, nobody cares. Here, even if you have a cover ... I've never personally experienced it yet, but even when you have that cover and you're not seeing the baby, but you know that the mom is feeding the baby.
- Participant 009

These participants, both EBF3, brought to light the differences in how breastfeeding is viewed in their respective countries compared to the United States. Culturally, breastfeeding, and breastfeeding in public, is normalized and there is no stigma associated with having your breasts exposed when you do so. The participant made the point that in the United States, even when moms had a cover on, people would
still get offended, highlighting the cultural bias against breastfeeding that exists in the United States, which even wearing a cover may not mitigate.

In summary, findings from this section on Community and Cultural Factors show the powerful influence of culture and community by demonstrating the powerful facilitators to breastfeeding such as generational history of breastfeeding and religious norms of breastfeeding. Conversely, the cultural barriers are the sexualization of breastfeeding, lack of publicly accessible lactation spaces, and the bias against breastfeeding in public in the United States.

**Health Care Institutional and Organizational Factors**

**Helpful Lactation Support as a Facilitator**

One of the major institutional factors that acted as a facilitator for breastfeeding for many mothers was the easily accessible lactation support from the hospital in which they gave birth.

> Yeah, and also, I agree with [Participant 3]. The hospitals, they give a lot of support. You know, lactation specialists are sent to your room upon delivery, and they kind of walk you through whether or not you’re going to breastfeed, pump, or formula. So they go through that. Then you have to have a follow up appointment with your pediatrician within two to three days. At our pediatrician, same thing. Support, lactation specialists and all, the nurse practitioner. Because I was saying I was having a difficult time with the breastfeeding at the beginning for this kid, the last one I had. The pediatrician was there, teleconference, all that other stuff, you know, support needed. So I felt they did a good job, hospitals and pediatrician. - Participant 013

This EBF3 participant was able to get support from the hospital through the proactive dispatch of lactation specialists soon after delivery. The lactation specialists walked her through all of the steps and made follow up appointments for her. There were also lactation specialists available at her pediatrician visit as well. The follow-ups and check-ins from the pediatrician office when she had difficulties with breastfeeding were vital in her being able to breastfeed. She also mentions that she was able to talk to the clinician through teleconference, an important facilitator for mothers who may not be able to come into the pediatrician’s office. This attests to the importance of health institutions that prioritize breastfeeding and support moms in their breastfeeding goals, both in person and virtually. An institution that encourages breastfeeding and provides ready access to lactation specialists can be a meaningful facilitator for
breastfeeding. One participant also voiced the instrumental role that encouragement from lactation support played in easing their worries about breastfeeding:

> It takes a while for the milk to come in. So they’ll come in and tell you that, "No matter what, don't get discouraged if your breastfeeding is not working out. If your goal is to breastfeed for the first couple of months, do not switch to formula." Because if you're in the hospital and you're getting discouraged or you feel like your baby's not getting enough milk, you're probably tempted to get the formula. So they'll come and speak to you too as a support and just like, "It's normal. The baby's not starving." Because they do check the baby's sugars and just tell you to keep pushing until the milk comes in two days later. - Participant 009

This encouragement from the lactation provider helped to assuage any worries that this EBF3 participant might have had about her milk supply or any perceived inability to satisfy her baby. Many mothers expressed feeling anxious about their babies starving or not getting enough milk, but reassurance from lactation providers helped encourage mothers to continue trying to breastfeed and to not supplement with formula right away.

**Doulas as a Facilitator**

Lactation support also came from other practitioners such as doulas, who play a significant role in assisting mothers.

> For me, I also had a virtual doula on the weeks going up to my birth. So I know she was explaining a lot of it. And even knowing the first few days will be hard, because you're not producing milk yet. So your baby will probably seem hungrier than you'd like, a lot fussier, but then when your milk comes in, it gets easier. So I feel like even knowing that made it easier, knowing like, this is like, it will end, it'll get easier after your milk comes in, it's not as stressful. - Participant 004

Doulas are critically important, especially in providing care for Black mothers, as many are trained specifically in providing culturally-cognizant care. Doulas, similarly to lactation providers, provide encouragement and education to mothers to set them up to meet their breastfeeding goals. The participant above, an EBF3 participant, pointed out that the education that she got from her doula made it much easier for her to breastfeed and to anticipate any trouble she might have. Stress around breastfeeding in the early days after delivery can cause mothers to default to formula out of fear for their baby’s health. But having the emotional and informational support from a doula can help to ease some of
that stress. Another EBF3 participant explained how her doctor also provided a lot of education and informational support:

*But I was educated from my doctor, was the first one who insisted for my first child. He was not interested. My doctor played a big part. He was the one who started to educate me then. He told me about that breastfeeding classes, even though I didn't go. I was given like a wealth of information. So even though I was breastfed and my family members and my husband encouraged me, I would say my doctor played a big part in it. He gave me a lot of resources. He was like, "If you're breastfeeding and you're having difficulty, this is the person who will call you. They have specialist." So I was given all that resource before I even had the baby.* - Participant 009

This quote re-emphasizes the important role that practitioners who are involved in the mother’s care play in supporting the mother and their breastfeeding decisions. By providing the mother with all of the resources ahead of time, the mother can reference them easily whenever they need, instead of asking for them once it is too late and they are already experiencing difficulties.

**Provision of Supplies as a Facilitator**

In addition to lactation and educational support, provision of supplies such as breast pumps can also be helpful.

*It wasn't so difficult because I had my baby through a C-section. I was in the hospital for about four days. When I was pregnant with the baby, I got support from the women's center. I got women's group, the breastfeeding, I forget what it's called, but they did call me a couple of times to encourage me. I got the breast pump, I got like two different breast pumps from them, beautiful ones. I got all the support that I needed from the hospital.* - Participant 011

This EBF3 participant specifically noted that the hospital providing her with breast pumps was particularly important. It is not necessarily enough to only provide lactation specialists, but mothers often need additional supplies to help them with breastfeeding, especially breast pumps. As mentioned previously, many moms do go back to work after giving birth and try pumping at work. Having these supplies readily available beforehand allows them to practice and get used to using them so that when the time comes to start pumping, they can make that transition smoothly.

**Historical Institutional Bias as a Barrier**
Interestingly, one EBF3 participant noted that she feels there has been a concerted push in the recent decade to target Black women specifically for breastfeeding efforts.

But I kind of remember it being one of those things where black women I feel like, weren't supported enough in terms of being encouraged to breastfeed. I feel like that's pretty new, like within the past 20 or 25 years, honestly, that it was like let's focus on actually encouraging African American, black and brown women, to breastfeed. Since then, for these past 20 or so years, I feel like there's been a push. I mean, just historically I feel ... I don't feel like it. I feel like for the past 20 or 25 years ... Actually, for the past I will say 15 years, I feel like there has been an intentional push to encourage African American mothers to breastfeed their children. Before that, I don't think that we were really being paid that much attention to in terms of the doctors and the physicians, and the researchers knowing the value of breast milk. They weren't encouraging black or brown women enough to do it. Whereas, we saw it more in the Caucasian. But that's systemic here in our country. - Participant 013

As the participant mentioned, public health institutions and organizations only recently started paying attention and pushing Black women to breastfeed, despite knowing the benefits of breastfeeding long before then. While this recent push to specifically target Black women for breastfeeding campaigns has sought to address disparities in breastfeeding for Black women, the fact that public health institutions historically ignored Black and African American populations is what contributed to disparities in the first place. This lack of understanding manifests itself into the numerous institutional barriers persisting today.

Inaccessible Lactation Support as a Barrier

One barrier that an NEBF3 participant experienced was a lack of lactation support outside of regular working hours.

When the clinicians and stuff like that is not available, and overnight, say like that, when we need help, it's more difficult, because nighttime, it's like, "Oh, well. It's bedtime," and stuff like that, but they're more fussy. Well, mines is more fussy and cranky at nighttime. And it's frustrating to not only him, but only for me, too. Because I'm wondering, "What's wrong with you? What's wrong with you? Because you just latch on and eat to get your nutrition and then go back to sleep." So to get that type of support overnight.

This participant stressed that not having access to clinicians or support overnight made it really difficult for her to continue breastfeeding. This lack of support around the clock can be a barrier for mothers who are struggling and want to reach out for help but can’t because the help does not exist. More
broadly, Black women may also face additional institutional barriers because they are disproportionately represented in the service-sector industry, which means they have variable work hours and may not be able to access lactation support at WIC or other programs during the traditional working hours of 9:00am - 5:00pm.

*Unhelpful Breastfeeding Support as a Barrier*

As previously mentioned, lactation support in the hospital soon after delivery is instrumental in setting the mother up to breastfeed. While this early intervention is important, the quality of the support can be variable, and low-quality or unhelpful lactation support can become more of a barrier than facilitator. Three participants raised the idea of finding the “right” lactation support. So, while some form of lactation support may have been available, participants found that finding a lactation provider who was culturally-relevant, empathetic, and willing to take the time to listen and work with the moms was critical to benefitting from that support.

*I would say in the hospital, the nurse who initially was telling me about how to do it. She wasn't really well versed. Like, there was a setting that you press. Once the flow starts, you're supposed to press a certain setting on the machine and it does a different type of pumping. She didn't know about that. I found out about it later because of the lactation specialist who came out to my house. Because, I had my son just before COVID hit, so now we're still able to get some in-home help. She showed me the button that you're supposed to press after the flow starts. I think if I would have known that, because I probably figured that out a month or two in, or whatever, it would've been less painful, because it was more efficient to do it that way. - Participant 016*

This NEBF3 participant detailed her experience with a provider who did not show her a setting on the breast pump that would have made pumping much easier. She ended up having to supplement with formula. This lack of helpful lactation support posed a barrier for this mother who had every intention to breastfeed. Perhaps a greater barrier than unhelpful lactation support is dismissive support:

*Yeah. It seems like they were just making their rounds and wanting to basically check you off to make sure, like, I did go see this person, whether or not they actually helped you. They would put down like, oh, I gave them the paperwork so they should be set when it's really like, that's not... I wasn’t happy by the time that they left. - Participant 004*
It seemed like in the hospital, a lot of the nurses made it seem like, "Oh, like, it's fine. You'll get it." Lactational consultant will come and then all the problems will be fixed. And then it seemed like when the lactation consultant came, the first one, she was like, "Here are the resources for when you leave the hospital." And I was like, "I want to make sure that she's able to latch before I leave." And then I ended up seeing a second one and she was more hands-on, but she was still, I don't wanna say rude, but she was very short with me and I was like, this isn't really helpful, or like not the support I was expecting. And then when I finally did see one outside of the hospital who was referred by my pediatrician, she was really nice, but she was far away. It was like a 25 minute drive away. Where I know that if I didn't have a car it would have been really inaccessible with a one-week-old baby. - Participant 004

This EBF3 participant described the negative experiences she had with the lactation support offered by the hospitals in which they gave birth. The first participant felt that they did not actually care whether she was helped in a meaningful way, just that someone provided her materials. This experience is illustrative of the dismissal that women, especially Black women, often feel from providers who do not take the time to hear them out or help them. The second participant had a similar experience in that she explicitly asked for more help with latching before she left but was just given a list of resources for when she left the hospital. She ended up needing a consultation with a second lactation provider but was still unsatisfied with the experience; the provider was short with her and was overall unhelpful. She noted that she was eventually connected with another lactation provider, but they were prohibitively far away from where she lived. All of these separate struggles with different lactation providers represents a crucial moment at which the mother could have given up on trying to breastfeed.

Lack of Lactation Supplies as a Barrier

The last major institutional barrier that a participant mentioned was the lack of supplies she was given once she left the hospital.

Well, my son didn't latch. Then I also got my pump later than I was supposed to. I got it maybe like three days after I left the hospital, instead of it being there when I got home. So, my supply was already enriched or something. It messed me up from the beginning. I think it was just a delay with taking my paperwork from the hospital room, because that's where they handle the ordering of the pumps. - Participant 016

As mentioned previously, a participant reported that the provision of a breast pump from the hospital really helped with her ability to breastfeed. However, this participant, an NEBF3, mentioned that
her lack of supplies and the delay in her breast pump arriving had a substantial impact on her ability to breastfeed. This has far-reaching implications for hospitals who are trying to promote breastfeeding; i.e. they need to ensure that women promptly receive all the supplies needed to assist with breastfeeding. For this mother, she explicitly linked the lack of a breast pump to messing up her supply from the very beginning. Again, the first few days after delivery of the baby can be a stressful time for mothers, and in order to set them up for the best chance at breastfeeding, accommodations need to be made as soon as possible. According to the participant, provision of a breast pump can be the defining factor in whether a mother is able to initiate breastfeeding.

In sum, some of the institutional facilitators to breastfeeding are having lactation support that is accessible and helpful, including lactation support from doulas. Another facilitator was the on-time provision of lactation supplies such as breast pumps. Conversely, the absence of available lactation support outside working hours was a barrier as well as lactation support that was unhelpful or dismissive. Finally, the lack of lactation supplies was a major barrier.

**Interpersonal and Social Support Networks**

**Support from Partners as a Facilitator**

Interpersonal relationships can also be instrumental in helping mothers to breastfeed, as mothers heavily rely on and look to their social support networks for help. An influential support network for mothers is their partners or significant others.

*And my husband like I said, he was amazing. I thought the total opposite. [I thought he] would have been like the total opposite, and he was just like, "No, you could do this. I know it's frustrating. Take a deep breath. You got this." So that was my push to like, you got this, your determination is going to be here no matter what, so. - Participant 001*

Having their partner, the person who is often the one who will be raising the child with them, be supportive of their journey to breastfeed is important. This EBF3 participant was already determined to breastfeed “no matter what” but the support of her partner in this decision and the encouragement she received from him helped to solidify her decision. For her, being in agreement with her husband about
infant feeding choices made it easier to try and breastfeed. Partner support can be a great facilitator to breastfeeding, as they can help make the process easier for the mother:

Yes, my boyfriend. We definitely both had a long talk about breast milk. Because we both definitely know that there’s a bunch of health benefits and positive everything when it comes to breast milk. So that was something that we both agreed on that they tried to make happen. And he tried to help any way he could. So yes, he was very, very on board with that. - Participant 021

This NEBF3 participant mentioned that her boyfriend did not just agree with her decision to breastfeed, but he also went a step further and tried to help her in any way that he could. Most of the participants, both EBF3 and NEBF3, similarly noted that their partners supported them in breastfeeding. Partner support was a huge facilitator for many of the mothers, and there was not any meaningful difference in support based on whether mothers were EBF3 or NEBF3, suggesting that for some mothers, partner support may have made a difference but that for others, it alone did not.

Support from Mothers as a Facilitator

Another aspect of social support networks that can play a role in influencing a mother’s decision or ability to start or continue breastfeeding is parental support, specifically support from their mothers.

My mom was my biggest support. She encouraged me and she taught me more about the values and the baby gets more nutrition from breast milk. She told me to do more breast milk, at least for the first three months. - Participant 011

For me, my pediatrician, of course, which they'd always recommend. And my sister also has a baby. Our babies are actually two weeks apart, so she's going through the same thing as I am. And my mother is also a big supporter since she breastfed also. - Participant 004

In a similar vein to the significance of generational breastfeeding, support and guidance from their mothers was very important. Their mothers taught them the importance of breastfeeding and encouraged them to breastfeed. These two participants in particular, both EBF3, noted that their mothers and the advice they gave were facilitators in their decisions to breastfeed. Many participants echoed similar sentiments of having the support of their mothers, including NEBF3 participants.

Support from Social Networks as a Facilitator
Although having the individual support of their partners or mothers was important, having a robust social network where most people around them were supportive, including doctors, was also critical:

My husband supported me. My mother, my father, my in-laws, everybody supported feeding your baby breast milk. It probably was more of a norm. - Participant 013

For me, I would say my husband and my mother-in-law and my mom, they really support me and of course, the doctors and everything like that. But there are like my biggest supporters of breastfeeding whenever I need to and stuff like that. - Participant 002

Yes. My mom, my husband, my sister and my dad. They’re very supportive of me breastfeeding. Then I have one friend that breastfed so she comes and she helps too, big time. She even gave me some type of tea that helps bring the milk in. Very helpful. - Participant 007

As illustrated by the participants above, who were all EBF3, strong social networks that are supportive of breastfeeding can help to create an environment where breastfeeding is seen as the norm. This sentiment is especially highlighted by the first participant who noted that everyone around her supported her breastfeeding and that it actually was more of a norm to breastfeed. Indeed, creating an environment where breastfeeding is seen as the cultural norm can facilitate breastfeeding as the default. This has important implications for public health practitioners to target messaging to the general community around the mother, rather than only the mother.

**Discouragement from Partners as a Barrier**

Conversely, the lack of partner support or active discouragement from the mother’s partner can be a huge barrier to breastfeeding.

For me, my child's father didn't really support it. Like the first day in the postpartum room he was like, "Are you ready to get formula?" And I'm like, "No, my milk hasn't even come in yet. I feel like you haven't given it a chance." And he's always just like, "Oh, there's always formula." And I'm like, "But it's a natural thing, it's going to happen." - Participant 004

Discouragement from a partner who is closely involved in the child-rearing process can cause a lot of tension and frustration. Being in disagreement about a fundamental issue such as infant feeding can
make breastfeeding more difficult because the partner’s immediate reaction to any difficulties is to default to formula and not to try and alleviate any trouble the mother may be experiencing. This participant in particular, an EBF3, was able to overcome her partner undermining her decision to breastfeed, but other mothers may not be able to do the same.

Discouragement from Mother In-Laws as a Barrier

In addition to unsupportive partners, having their partner’s parents be unsupportive can also pose a barrier.

Yeah. Like I said, my boyfriend's mom, she was just like, "Give that baby formula. He's not being full. He feeds too much." Or, "It'll be a lot easier for him if you give him some formula." She was like, "You can still breastfeed, but just give him some formula." So.
Mostly her. - Participant 015

Navigating relationships with in-laws can be difficult, as they often feel they have a stake in the child-rearing process as well. Discouragement from a partner’s in-laws can become overbearing and mothers, who are already dealing with the stress of having a newborn, can become overwhelmed and feel like they must please their in-laws. This NEBF3 participant noted that while she wasn’t actively discouraged from breastfeeding, her mother-in-law still pressured her to at least supplement. Many mothers may succumb to this pressure and end up supplementing their children even if they had originally intended to exclusively breastfeed.

Discouragement from Social Networks as a Barrier

This pressure from those in close social networks to supplement or formula feed is magnified when almost everyone in a mother’s network is unsupportive:

Pretty much my entire family [was unsupportive], because they said that they would be clingy to me and they would be spoiled and stuff, but I still did it. - Participant 019

It was my whole family, because she said, "It's like the baby's being clingy to you and needing more time and patience," and stuff like that. - Participant 020

These two participants above, both NEBF3, mentioned that nearly their entire family was unsupportive of them giving their infants breast milk.
Everybody. Everybody. My mom says I should stop giving her the breast because that's why I'm so skinny and all of that. Everybody was upset with me. Like, "You just need to stop giving her the breast." Honestly, - Well, like my mom, my grandma, her side. Our grandma and stuff. And my friends, they would tell me that, "You need to stop." - **Participant 006**

For this EBF3 participant, she talked about how everybody around her was not just unsupportive, but outright hostile to her for breastfeeding. Although they had the best intentions and were only worried about her health and how much weight she was losing, they were aggressive with pressuring her to discontinue breastfeeding. Having the pressure of their entire social network and the people closest to them can be an insurmountable barrier. Again, this participant was able to ignore this intense pressure from her entire social network, but others may be persuaded.

Ultimately, interpersonal networks play an important role in facilitating or being a barrier to breastfeeding. Support from those closest to the participants such as partners, mothers, and other family and friends are facilitators to breastfeeding, while discouragement from the same people can be a barrier.

**Individual Factors**

**Determination to Breastfeed as a Facilitator**

While breastfeeding is a very sensitive personal choice and there are numerous individual factors that can contribute to breastfeeding initiation and continuation, it is important to underscore that these individual factors act within a wider context that involves complex interactions between social and institutional systems as outlined in the previous sections. However, one facilitator that many mothers, most of them EBF3 participants, highlighted was their strong commitment to breastfeeding.

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**I believe her name was [redacted]. Like how she said, with the lactation specialist, the first one I seen was the same thing. It was here's your information and that's that where, like I said, I never breastfed my other kids, I was unsuccessful. So I was determined and that right there, if I wasn't so determined, would've probably discouraged me. - **Participant 001**

**With me, it's like I said, having my older children and I wanted it to be different this time. I wanted to try breastfeeding, so that was my big push up. Let's go, you're going to try this no matter what, you're not going to be discouraged about it, no matter what's going to go on. - **Participant 001**

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This participant, who contributed both quotes, was determined to breastfeed “no matter what.” She especially noted that if she had not been so determined, she might have been discouraged by the lack of lactation support. Her conviction to stick with breastfeeding helped to facilitate her breastfeeding goals.

Another EBF3 participant discussed a related position:

*I don't listen to the negative. I'm very positive about anything that I ever do, so I don't listen to ... I just make up my mind with breastfeeding, and it's just for a time so I just give my time to the baby, because I know it's just for a while. You don't breastfeed forever for me, so I don't listen to the negative. I just go with the baby. For me, it's just about the baby because the baby needs all the time, all the care, all the energy, positive energy, so I don't listen to that. I don't have anybody around me trying to discourage me.* - Participant 011

This participant was similarly determined to breastfeed because she wanted what she thought was best for her baby. She reassured herself that she would not need to breastfeed forever and that she was willing to make this short-term sacrifice for her baby’s health. She mentioned that she also tuned out any negative opinions that people might have had about her breastfeeding but also says that there was not necessarily anyone around her discouraging her. This is important because, as discussed previously regarding social networks, the pressure on mothers from the people around them can have an impact on their ability to breastfeed. This mother was not only determined to breastfeed, but had no one in her circle of support who was discouraging her from doing so. Other mothers did not have the same experience.

*I think it honestly depends on the babies, right? Because, I wanted to breastfeed her. Obviously, I did. I wanted to go past six months. I wanted to do almost up to probably a year. And, she just didn't ... I don't know why she didn't like it. She didn't like it at all.* - Participant 014

This participant, an NEBF3, was also just as determined to breastfeed as the mothers who were able to, but she perceived that her child did not like breastmilk and did not take to breastfeeding like the mother wanted. This illustrates that although determination is an important facilitator to breastfeeding, it is not sufficient on its own as baby behaviors also influence infant feeding decisions.

*Benefits of Breastfeeding as a Facilitator*
Another facilitator to breastfeeding for many of the participants was having prior knowledge of the benefits of breastfeeding:

*Well, I will say that for me, that was just a personal choice. I know the nutritional value behind breast milk and how it's like liquid gold. When my first born, she probably had one ear infection her entire life. So it's the best option.* - Participant 010

As mentioned by this EBF3 participant, she knew of the benefits that came with breastfeeding and equated human milk with “liquid gold.” The health benefits of breastfeeding such as preventing general sicknesses and colds, a theme mentioned 27 times, was a major motivator for many participants.

*I know breast milk, babies who are fed breast milk, they don't get sick. They hardly get sick, for me, and that's one thing that my other babies with breast milk, they were never sick, really. They were never sick. They didn't have allergies, I didn't have to go to the hospital for anything or diarrheas and stuff. For me, breast milk has more nutritional values for me.* - Participant 011

*It just helps them build up their immune system to where they're not sickly as far as like always getting colds or getting ill.* - Participant 007

For these participants, both EBF3, the health benefits of breastfeeding played a considerable role in their decision to want to breastfeed. Their babies did not get sick or as sick because of the health-protecting factors of breast milk. Another benefit that motivated many mothers, as it was mentioned 19 times by participants, was the benefit of bonding.

*I would say the same thing, the bonding. Because my mom said when you breastfed the baby, you bond more with them. Sometimes they look you in the eye while you breastfeed them. They're trying to understand you, recognize your face. They get used to your voice, the warmth, the feeling. So for me, that's the greatest part of breastfeeding. That's the greatest part for me, the bonding and the health benefit.* - Participant 011

This EBF3 participant noted that the benefit of bonding that comes from breastfeeding was the “greatest part of breastfeeding”. She also mentioned the health benefits of breastfeeding, but for her, the bonding incentive was a major facilitator.

*Education and Knowledge of Breastfeeding as a Facilitator*
This knowledge does not necessarily have to come from prior experiences, as many mothers talked about doing research about breastfeeding before having their baby:

*Participant 011*

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I would say I did more research with my last baby. With the first one, my mom was there all through. She was my support and I had more encouragement from her. My last baby, this baby that I just had five months ago, I did more research because the COVID, I'm home, I lost my job, so I had more time to do other stuff, stuff that I wanted to do that I never had time to do. So I did more research while I was pregnant because I wanted to know what I wanted to do with the baby, because I didn't know I was pregnant with her. I found out when I was nine weeks. I did more research on breast milk and the values and stuff. I did more research with this baby more. - Participant 011
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This participant, an EBF3, discussed how she did more research about the benefits of breastmilk with her most recent baby, since her mother was no longer around to provide guidance. This illustrates the importance of having clear and consistent information on breastfeeding for mothers who are looking to learn more, especially since mothers are already bombarded with a great deal of information on what they should and should not do. Clinicians can also be facilitators in providing this information to mothers:

*Participant 002*

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I mean, it didn't... I thought breastfeeding would probably harm my baby because I'm a new mom. I don't really know anything. So anything I have questions I would ask the doctors about, and they was like, "No, it's naturally... It's really good for your baby. And there's more bonding with your baby at that. And it's more healthier for your baby than formula." Which I didn't know. So I was like, "Oh, okay. So I could just breastfeed my baby any time, any place, anywhere, if I need to. So I find breastfeeding is very good for new moms, and it will bring you and your baby together and just have that bond. And it's very good for your baby to have. - Participant 002
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For this EBF3 participant, her doctor played a big role in educating her about the benefits of breastfeeding. She talked about how she was a new mom and did not know anything about breastfeeding. She also discussed that prior to meeting with her doctor, she did not know much about breastfeeding and thought that it might even be harmful to the baby. For her, this information and encouragement from her doctor was instrumental in facilitating her breastfeeding journey. Once she learned of the benefits, she was willing to give it a try. Participants repeatedly mentioned their clinicians providing them with information on breastfeeding and encouraging them to breastfeed.

*Staying at Home as a Facilitator*

An additional important facilitator for many of the mothers was being able to work from home.
With my baby, it's just different. She's a girl. She's adorable. I give her more breast milk. Like she said, I know the nutritional value of breast milk, so I tend to give her more often. She's five months now. I'm not planning on stopping. I don't know how far ... Then I'm working from home, so it makes it a little more easier. She takes bottle feed, like formula, but for now, I know the nutritional value with breast milk, so I just intend to go far. - Participant 011

This EBF3 participant was able to exclusively give her baby breastmilk for at least five months because she was able to stay at home and focus on the baby. As mentioned previously regarding workplace policies, having to go back to work can be a barrier to breastfeeding, and even those who are allowed to pump at work do not necessarily want to. However, by working from home, she does not have to worry about any pumping difficulties that can come from trying to pump at work.

It's a little different now because I'm home, I just have her to take care of, I don't have to think about going to work, so it's just breast feeding. - Participant 011

For me, what made it easier was the fact that I was home. I was able to be home with him 24-7. Also, like she says, lactation help. - Participant 015

These two participants, an EBF3 and a NEBF3, respectively, talked about how being home made it easier for them to breastfeed because they were able to concentrate solely on their babies and breastfeeding. It is important to note that staying at home is not a luxury that most mothers are afforded, and working from home or staying home from work is a policy-level decision. However, these participants did not mention that their ability to stay home was specifically linked to employment.

The Time-Consuming Nature of Breastfeeding as a Barrier

One barrier that many participants discussed was the amount of time that breastfeeding can take.

Now comes the baby, and I'm like oh man, it takes time to breastfeed. I didn't realize it takes a lot of time. I breast fed him solely until like six months. Then I was done. I could not wait until six months were over, and I bought formula. I never bought formula before. I bought formula for the first time, and it was so expensive. Now I remember why I was breastfeeding. It was so expensive. Oh my goodness. Breastfeeding is so time consuming. You really have to be intentional about breastfeeding. You have to be intentional about eating. You have to be intentional about your schedule, and I was a working mom this time. So it was very different, very, very different. - Participant 013
With this EBF3 participant, the time that it can take to breastfeed was a major barrier for her. She mentioned that it was so time-consuming that she could not wait until the baby was six months old to stop breastfeeding. Breastfeeding can be quite time-consuming, especially if mothers want to start pumping. Pumping requires advanced planning and set-up, and not all mothers have the time to breastfeed. This participant in particular is also a working mother, which presents an additional challenge in terms of having enough time to breastfeed her child.

Returning to Work as a Barrier

Another participant, an NEBF3, mentioned that going back to work was one of the main reasons she chose not to breastfeed:

> Just then, I didn't breastfeed my other kids. I wanted to do something different with [this child] ... But then I'm like, to be honest, I didn't want my boobs to sag. And I was starting back work. - Participant 018

In addition to starting work again, this participant mentioned that she did not want her breasts to sag. Again, breastfeeding is a personal choice for many mothers, and there are numerous factors that affect whether they want to breastfeed.

Difficulties with Pumping as a Barrier

Another barrier to exclusive breastfeeding that mothers mentioned was having to pump and the difficulties with pumping and not being able to produce enough milk as a result. One NEBF3 mother, said:

> Once he started daycare, I couldn't pump as much. So, I weaned from ... Because the first six weeks, he had only breast milk. But once we started going to school, to daycare, I couldn't give him enough. I felt like I wasn't giving enough. So, I also bought formula. So, that's why he had a supplement. - Participant 015

This sentiment was mentioned six times by other participants who felt that when they had to switch to pumping, they were not making enough milk. They felt that pumping affected their milk supply and that their babies were not being fed adequately with just breastmilk. Due to this perceived disconnect in milk supply and satiety of the baby, many chose to supplement with formula.
The Need for Lifestyle Changes as a Barrier

The last major individual-level barrier that many of the mother’s mentioned was the need to change their lifestyle or habits. One lifestyle change that was mentioned by a few participants was having to abstain from drinking alcohol or smoking:

*I want to add that I missed having a drink. I'm not a hard drinker, but a little cocktail, a little wine or something, it's either you drink or you won't. I don't believe in pump and dumps. I don't do that. That's just a lot of work. That's just disrespect to me. I haven't had a drink in two years. It feels like two years. I miss that.* - Participant 010

*I discouraged myself at some point in time because I also used to smoke cigarettes, and I had to wean off the cigarettes. It was like you can't do both. If I smoked cigarettes and then on top of it tried to breastfeed, I was kind of discouraging myself because I was like I don't want the nicotine to get inside the baby.* - Participant 012

Having to abstain from alcohol or smoking can be a challenge for mothers, especially after abstaining for the duration of the pregnancy. This additional barrier can be too difficult or discouraging and force mothers to make a difficult choice. Furthermore, both EBF3 and NEBF3 participants cited having to be on a specific maternal diet as a barrier to breastfeeding:

*The baby's stomach is full and then you remember that you have to feed that baby after two hours again. So that's why you always have to eat the right food, make sure you have the right food that you have to eat. You have your food up and you have your menu and what to eat and what not to eat. That's the disadvantage of it.* - Participant 005

*I could say, some of my friends, they said they diet, the diets they have to be on in order to breastfeed is very discouraging.* - Participant 020

This idea that they needed to be on a specific diet came up 16 times for participants. They talked about how they have to avoid certain foods because they can dry up their supply and eat cleaner in order to ensure their babies are receiving the necessary nutrients. Mothers are already overwhelmed with a new infant, and having to adjust their lifestyle again can be an additional challenge.

In summary, while individual facilitators and barriers to breastfeeding may have an impact on breastfeeding, these factors need to be contextualized within other factors such as policy or culture. Individual determination was identified as a facilitator to breastfeeding along with the reasons for this
motivation such as the health benefits or bonding incentives. The other facilitators were having education or knowledge of breastfeeding and working from home. The individual-level barriers mentioned by participants were that breastfeeding is time-consuming which is especially difficult for working mothers. Another barrier was that having to pump made breastfeeding more difficult. Finally, the lifestyle changes such as changing their diet or abstaining from alcohol also posed a barrier to the participants.

Discussion

Based on the analysis of these focus groups with Black mothers in the Greater New Haven area, we were able to better understand the diverse additional barriers that Black women face when it comes to exclusively breastfeeding for 3 months. At the policy level, a common barrier was a lack of awareness of the policies or laws that protect their rights to breastfeed, especially in the workplace. Breastfeeding-friendly workplace policies such as allowing time to pump or providing space to pump can be conducive to continued breastfeeding because they allow mothers to continue expressing milk regularly and consistently, which is important for their milk supply. This is especially important as research has shown that employment or returning to work is a major barrier to continued breastfeeding (DeVane-Johnson et al., 2017).

Within the community and cultural level, a major barrier was the historical stigmatization and sexualization of breastfeeding, which can be amplified for Black women, who have had a history of being sexualized in popular media (Benard, 2016; Freeman, 2018, 2019; Johnson, 2018). Disentangling sexualization of the breasts and the nurturing quality of breastfeeding is critical in fostering a cultural norm that is favorable for breastfeeding, especially in public. Another barrier was a strong social bias against breastfeeding. Four mothers noted that there is a significant difference in how breastfeeding is viewed in their countries of origin compared to the United States, where it is still stigmatized, especially in public. This is consistent with evidence showing that breastfeeding rates for foreign-born Black mothers in the U.S. are much higher than U.S. born Black mothers (Fabiyi et al., 2016; Safon et al., 2021).
At the institutional level, many of the participants noted that they did not feel heard or listened to when trying to get help with breastfeeding. They were often dismissed or ignored when they wanted to get additional help beyond receiving a list of resources, which is consistent with evidence that Black mothers are less likely to receive breastfeeding counseling from their providers (Beal et al., 2003; Kulka et al., 2011). One participant made a poignant remark about how she felt that Black women were previously ignored in any breastfeeding promotion efforts, despite the health benefits being well known. It was not until the last couple of decades that Black women were included in breastfeeding promotion (Freeman, 2019).

Appearing within the interpersonal level, a common barrier was overall lack of support from mothers’ social networks and those who were closest to them. Participants reported being discouraged to breastfeed by their family and friends which can be impactful because they do not have anyone to turn to if they need help. Indeed, research has shown that breastfeeding behavior is influenced by a mother’s social network and that just having one supportive person in their network can be enough to encourage breastfeeding (Carlin et al., 2019).

At the individual level, the most common barriers were having to return to work and having to make significant lifestyle changes, such as changing their diet or refraining from alcohol or cigarettes. The combination of these factors has an impact on whether mothers are able to both initiate breastfeeding and exclusively breastfeed. There is not necessarily a single, isolated barrier that is the determining factor. Rather, these barriers operate all together, creating a complex environment that can be unfavorable to breastfeeding.

While this study has provided the rich and detailed experiences of Black mothers and their breastfeeding journeys, there are some important limitations to note. Perhaps the most important limitation was the way participants were recruited. The research team distributed the flyer through social media and community organizations, but the majority of participants, all but one or two, ended up being recruited through a community partner organization that is strongly vested in promoting breastfeeding. Because of this, most of our participants, including NEBF3s, had at least tried breastfeeding and many of
them breastfed for three months or more, just not exclusively. Indeed, there were only two NEBF3 participants out of nine who did not breastfeed at all, the rest breastfed and supplemented with formula.

Therefore, it was not surprising that EBF3 and NEBF3 participants reported similar barriers and facilitators to breastfeeding. Perhaps, if we had made the inclusion criteria for NEBF3 participants more stringent and only recruited those who did not breastfeed at all, there may have been more substantial differences.

Similarly, there were 13 EBF3 participants and only 9 NEBF3 participants. This was due to difficulties with recruitment of NEBF3 participants. Multiple NEBF3 focus group sessions had to be canceled and rescheduled, suggesting there may have been some systematic difference in EBF3 and NEBF3 participants in terms of willingness to participate in a study about infant feeding. To address this, we did our best to emphasize that we were looking to recruit both mothers who breastfed and those who did not by using inclusive language on the flyer. However, as cultural norms are shifting and breastfeeding is becoming more of the norm, formula feeding has become stigmatized. Therefore, many mothers who exclusively formula-fed may not have felt comfortable talking about their infant feeding practices. Indeed, we saw this with one participant who mentioned that she “knows it makes her look bad” because she formula-fed. This suggests there may have been other mothers who felt shame around formula feeding and did not want to share their personal choices with us.

**Conclusion**

This research has a few important implications for public health practitioners who seek to address racial disparities in breastfeeding rates. First, there needs to be a more concerted effort to educate the public and mothers on their rights to breastfeed in the workplace. Return to work is one of the most common barriers to breastfeeding, and this research confirmed the importance of workplace breastfeeding policies for mothers to continue breastfeeding (DeVane-Johnson et al., 2017). By increasing awareness of breastfeeding laws, employers could proactively implement breastfeeding-friendly policies.

In addition, practitioners looking to design breastfeeding promotion campaigns and programs need to be acutely aware of the additional barriers that Black women face when trying to breastfeed.
Consideration of the historical, racist context of breastfeeding and the present-day manifestations of inequities in barriers to breastfeeding need to be taken into account before proceeding with programs or campaigns that target the individual or put the onus of change solely on mothers (Freeman, 2018, 2019). As demonstrated by the findings of this study, barriers to breastfeeding exist at every level, including at the policy, cultural, institutional, and interpersonal level. Conversely, an important facilitator is having a plan and conviction to breastfeed in advance of giving birth. This points to the need for focus on preconception education that includes anticipatory guidance on breastfeeding in order to reach mothers early on about the benefits of breastfeeding.

Finally, as one participant noted, Black women have been systematically ignored and excluded by public health professionals throughout the entirety of history, so any efforts to address disparities not only need to target every level, but they need to consider the deep-rooted racism that exists in our own field of practice.

References


Appendix 1a: EBF3 Focus Group Guide

**WARM UP**

I’d like to start out with some introductions to get to know one another a bit more.

1. Let’s go around and introduce yourselves (first names only!), and tell us how many children you have and how old they are?
2. As a mom, what is one thing you think all moms have in their bag?

**BREASTFEEDING DETERMINANTS**

Now, I want to ask you some questions about breastfeeding your baby, and would like to hear more about your experiences or perspectives on this. These questions are just about your opinion, and there are no correct or incorrect answers. Also, there may be many different answers to the same question—feel free to give me all the responses you can think of, or build off of what someone else has said. The focus of these questions is about breastfeeding your baby; we are interested in your unique experiences or perspectives on this, as well as stories or reflections on the wider community in which you live.

**Self-efficacy**

3. What made it *easier* for you to give only breastmilk to your baby for the first 3 months? (probe: what else?)
4. What things made it *difficult* for you to give only breastmilk to your baby for the first 3 months? (probe: what else?)

**Positive & Negative Consequences**

5. What were some *advantages*, or what do you think of as advantages, of giving breast milk only to your baby for the first 3 months? (probe: what else?)
6. And what about disadvantages? What were some *disadvantages*, if you encountered any, of giving only breast milk to your baby for the first 3 months.

**Social Norms**

7. Can you reflect back on all the people in your life who support you giving only breastmilk to your baby for the first 3 months? (We don’t need any names! Just would like to hear about the types of people who may support you in giving only breastmilk to your baby for the first 3 months.)
8. Can you reflect back on some of the people in your life who may discourage you from giving only breastmilk to your baby for the first 3 months? (We don’t need any names! Just would like to hear about the types of people who may not approve of you giving only breastmilk to your baby for the first 3 months)

**Access**

9. How difficult was it to get the *support* you needed to give only breast milk to your baby for the
first 3 months? What were some of those difficulties? (probe: Here I’m asking about breastfeeding support services such as doctor/nurse/midwife support, lactation counselors/doulas/WIC peer counselors, maybe mothers’ groups, or simply access to pumps or lactation space you may have needed to help you breastfeed?)

Susceptibility / Perceived Risk

10. When you decided to give breastfeeding a try, can you tell me about why you chose to do this? What are the benefits to breastfeeding?
   a. probe: Were you concerned about your baby’s health or any specific conditions s/he might be at risk for if you hadn’t breastfed? Were you concerned about YOUR health? What are the benefits? Did you have any other concerns about what might have happened if you hadn’t breastfed? (list specific things they were aiming to prevent by breastfeeding, like weakened immune system, allergies, or obesity/chronic disease)
      i. __________________
      ii. __________________
      iii. __________________
      iv. __________________

Severity

b. Follow up: how serious would it have been if your baby had developed [insert any health concerns mentioned above: weakened immune system, allergies, obesity, chronic disease, cancer, etc.]? (probe: hmm tell me more, why do you think that is?)

Action Efficacy

c. Follow up: how likely is it that your baby would develop [insert health concerns mentioned above] if you give only breast milk to your baby for the first 3 months? (probe: hmm tell me more, why do you think that is?)

Divine Will

11. Does your religious tradition or beliefs influence your decision to breastfeed? (probe: how so? Tell me more.)

Policy

12. Are there any laws or policies in place that made it more likely for you to give only breast milk to your baby for the first 3 months? Like what? (probe: I’m thinking of things like workplace policies that support breastfeeding moms, or maybe a city or state policy that you know of.)

Culture

13. Are there any cultural norms or stigmas against breastfeeding in your community? Like what? (probe: How do people feel about a woman breastfeeding in a public place? How is breastfeeding viewed by members of your community? Do any stories come to mind?)

Appendix 1b: NEBF3 Focus Group Guide

WARM UP
I’d like to start out with some introductions to get to know one another a bit more.

1. Let’s go around and introduce yourselves (first names only!), and tell us how many children you have and how old they are?

2. As a mom, what is one thing you think all moms have in their bag?

BREASTFEEDING DETERMINANTS

Now, I want to ask you some questions you may not have thought about before. Feel free to take time to reflect if you need to. These questions are just about your opinion, and there are no correct or incorrect answers. Also, there may be many different answers to the same question—feel free to give me all the responses you can think of, or build off of what someone else has said. The focus of these questions is about feeding your baby: we are interested in your unique experiences or perspectives on this, as well as stories or reflections on the wider community in which you live.

Self-efficacy

3. What would make it easier for you to give only breastmilk to your baby for the first 3 months? If this doesn’t apply to you, think about people in your community. What would make it easier for moms in your community to give only breastmilk to their baby for the first 3 months? (probe: what else?)

4. What things make it difficult for you to give only breastmilk to the baby for the first 3 months? If this doesn’t apply to you, think about people in your community. What would make it difficult for moms in your community to only give breastmilk to their baby for the first 3 months? (probe: what else?)

Positive & Negative Consequences

5. What do you think may be some advantages of giving breast milk only to your baby for the first 3 months? (probe: what else?)

6. And what about disadvantages? What would be the disadvantages of giving only breast milk to your baby for the first 3 months.

Social Norms

7. Can you reflect back on all the people in your life, who would be supportive of you giving only breast milk to your baby for the first 3 months? (We don’t need any names! Just would like to hear about the types of people who may approve of you giving only breastmilk to your baby for the first 3 months.)

8. Can you also think about some of the people in your life who may discourage you from giving only breast milk to your baby for the first 3 months? (Again, we don’t need any names here! Just would like to hear about the types of people who may not approve of you giving only breastmilk to your baby for the first 3 months.)

Access

9. How difficult would it be to get the support needed to give only breast milk to your baby for the first 3 months? What were some of those difficulties? (probe: When I say support, I mean breastfeeding support services such as a clinician (doctor/nurse/midwife), lactation counselor, doula, WIC peer counselor, a mothers’ groups, or simply access to pumps or lactation space
you may have needed to help you breastfeeding?)

Susceptibility / Perceived Risk

10. When you think about breastfeeding, and anyone you know who gave breastfeeding a try, can you tell me about why they chose to do this? (reference advantages listed under Q. 4 if any pertained to prevention of a health condition) What are the benefits to breastfeeding?
   a. probe: Are there any specific health risks or illnesses that they were trying to avoid, for their baby or themselves, by breastfeeding? (list specific things they were aiming to prevent by breastfeeding, like weakened immune system, allergies, or obesity/chronic disease)
      i. __________________
      ii. __________________
      iii. __________________
      iv. __________________

Severity

b. Follow up: how serious would it have been if your baby had developed [insert any health concerns mentioned above: weakened immune system, allergies, obesity, chronic disease, cancer, etc.]? (probe: hmm tell me more, why do you think that is?)

Action Efficacy

c. Follow up: how likely is it that your baby would develop [insert health concerns mentioned above] if you give only breast milk to your baby for the first 3 months? (probe: hmm tell me more, why do you think that is?)

Divine Will

11. Does your religious tradition or beliefs influence your decision to breastfeed? (probe: how so? Tell me more.)

Policy

12. Are there any laws or policies in place that make it more likely for people in your community to give only breast milk to their babies for the first 3 months? Like what? (probe: I’m thinking of things like workplace policies that support breastfeeding moms, or maybe a city or state policy that you know of.)

Culture

13. Are there any cultural norms or stigmas against breastfeeding in your community? Like what? (probe: How do people feel about a woman breastfeeding in a public place? How is breastfeeding viewed by members of your community? Do any stories come to mind?)
Appendix 2: Recruitment Flyer

Join our community meeting with:
MOMS IN THE GREATER NEW HAVEN AREA

This study will look at various factors that contribute to your family's decisions around feeding your baby—whether breastfeeding or formula feeding. Participation will involve being part of a virtual community meeting on these topics.

Do you identify as:
• a Greater New Haven Area Resident
• a Black or African American mom who has given birth within the last 18 months

If so, please consider joining this study taking place in March.
Participants receive a $40 Visa gift card.
Note: If your family receives WIC/other government benefits, they will not be affected.

Contact: reesea3@southernct.edu
Phone: (203) 868-0590 (call or text)

IRB #: 2000028392