Initiating and Sustaining Breastfeeding in African American Women

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Abstract:

Objective: To explore issues related to initiating and sustaining breastfeeding in African American women.

Design: Qualitative design using focus groups, guided by Leininger's theory of culture care diversity and universality.

Setting: Three different regions of a southeastern state in the United States.

Participants: Fifteen self-identified African American women who had recently breastfed were recruited by lactation consultants and by word of mouth.

Methods: Three focus groups were conducted with initial guiding questions. New ideas that emerged were fully explored in the group and included as a guiding question for the next group.

Results: Categories identified from the data were reasons to start and stop breastfeeding, advice about breastfeeding that was useful or not useful, and cultural issues related to breastfeeding that were perceived to be unique among African Americans. Three overall themes were identified that cut across categories: perceived lack of information about benefits and management of breastfeeding, difficulties breastfeeding in public, and lack of a support system for continued breastfeeding.

Conclusion: Women need to be taught early in their pregnancies about the benefits of breastfeeding and offered continuing support and teaching once breastfeeding is established. Peer support groups for breastfeeding African American women should be established.

Keywords: breastfeeding | African-American | focus groups | culture

Article:

Breast milk is recognized as the ideal food for human infants, with important health benefits for infant and mother (Hale, 2007), yet African American women initiate and continue breastfeeding at lower rates than all other ethnic groups in the United States. According to the most recent statistics released by the Centers for Disease Control and Prevention (CDC) in 2008, 74% of U.S. women initiated breastfeeding, 43% breastfed for 6 months, and 21% breastfed for 1 year. African American women showed the greatest improvements of any population group in these statistics but still fell far short of other groups, with 61% initiating breastfeeding, 29% breastfeeding to 6 months, and only 13% breastfeeding for 1 year (CDC, 2008).

The reasons for disparities in breastfeeding practices between White and African American women are not clear (Cricco-Lizza, 2006; Saunders-Goldson & Edwards, 2004). Demographic factors associated with breastfeeding initiation and duration include age, marital status, education level, and socioeconomic status (McDowell, Chia-Yih, & Kennedy-Stephens, 2008). Women who are more likely to breastfeed are White, older, married, and have a higher education level and a higher socioeconomic status. Social influences associated with breastfeeding initiation and duration include support from the infant's father, support from family friends, nurses, and physicians (Meier, Olson, Benton, Eghtedary, & Song, 2007; Wambach & Koehn, 2004). Factors that affect breastfeeding initiation and duration for all races include knowledge of the benefits of breastfeeding, beliefs about breastfeeding, and the need to return to work (Flower, Willoughby, Cadigan, Perrin, & Randolph, 2008; McInnes & Chambers, 2008; Saunders-Goldson & Edwards).

A less well studied factor that may also affect the breastfeeding practices of African American women is culture. Unfortunately, most studies have used combined race samples to examine issues associated with initiation and duration of breastfeeding in African American women, making it difficult to isolate cultural influences. In one study by McCarter-Spaulding (2007) that examined the experience of breastfeeding in African American women who had breastfed a child, the sample consisted only of Black women; however, participants reported 74 different ethnic backgrounds, including West Indian/Caribbean, and only one participant self-identified as American. In addition, the influence of culture was not specifically addressed. Thus, there is a need for research that focuses on culture to better understand how this may contribute to the breastfeeding disparities that exist between African American and White women.

Methods

The current qualitative focus group study explored issues related to initiating and sustaining breastfeeding in African American women. The research was guided by Leininger's theory of culture care diversity and universality (Leininger & McFarland, 2006), which states that one of the first steps in designing culturally sensitive interventions is obtaining information about health

issues directly from the members of the targeted culture. Focus groups allow participants to share information and react to each other's statements. They are especially useful for collecting data on feelings and perceptions (Krueger & Casey, 2000). By using focus group methods, we were able to hear directly from African American women who had breastfed about facilitators and barriers to breastfeeding initiation and continuation.

Sample

To be included in the study, women had to be age 18 or older, self-identify as African American, and be currently breastfeeding or have breastfed within the past year. Fifteen women participated in one of three focus groups held in different locations in a southeastern state in the United States. All participants were recruited by local lactation consultants and by word of mouth, and all delivered in the same hospital in the city of each of the focus groups. The hospitals drew from urban, suburban, and surrounding rural areas.

The 15 participants ranged in age from 18 to 38 (Table 1). Educational levels varied from high school completion to graduate school, with the most common category of 1 to 3 years of college. Twelve women had given birth to one child, two had two children, and one had three children. Six participants were still breastfeeding. The length of time the women breastfed varied, with the majority of them having breastfed more than 6 months but less than 1 year, which is the time recommended by the American Academy of Pediatrics (2005).

Table 1. Characteristics of Participants

	Mean (Range)
Age	27 (18-38)
Length of time breastfeeding	
First baby (*n*=15; 3 still breastfeeding)	7 months (<1-22 months)
Second baby (*n*=4; 1 still breastfeeding)	5 months (2-9 months)
Third baby (*n*=1; still breastfeeding)	

Group sizes ranged from three to nine. Three focus groups with the same type of participants are generally sufficient to gain saturation on a topic (Krueger & Casey, 2000). We left the option open to conduct additional focus groups if new issues continued to emerge, but by the third group we were encountering no new issues, so we concluded data collection with that group. The study was approved by the University Institutional Review Board (IRB) and two other institutional IRBs where the lactation consultants worked. All women signed consent forms

before participation. Each woman received a $20 gift card from a discount store as a thank-you gift.

Data Collection and Analysis

The focus groups were conducted by the researchers, one of whom is African American and one White. The focus groups were audiotaped and professionally transcribed verbatim, and after verification with the audiotapes, these transcripts were used for the analysis. Additionally, one researcher took written field notes at the focus groups, while the other talked to the participants, and these were used to inform the analyses. Each focus group lasted approximately 1.5 hours.

A series of open-ended questions was used to guide the focus groups (see Table 2), but women were encouraged to also discuss other topics related to their breastfeeding experiences. The guiding questions and focus group procedure were first pilot tested with a group of nine women (White and African American) who had breastfed children and were also knowledgeable about qualitative research, and the guiding questions were refined based on that feedback. A specific suggestion the pilot group had was to ask the women about anything that could have been done to help them breastfeed longer, so this question was added. The pilot group did not recommend any changes in the procedure of the focus group.

Table 2. Focus Groups Guiding Questions

• Think back to when you first decided to breastfeed. When did you first decide to breastfeed?
• What thoughts went through your mind about reasons to breastfeed and reasons not to?
• Tell me about what your breastfeeding experience was like.
• What kind of help or advice did you get with breastfeeding that was useful?
• What kind of help would have been useful, but that you didn't get?
• When you stopped breastfeeding, what reasons did you have for stopping?
• Was there anything anyone could have done to help you breastfeed longer?
• Do you think there is anything about the African American culture that makes a woman want to breastfeed or not want to breastfeed?
• Of all the things we have discussed today, which would you think is the most important?

We began each research focus group by going around the room and asking for responses from each participant for each question. During the discussion of almost every question, a dialogue developed between the participants. It was rare that one person got through her response without

being interrupted, but if the dialogue went off on a tangent, the researcher would bring it back to the original question until each participant had a chance to respond. If a new topic emerged that was not one of the predetermined questions, this was fully discussed and each participant had an opportunity to give her opinion. Consistent with a qualitative emergent design, when a group identified issues that were not in the guiding questions, the researchers also raised these issues with subsequent participants. For example, at the first focus group, one of the women spontaneously brought up issues related to breastfeeding in public and that generated a lively discussion, so we added that question to the other two focus groups.

Data were analyzed using the process recommended by Krueger and Casey (2000). The researchers initially examined the data question by question: first by individual group, then across groups. Next, categories of the responses were developed from the data, and last, overall themes that cut across categories were identified. Both researchers participated in the data analysis: each researcher initially coded the transcripts individually, then discussed the codes with the other researcher. After initial individual coding, all other analysis, including categories and overall theme identification, was completed by both researchers together, and 100% agreement was reached.

Results

Categories identified from the data were reasons to start and stop breastfeeding, advice about breastfeeding that was useful or not useful, and cultural issues related to breastfeeding that were perceived to be unique among African Americans. These categories closely matched the guiding questions but were not identical. Among the categories, three overall themes were identified that cut across categories: perceived lack of information about benefits and management of breastfeeding, difficulties breastfeeding in public, and lack of a support system for continued breastfeeding.

Reasons to Start Breastfeeding. All the women said that a reason to start breastfeeding was that it was a healthy choice for infant feeding and a good way to bond with the baby. One woman described it this way: “I just have always known it was just more healthier than any kind of manmade milk, you know that was coming from me it was the most natural thing that I could give her.” Another talked about her decision to keep breastfeeding after her initial try in the hospital, “That is why I kept going cause he liked it and I just loved to see my baby look up at me and he's holding on to me, and it's like can't nobody can give you this but me. It's just me and you.”

Some women pointed to positive family influences for breastfeeding, “My mom breastfed me, so that helped me to make up my mind that I wanted to breastfeed, ‘cause a lot of older people told me that if you were breastfed that it is healthier for your baby if you breastfeed, so that's the reason why I chose to do it.”

Reasons for Stopping Breastfeeding. In this sample, breastfeeding was usually stopped out of necessity rather than plan or choice. Women reported becoming frustrated with the process of breastfeeding, and they also anticipated problems when planning a return to work or school. It seemed easier to fit formula feeding into a busy schedule. One woman reported, “I am using the bottle, I really didn't want to but I was getting ready to go back to school and going home feeding her, it just got to be too much.” Worries about the logistics of breastfeeding while working caused one woman to stop, “The big thing was when I decided to go back to work. I was a waitress and worried about leaking.”

Useful Advice. Women in our sample reported access to a lot of written information about breastfeeding, but they craved practical advice from professionals and other women experienced in breastfeeding. One woman described how a nurse helped her get her baby latched on: “She showed me some positions, and how to hold my breast a certain way and sugar water that helped him to latch on and it actually helped.” Many of the questions about which they sought advice were about feelings and sensations to expect and what was abnormal. One woman described some anticipatory guidance from a lactation consultant as helpful: “She said next morning your breasts are gonna feel like, you've got bricks in your bra.” Another woman found comfort from her friend who had experienced breastfeeding: “My best friend, she was like, well take your time, eventually the swelling will, I was very concerned about would my breasts ever get back to normal size and she was like, eventually they will go down.”

Advice That Was not Useful. Sometimes when women sought help for breastfeeding problems, the assistance they received did not help. One woman talked about seeking help with breastfeeding from a public health nurse:

> My baby wouldn't latch on, and we had to undress him and weigh him, and so he got so irritable, you know, he was crying, and I couldn't, you know, calm him and so the nurse said, “Do you have any formula?” and she said, “Because you know, he'll have to eat.”

One woman said that her husband became hesitant about her breastfeeding after seeing nurses in the hospital trying to help her latch on:

> But they would show me how to latch him on, and just the way they would handle him, you know, grab his head and kind of push his face and he (husband) did not like that, so that was one of my downfalls with them on that. So he was just like, they handle him too rough, he is only you know a day old, you know or something or two days or whatever, so. He didn't like that at all.

African American Cultural Issues Related to Breastfeeding. Data related to cultural issues included responses from all the questions asked where the participants described experiences that they identified as being potentially unique to African Americans. Specific perceived cultural issues addressed by the women often related to comments from friends and family. Friends and family members were the support network for these women and shared information and opinions

that could have either positive or negative effects on breastfeeding behaviors. Women reported very mixed messages from family and friends about breastfeeding. Although some reported positive family influences, many reported having to defend their feeding choice and receiving negative comments, such as, “You shouldn't breastfeed if you weren't breastfed” and “That's what White people do.” One woman said, “Everybody and their momma would give you a horror story. Oh, it is gonna hurt and you are not gonna want to do it.” There was concern that the milk would be harmful: “My mother-in-law told me that … it starts to rot their teeth because the milk is too sweet.” There was also concern, especially for male children, that breastfeeding would spoil the child and make him too dependent on his mother, “Older black men say if you breastfeed a boy, you make him soft.” Family members and friends sometimes caused women to doubt their ability to successfully breastfeed:

> My mom, she was for it. My husband was for it. But friends, I had a friend tell me, “Well don't say you're going to breastfeed, say you're going to try because it might not work.” And I, I knew there was a possibility it might not work, but if I don't go into it positively, then, you know. But yeah, a lot of negative, mostly friends, people my age, coworkers.

Themes

Three themes seemed to have an impact on the women's breastfeeding experiences. They were perceived lack of information about breastfeeding, breastfeeding in public/pumping at work, and lack of support system for initiating and continuing breastfeeding.

Perceived Lack of Information About Breastfeeding. Participants said there was lack of information available to them about breastfeeding, despite the availability of written materials. Some of the information they lacked was related to the benefits of breastfeeding, the actual physical aspects of breastfeeding, and complications of breastfeeding, such as sore nipples. One woman said:

> If they would have said, you know, breastfeeding her exclusively would still have met her nutritional needs, I would have continued. I wouldn't have put her on solids, but because the information I received was that she could eat solids now, I think if they would have stressed that she can, you know breastfeed exclusively, I think I would have, but that information wasn't passed on in that way, it was more saying, it is time for her to go to cereal and solids.

Another woman said:

> I think that if the doctor could give out information, or have someone in their practice that can go ahead and talk to those women who are kind of on the fence about whether or not they are gonna breast or bottle feed. If, you know, they could do that, I think that would help, because you can go ahead and make that educated decision from that point

> instead of at the last minute being asked, “Are you gonna breast or are you gonna bottle,” and seeking out information and support on your own in those beginning stages.

One woman talked about how she felt unprepared for the reality of breastfeeding: “I wish someone had told me how lonely it gets at night; I wish I had been prepared for that, the sole provider, you're the only one who can do it every single night.”

Near the end of each focus group, some of the women who had stopped breastfeeding spontaneously said that they wished they had had the opportunity to talk with other women as they had done in the focus groups, and said this might have encouraged them to continue breastfeeding. One woman said:

> We are not aware of our numbers. We are not aware of how small our breastfeeding numbers are or how quickly we stop. How we compare to others. I think had I known, I would have been like, well I'm gonna be different.

Breastfeeding in Public/Pumping at Work. Although women did not report thinking about breastfeeding in public or the logistics of pumping at work when they made their decision to breastfeed, once breastfeeding began, this quickly became an important issue. Participants were discouraged from breastfeeding in public and found it difficult to pump at work. Many of the issues related to pumping seemed to be related to finding a private place to pump and store the breast milk. Although women felt that breastfeeding was a private decision and ideally a private act, the baby's need to eat and the breasts' need to be emptied on a regular basis at times pushed this into the public arena. One woman related her partner's discomfort with public breastfeeding: “Her father, he wasn't like don't do it, but he was kinda more like most men, like ‘I don't want you having to breastfeed her out in public,’ and he wasn't like don't do it, he was just kinda suspicious about the whole having to breastfeed in public.” Another woman described a stranger's reaction: “In a restaurant, someone said to feed him in the bathroom, and I said to him ‘Well you go get your food and come on in the bathroom and you can sit with me while I feed my son.’” Frustration with both pumping and milk storage while at work was an issue. One woman described work that required her to travel to clients' homes:

> I found myself pumping while I was driving to my consumer's houses, … and I was pumping while I was driving, and one day I forgot the fridge pack … and I was like “Can I store this bag in your refrigerator?” That's one of those things. OK, no. I can't continue to put my breast milk in peoples' refrigerators.

Lack of Support. Lack of support for initiating and continuing breastfeeding was also a problem. Participants felt a lack of support from family and health care personnel and expressed feelings of isolation due to lack of contact with other breastfeeding mothers. One woman said, “I think if you know you aren't the only one out there, that helps a lot.” An important role of nurses is patient teaching, but these women reported that nurses they saw were not always helpful. “They said, ‘The doctors aren't going to agree, and don't tell them that we told you, but put some

cereal in her bottle and she'll sleep.' So that is all we really talked about as far as feeding with nurses." Sometimes, although people verbally expressed support, the breastfeeding woman did not feel supported. One woman expressed it this way, "My mom, and they all joke about it but say whatever is best for the baby. But they have all, you know, made little comments."

Some of the women felt a lack of support from their families and wanted to encourage other women to not be discouraged by negative comments as they had been:

> I think just don't let the comments … whether people intend to be negative or not, just don't let it discourage you. Like, I've had, and I think a lot of it, like you said, is age and generation but even though my mom breastfed, she said that when she had me, it wasn't the thing to do to breastfeed. But when my brother came along, it was. So even my mom's sister had made comments to me I mean, we'll be at a family gathering, and they'll leave, and come back, and say "Are you still feeding?" You know, but just to not let it discourage you. My mother-in-law she had seven children and breastfed all of them, but she said when she was in the hospital, she had nurses coming in her room, like, "Oh you're the lady who's breastfeeding her kid" because it wasn't the in thing to do. So I just think that people need to make their own decision, even my mother-in-law is on me about breastfeeding my daughter so long. I mean, you know, "Where's her bottle, oh I forgot she doesn't have a bottle." You know, so just, to be honest, most of the negative comments I got was from other African Americans.

Some women expressed gratitude for any type of support but said that it would be even more helpful if that support could be from another African American woman.

> I think, too, and not to make it a racial thing, but sometimes you need to see someone that looks like you and lives the same life and has the same challenges as you have, to help you. And so maybe, pairing, and I know people have to volunteer, or put themselves out there for that, but … maybe it would help somebody if that person was African American. And not, like I said, not to make it racial, like "You're Black, you're Black, I'm going to put you together," but I mean it helps to see somebody like you, to set the example.

Another woman told the story of going to a La Leche League meeting: "I went to one of the La Leche and to be honest, I didn't go back because I was the only one [African American], and it doesn't really bother me to be the only one, but I felt uncomfortable."

Limitations

Because this was a qualitative study with a small nonrepresentative sample, the results cannot be generalized to other populations. The women in our sample had all breastfed and had longer mean duration of breastfeeding than many African American women. Although this made them

uniquely qualified to answer many of our questions, it also limits the generalizability of our results to women who have not chosen to breastfeed or have not breastfed very long.

Discussion

These study results have several implications for practice. First, women need to be taught early in their pregnancy about the benefits of breastfeeding so they can make an informed decision about how they want to feed their infant. Although the American College of Obstetricians and Gynecologists (ACOG) urges women to discuss breastfeeding with their provider early in pregnancy and states that providers should be the primary resource to patients about the benefits and management of breastfeeding (ACOG, 2001, 2003), many of our participants reported that no health care provider substantially discussed breastfeeding with them during pregnancy; mention of breastfeeding usually occurred late in the pregnancy or during labor and was limited to asking which method of feeding the woman had chosen.

Other studies have found a similar lack of breastfeeding education during pregnancy (Cricco-Lizza, 2006; Miracle, Meier, & Bennett, 2004; Sarasua, Clausen, & Frunchak, 2009). Clearly, as health care providers, we should be proactive in teaching women about the benefits of breastfeeding to themselves and to their babies, before they have decided to formula feed. Given our knowledge of the clear benefits of breastfeeding over formula feeding, many would argue that we have an ethical responsibility to share that information so a pregnant woman can make an informed choice (Miracle & Fredland, 2007). This may be even more important for groups that have a historically low rate of breastfeeding, and a high rate of health disparities, some of which breastfeeding could help to ameliorate.

Second, once breastfeeding is initiated, women need continued assistance with breastfeeding by nurses or lactation consultants so they are able to breastfeed for longer periods of time. Studies have shown that women who receive such support breastfeed longer than women who do not receive professional support (Bonuck, Trombley, Freeman, & McKee, 2005; LaMontagne, Hamelin, & St.-Pierre, 2009), but given the realities of funding for lactation services, that free support may not be possible once the woman is at home. Women may only have access to information from nurses while visiting offices or clinics for check-ups for themselves or their babies. Nurses who have contact with breastfeeding women should not wait for the women to ask questions but actively inquire about how breastfeeding is going and offer evidence-based information.

Third, support groups need to be developed that include women with similar backgrounds, to encourage women who may be reluctant to participate because they fear they will be the only African American present. One study found that Black women who attended peer support groups were twice as likely to initiate breastfeeding as women who did not attend a support group (Mickens, Modeste, Montgomery, & Taylor, 2009), and peer support has also been shown to increase breastfeeding duration (McInnes & Chambers, 2008; Rossman, 2007). The women in

the current study indicated that peer support was useful when they had access to it, and it was especially useful if the peers were African American. One of our participants said, “In a way, you would like someone who is of your ethnicity to talk to.” Although it is unlikely that peers could be matched on every demographic variable, it is important that women feel they can relate on a personal level to peers in a support group. Peers can help encourage women when they have questions or are being pressured by others to introduce formula, which has been shown to be predictive of early breastfeeding cessation (Bolton, Chow, Benton, & Olson, 2009). Women who have access to peer support may feel more self-confident in breastfeeding, and self-efficacy related to breastfeeding has been identified as important for women to breastfeed longer (O'Brien, Buikstra, Fallon, & Hegney, 2009).

Finally, all of these nursing implications have cultural relevance. Although only one question specifically mentioning culture was asked, these African American women frequently mentioned cultural issues in the context of the other questions. Some of their comments would most likely resonate with women of other cultures as well, such as mixed messages from family and friends, or comments about breastfeeding in public. However, these women spoke of them in a cultural context, and frequently made reference to “other African Americans” when mentioning mixed messages or comments about their breastfeeding. Even if the issue crosses cultures, if it is perceived to be culturally based by the woman involved, it should be treated as such by the nurse, so that we can be sensitive to women's cultural issues. Arguably, all women are influenced to some degree by their cultural backgrounds and those of their families and close friends. As much as possible, nursing interventions should be informed by knowledge of cultural practices, especially when the cultural group has a health disparity, as is the case with African Americans and breastfeeding initiation and duration. When Leininger and McFarland (2006) discuss culturally-sensitive nursing interventions, they stress the importance of talking to the women involved to get a sense of what they perceive as culturally related, so they can then also perceive that nurses are taking their culture into consideration when planning nursing care and patient education.

Future research should examine the effects of culturally sensitive educational and support interventions. There is ample literature about culturally sensitive interventions for various health conditions, and some of these could be applied to breastfeeding. It would also be important to examine the impact of including family members in these interventions, because family members have been shown to be an important source of information and support for breastfeeding women (Grassley & Eschiti, 2008).

It is also be important to examine where women learn about the benefits of breastfeeding. Women in the current study reported that they rarely heard first about benefits from their health care providers. Nurses are missing opportunities to discuss the benefits of breastfeeding with women of childbearing age in preconception and early pregnancy care settings. Future research could also explore potential differences in infant feeding discussions by race of the patient. Research on provider/patient communication in cancer diagnoses has found that African

American women were offered less explanation and less time in relationship-building behaviors than White women (Siminoff, Graham, & Gordon, 2006). It is unknown if this communication pattern exists with pregnant women regarding infant feeding. Finally, it is well documented in the literature that returning to work can negatively affect breastfeeding duration. Future research should explore interventions to increase the ability of women who do return to work to breastfeed their infants more successfully.

The factors identified in the current study as important in breastfeeding initiation and duration are not new: other studies have also shown that education and support are important determinants of breastfeeding initiation and duration (Thulier & Mercer, 2009). However, these remain real issues in the day-to-day lives of pregnant and breastfeeding women and should be attended to by nurses in all settings where women of childbearing age are encountered. African American women breastfeed less than White women. Their unique experiences, perceptions, and concerns must be explored and addressed, and nurses should be proactive in encouraging and supporting breastfeeding among these women.

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