Experiences of Nurses Providing Breastfeeding Support to Black Families in the Immediate Postpartum

BY

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THESIS

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This thesis is dedicated to the individuals and families who welcomed me into their lives and made me a midwife. I am honored by your trust.

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LIST OF ABBREVIATIONS

CLC	Certified Lactation Consultant
IBCLC	International Board Certified Lactation Consultant
ILCA	International Lactation Consultant Association
BFHI	Baby Friendly Hospital Initiative
WHO	World Health Organization
WIC	Special Supplemental Nutrition Program for Women, Infants and Children
CDC	Centers for Disease Control
PRAMS	Pregnancy Risk Assessment Monitoring System
NCLEX	National Council Licensure Examination
AAFP	American Academy of Family Physicians
ACOG	American College of Obstetricians and Gynecologists
ACNM	American College of Nurse-Midwives
NICHD	National Institute of Child Health and Human Development
NICU	Neonatal Intensive Care Unit
IOM	Institutes of Medicine
ACEN	Accreditation Commission for Education in Nursing
CCNE	Commission on Collegiate Nursing Education
NIS	National Immunization Survey

SUMMARY

Background

Exclusive breastfeeding is recommended for the first six months of an infant's life (American Academy of Pediatrics [AAP], 2012; World Health Organization [WHO], 2003). Despite efforts from health organizations, babies in the United States are significantly less likely to ever breastfeed or to meet breastfeeding targets than are babies in most other high-income nations (WHO, 2003). Overall 79.2% of babies are ever put to the breast, and only 20% are exclusively breastfeeding at six months. Racial disparities are particularly stark, as 64.3% of Black non-Hispanic babies are ever breastfed, and only 14% are exclusively breastfeeding at six months of age (Anstey et al., 2017).

Disparities continue throughout the life course as infants who are fed formula instead of breast milk are at higher risk for illness and death in infancy and childhood, have more pediatrician visits, and more hospitalizations (Ip et al., 2007; Marom et al., 2014). Mothers who do not breastfeed are also at higher risk for postpartum depression, breast and ovarian cancer (Sipsma et al., 2013; Ip et al., 2007). Formula feeding leads to higher environmental, manufacturing, and healthcare costs, as well as lost work hours for parents caring for ill children.

The racial disparities in breastfeeding literature tends to focus on identifying factors that influence infant feeding choices among Black parents. Parents identify peer and family support, community norms, and exposure to breastfeeding as important influences, along with education and support from healthcare providers (Mickens et al., 2009; Bentley et al., 1999; Robinson, 2011 Racine et al., 2009; McCarter-Spaulding & Gore, 2009; Cricco-Lizza, 2005, 2006). However, Black parents are less likely to receive information about breastfeeding from their healthcare providers during their pregnancy, and also receive less breastfeeding support in the postpartum (Cottrell & Detman, 2013; Robinson 2009; Robinson & VandeVusse, 2011; Cricco-Lizza, 2005). This suggests

that healthcare providers play a role in the production of health disparities and can act as barriers to successful breastfeeding for Black parents.

When establishing breastfeeding, the first hours and days after birth are critical, with parents who give birth in healthcare facilities that provide systematic breastfeeding support much more likely to initiate breastfeeding and to meet breastfeeding recommendations. Though physicians, midwives, and lactation consultants are part of the healthcare team, postpartum nurses have the most direct and prolonged contact with new parents and babies and are responsible for organizing postpartum care. Despite evidence that breastfeeding support provided by nurses is vital to breastfeeding initiation and continuation, and that Black parents are less likely to meet breastfeeding recommendations, there are few studies focusing on how nurses provide breastfeeding support to Black parents.

Specific Aims

This study aims to describe how postpartum nurses plan and provide breastfeeding support to Black parents. Long-term goals are to increase nurses' awareness of their impact on breastfeeding support on breastfeeding initiation and continuation for Black parents.

1. Document how postpartum nurses describe their delivery of breastfeeding support for Black parents.
2. Explore how nurses plan their breastfeeding support for Black parents.
3. Describe how nurses integrate breastfeeding support for Black parents into their workflow.

Methodology

This thesis presents two complementary manuscripts that meet the objective of this dissertation work. The integrative review of the literature examines how healthcare professionals as a group interact with and impact breastfeeding for Black families. The search criteria are broad because there is little to no literature focusing exclusively on the interactions of nurses and Black

families. Results from the integrative review sets the stage for the original research topic by summarizing the current knowledge. The original research manuscript describes the findings of a qualitative descriptive study during which labor and delivery and postpartum nurses were interviewed about their experiences in providing breastfeeding support to Black families in the immediate postpartum period. Using qualitative descriptive analysis, themes and subthemes are identified from the data and presented in the manuscript. Appendices containing approval letters from the Institutional Review Board at the University of Illinois at Chicago are also included.

Conclusion

Collectively, these two papers show that racism is the norm rather than the exception and is enacted by well-meaning nurses in postpartum care. The breastfeeding support needs of Black families are not different from those of White families, but they are less likely to receive adequate breastfeeding support. In order to provide equitable care, hospitals must prioritize breastfeeding policy guidelines in order to minimize the impact of individual bias by requiring the same standard of care for every patient, with monitoring of implementation and regular review. Future research is needed to examine the role of racism and bias in breastfeeding support for nurses, physicians and midwives, along with interventions to prevent enactment of racism in birth and breastfeeding care.

Healthcare Provider's Role in Breastfeeding Support for Black Families: An Integrative Review of the Literature

Holly Houston, MSN, CNM

Introduction

It is widely accepted that human milk provides optimal nutrition for infants through age six months. Every professional health organization encourages exclusive breastfeeding for six months and continued breastfeeding for at least the first year. The provisioning of human milk is almost universally beneficial for infants and lactating parents; however, the practice is not universally adopted.

Breastfeeding Statistics

Infants in the United States are significantly less likely to receive human milk than are infants in other high-income nations (Save the Children, 2012). Overall, in the US, nearly 80% of babies are fed some human milk, but only 20% meet the American Academy of Pediatrics (AAP) recommendation by being exclusively fed human milk through six months of age (AAP Section on Breastfeeding, 2012. Racial disparities are particularly stark, as 64.3% of Black non-Hispanic babies are ever fed human milk, and only 14% are exclusively breastfeeding at six months of age (Anstey et al., 2017).

Breastfeeding inequities by race are marked throughout the United States, though they vary by region. The inequities are most dramatic in the Southeast. According to National Immunization Survey (NIS) data (Anstey et al., 2017), of the 34 states that compared breastfeeding rates by race,

22 of those states reported significantly lower breastfeeding initiation rates among Black infants, and 14 states, primarily in the Southeast, reported a difference of 15 percentage points or more.

Definitions and Terminology

Definitions and terms used in this paper reflect those of the Centers for Disease Control (CDC) and state health departments. These organizations monitor breastfeeding rates through the Pregnancy Risk Assessment and Monitoring System (PRAMS) survey which is conducted annually (Shulman, et al., 2018, Ahluwalia et al., 2012). This survey gathers information on health during pregnancy, childbirth, and infancy, including data about providing human milk and supplementary feeding. Categories include breastfeeding, defined as ever received human milk/attempted to breastfeed, and exclusive breastfeeding, defined as did not receive any other nutrition than human milk. Continuation of human milk feeding is also tracked in categories that include breastfeeding to six months and 12 months, again, meaning the infant received any human milk, and exclusive breastfeeding to three months or six months, where the only nutrition was human milk.

Provision of human milk is a term that encompasses any method of feeding with human milk. This can imply putting the baby directly to the breast, but also includes providing donor milk, or providing human milk through bottle or tube feeding. Tube, spoon, or bottle feedings are often the method of feeding for critically ill infants but may be used for healthy infants in the case of insufficient milk supply, feeding by a non-gestational parent, or at the lactating parent's discretion. Breastfeeding and chestfeeding are more specific terms, indicating that the infant is connected to the nipple to feed, but the term is often used more broadly to include the provision of human milk by bottle or tube feeding in some literature.

Language Choices Surrounding Gender and Race

This paper strives for accurate and meaningful use of language, and therefore makes every effort to accurately represent those who breastfeed. Women, men, and nonbinary individuals all

breastfeed, so I have chosen to primarily use the terms parent or family rather than mother. The exception is when directly discussing existing literature; in that instance language used reflects the language in the study or paper being examined. Much of the literature and discussion around breastfeeding is traditionally gendered, particularly literature from the past, so when reviewing or summarizing those papers the language used in those manuscripts will be reflected. This also influences my use of the term breastfeeding rather than chestfeeding. Though both are accurate, breastfeeding is almost universally used in studies and papers concerning lactation.

Language for race follows guidance from the American Psychological Association (APA) publication manual (2019), using the term Black when referring to people of African descent and White when referring primarily to people of European descent. However, both of these categories are necessarily fluid, and most studies rely on self-classification rather than ancestry. Latinx is used as a gender-neutral term to refer to people of Latin or Hispanic origin or descent. Again, when discussing specific studies or quotes, the original language is used for accuracy. White, Black, and Latinx are capitalized in this manuscript to align with APA guidelines.

Background

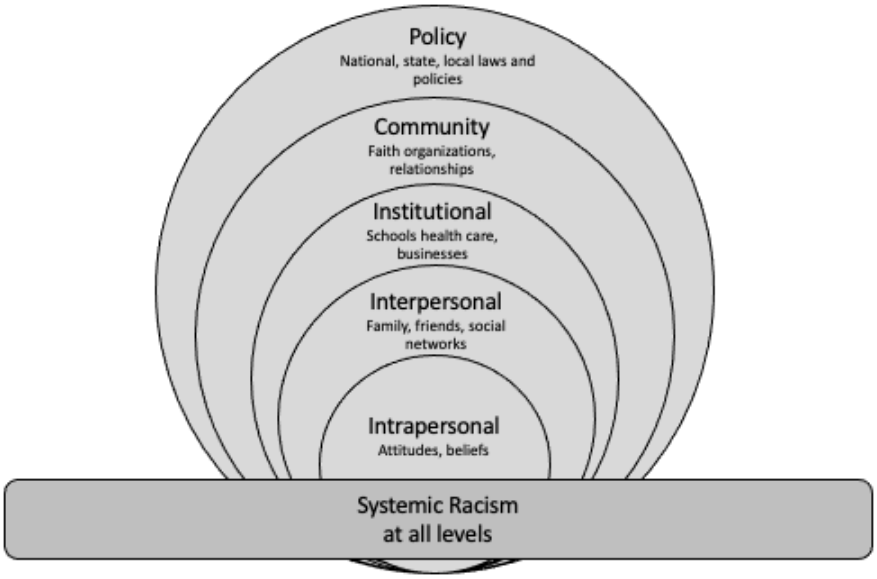
Factors Influencing Breastfeeding

Social Ecological Model

When assessing what is currently known about breastfeeding, the Social Ecological Model for health behaviors (McLeroy, 1988) can be used to organize the presentation of the vast amount of information. This model centers on the individual but includes spheres of influence to demonstrate forces influencing individual health behaviors. The Social Ecological Model posits that forces outside of the individual must be considered to understand any health behavior or plan any health promotion intervention.

Figure 1

Modified Social Ecological Model



Intrapersonal level. The individual level of the model focuses on personal attitudes, beliefs, knowledge and behaviors. Intention to breastfeed is necessary for breastfeeding initiation, but not entirely predictive (Corbett, 2000; Meyerink & Marquis, 2002). Though as many as 79% of Black women in one sample (Persad & Mensinger, 2008) intended to breastfeed, most ended up primarily using formula. This points to the importance of other factors as influences on enacting breastfeeding behavior. Black mothers report that perception of low milk supply, embarrassment about breastfeeding in public, and comfort with formula contributed to cessation of breastfeeding (Brownell, 2002; Cricco-Lizza, 2004; Nommsen-Rivers et al., 2010). Pain with feeding and difficulties with feeding were also common reasons for breastfeeding cessation (Brownell, 2002; Hurley et al., 2008; Wambach & Koehn, 2004). Family history of breastfeeding, as well as a sense of

self-confidence with breastfeeding were predictive of breastfeeding for more than one month (Meyerink & Marquis, 2002; McCarter-Spaulding & Gore, 2009).

Interpersonal level. The interpersonal level of the model focuses on interactions with others; most often family, friends, and health care professionals. Persad and Mensinger (2008), found that Black women who planned to breastfeed had positive feelings about breastfeeding, had support from family and friends, were older, more educated, and wealthier. Women in another study reported that their own mothers' opinions and experiences, as well as the opinions of their partner, were influential in their decision (Bentley et al., 1999).

Black mothers identify peer and family support, community norms, and exposure to breastfeeding as important influences, along with education and support from healthcare providers (Mickens et al., 2009; Bentley et al., 1999; Robinson, 2011; Racine et al., 2009; McCarter-Spaulding & Gore, 2009; Cricco-Lizza, 2005, 2006). However, Black mothers are less likely than their White counterparts to receive information about breastfeeding from their healthcare providers during their pregnancy, or support for breastfeeding postpartum (Cottrell & Detman, 2013; Robinson 2009; Robinson & VandeVusse 2011; Cricco-Lizza, 2005).

Johnson et al. (2015) conducted focus groups with Black mothers in Michigan and found that though mothers believed breastfeeding was healthy, they did not think that health care professionals were supportive of breastfeeding and even discouraged breastfeeding. Mothers also reported a distrust of the information given to them by healthcare professionals and were more likely to listen to their friends and family. In interviews, Kaufman et al. (2010), and Cricco-Lizza (2005, 2006), found that Black women reported receiving little support or encouragement about breastfeeding from healthcare professionals after delivery as well, including their obstetrical providers, nurses, hospital staff, and pediatricians (Robinson, 2009; Robinson & VandeVusse, 2011; Cricco-Lizza, 2005).

Institutional level. The organizational level of the model encompasses interactions with hospitals, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and local health departments. Interventions that focus on breastfeeding support in the hospital have proven effective at increasing breastfeeding rates. Hospitals that implemented supportive breastfeeding policies such as those in the Baby Friendly Hospital Initiative (BFHI) found that the greater a facilities' compliance with breastfeeding support practices, the higher the rates of breastfeeding initiation and duration among their clients, regardless of race (Brenner & Buescher, 2011; Vasquez & Berg, 2012; Digirolamo et al., 2008; Perrine et al., 2012; Hawkins et al., 2014). Rollins et al. (2016) meta-analysis calculated that access to individual counseling or group breastfeeding education, immediate breastfeeding support after delivery, and lactation management services increased exclusive breastfeeding rates by 49%, and any breastfeeding by 66%. For Black mothers specifically, Ahluwalia et al. (2012), reports that breastfeeding within the first hour after birth, not giving baby a pacifier, individualized assistance from hospital staff, and breastfeeding on demand are associated with higher rates of exclusive breastfeeding at six weeks postpartum.

WIC provides income-based services, including nutritional support for infants directly in the form of formula or indirectly by providing food for lactating parents. As an organization they promote breastfeeding through nutritional counseling, peer support for breastfeeding, and provide manual or electric breast pumps for parents who qualify. For many low-income parents this program provides essential support, though there is some evidence that participation in the WIC program may not actually increase breastfeeding rates (Ryan & Zhou, 2006). While many Black mothers credit their WIC peer counselor as an important support during breastfeeding (Cricco-Lizza, 2006), some Black women reported receiving less information about breastfeeding from their WIC counselor than did White women (Beal et al., 2003).

Community level. The community level of the model includes workplaces, community groups, and media. As many parents in the United States return to work only a few weeks after giving birth, workplace policies and supports are important if they desire to continue breastfeeding. The US Department of Labor requires employers to provide adequate breaks and facilities for hourly workers to express and store breast milk while at work. However, this regulation is inconsistently enforced, and some employees may not feel equipped to bring this up with their employer, especially if they perceive their job could be at risk.

Community Organizations. Parents who desired to breastfeed but felt they had little support from existing healthcare or social structures have created their own community support organizations and movements. La Leche League International is well known, established in 1952 by a group of middle class, stay-at-home White women in the Chicago suburbs (Weiner, 1994). At the time of its establishment, breastfeeding rates in the United States were as low as 22%, with doctors and manufacturers promoting formula as healthier and better for infants than human milk. Over the years many lactating parents have been supported by the organization, but its membership remains largely White, middle-class, and focused on traditional family structure. Black women have created their own spaces as well, with organizations and social media campaigns like Black Mamas Matter Alliance (Muse, et al., 2018), Black Women Do Breastfeed (Sandiford, 2020), Chocolate Milk Mommies (Edwards, 2017), Black Mothers Breastfeeding Association (BMBFA, 2020), and Reaching Our Sisters Everywhere (ROSE) (Bugg and Bugg, 2013). These, and other, organizations reach out to Black families on a local and national level, as well as online and in social media.

In addition, many of these organizations are on the forefront of promoting Black maternal and infant health. BMMA has published a "black paper" instead of a white paper that advocates for and specifies steps that healthcare providers and systems can take to provide safer and more effective care for black families (Muse, et al., 2018). Black Mothers Breastfeeding Association holds

an annual conference and provides classes for parents, doulas, and guidance for healthcare providers who support black families during childbearing and breastfeeding. ROSE holds annual conferences as well, promoting scholarly work around breastfeeding and also provides classes to educate community breastfeeding advocates to support black families (Bugg and Bugg, 2013). Though these organizations and their members do meaningful, rigorous, and vital work, they are rarely published in journals and therefore not included in the academic breastfeeding literature.

Breastfeeding in Media. Representation of breastfeeding in media has been sparse. Sexualization of the breast, along with conservative standards around exposure in the United States has made it unusual to see breastfeeding depicted in media (Duval, 2014; Brown & Peuchaud, 2008). This contributes to public perception that breastfeeding is, if not shameful, at least a very private and mysterious process. Most state and local laws support a parent's right to feed their child in any setting, including at the breast, but that does not prevent strangers from encouraging breastfeeding parents to cover up or go to a bathroom to feed. Some businesses and restaurants do provide designated comfortable spaces to breastfeed, but parents should not feel pressure to retreat to private spaces to feed their child. Social media has been powerful in allowing parents to share images of themselves feeding their children, helping to normalize the practice. Even celebrities who have shared photos of breastfeeding their children have largely used social media rather than traditional media. Black mothers specifically report using social media for information and social support during pregnancy and breastfeeding (Asiodu et al., 2015).

Policy level. At the policy level, the model focuses both on laws as well as clinical and program policies of national and local organizations. In the United States, governmental and healthcare agencies often acknowledge the value of breastfeeding, and sometimes enact policies that provide more tangible measures of support. Healthcare organizations such as the AAP (2012), the American Association of Family Physicians (AAFP, 2017), the American College of Obstetricians

and Gynecologists (ACOG Breastfeeding Expert Work Group, 2018), and the American College of Nurse-Midwives (ACNM, 2016) all have statements affirming breastfeeding and policies in place to guide their members in the care of breastfeeding parents and infants. The National Institutes of Health's division of Child Health and Human Development (NICHD) includes a statement about breastfeeding and includes a list of goals to guide breastfeeding research (NICHD, 2019). The CDCs division of Nutrition, Physical Activity, and Obesity identifies breastfeeding as a key component of public health (CDC, 2019).

Breastfeeding Inequities in the Context of Racism

Though the Social Ecological Model provides a framework for understanding how levels of society influence individual health decisions, the model itself exists in an even larger social structure. It is impossible to discuss health disparities for Black mothers and babies without acknowledging the influence of historic and pervasive racism.

History of Racism

From a more than 400-year history of enslavement, to another 80 years of Black codes and Jim Crow laws, to an epic and costly struggle for basic civil rights, the history of unequal treatment due to race in America is long and horrific (Praether et al., 2018; Anderson, 2016). Enslaved women were subject to sexual violence without recourse, had no opportunity to care for their own children while being forced to care for the children of those who enslaved them, and were subject to medical experimentation without consent and without anesthesia (Anderson, 2016; Praether et al., 2018; Roberts, 1997; Washington, 2006). Further, Black women have been relegated to second class medical treatment, while programs of forced or coerced sterilization surgeries, rationalized by racist theories of eugenics and population control, were carried out well into the 20th century (Roberts, 1997; Ross, 2016; Praether et al., 2018).

Racism in Healthcare Today

Even today, Black women are often denied the right to plan and control their own childbearing, as birth control is often either withheld or pressed (Roberts, 1997; Bridges, 2011; Ross, 2016). Holistic, quality care during the childbearing years is often unavailable (Scott et al., 2019; Altman et al., 2019). Black women report feeling dismissed or minimized when talking to their healthcare providers (McLemore et al., 2018; Altman et al., 2019), and find health education and informed consent lacking in the context of pregnancy and childbirth. Black women often feel that their complaints and concerns are not taken seriously or adequately addressed by their healthcare providers (Altman et al., 2019). In some studies, Black women say that they feel their healthcare providers are quick to push birth control or sterilization procedures upon them (Gross et al., 2017; Lutenbacher et al., 2016). Unsurprisingly, Black women may not trust their healthcare providers, particularly White healthcare providers, especially when they do not have an established relationship (McLemore et al., 2018; Altman et al., 2019).

Structural Racism

Racism is often conceptualized as primarily individual and intrapersonal, but in fact the most damaging effects of racism stem from structures of racism that exist in a White supremacist society, such as exists in the United States. Structural racism consists of "macrolevel systems, social forces, institutions, ideologies and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups" (Gee & Ford., 2011, p 116). Jones (2002) as well as Gee and Ford (2011) describe racism as an iceberg, with the tip of the iceberg representing visible and obvious acts of racism, like the use of racial slurs or cross burning. The base of the iceberg, which is of course the bulk of the phenomenon and lies below the surface of the water, represents structural racism. Examples of structural racism include segregation of neighborhoods, schools, workplaces, and health systems (Gee & Ford, 2011), separating the fates of White and Black residents and

making it easy to direct resources to some citizens and away from others. In the United States, White people have long benefited from generations of advantage, including educational and employment opportunities, neighborhoods with less crime and pollution, higher quality health systems, and political power (Wallace, 2017). Critical Race Theory conceptualizes racism in a White supremacist society as everyday and ordinary rather than exceptional. In fact, the very ordinariness of racism makes it invisible to most people and makes it difficult to address or remedy (Delgado, 2017).

Including structural racism as a primary cause of health inequity means that we can seek real solutions to health problems. This approach instead shifts from the blaming some people for their health problems, and congratulating others for their good health, to focusing on health systems and organizations to change the policies and practices that perpetuate inequity.

Mother-Blaming Narratives

The current body of literature around breastfeeding and race focuses heavily on asking Black parents why they do not breastfeed. Focusing solely on individual factors ignores the layers of influence acting on the individual. Failing to scrutinize the healthcare system and the role of healthcare providers limits understanding of how these institutions fit into the larger historical and social context.

Throughout history and still today, Black women have been stereotyped as sexually promiscuous and irresponsible Jezebels (Roberts, 1991) in order to minimize blame for their sexual abuse and ill treatment during times of slavery and oppression. These tropes were also used to promote the idea that Black women were not good or caring mothers, to justify the obliteration of family units as children were taken from parents (Rosenthal & Lobel, 2016). In recent decades the myth of the Welfare Queen emerged, stereotyping Black women having as many children as possible in order to qualify for and maximize public assistance payments (Rosenthal & Lobel, 2016). Again, this included the notion that Black women were bad mothers, not caring for their many

children properly. These racist ideas have been used to justify reduction of public assistance for poor families and impose barriers to qualifying for benefits. Social support agencies have also historically valued the traditional nuclear family structure as a sign of stability. Glorification of this traditional structure has led to increased scrutiny for Black female-led households. It ignores the fact that Black families were torn apart during slavery and that the current prevalence of unjust incarceration of Black men has necessitated alternative family structures (Roberts 1997; Rosenthal & Loebel, 2016).

Mother-blaming narratives have a significant effect on the health of Black women and infants. Focus on the individual to the exclusion of the systems surrounding them can ignore the reality that every individual is impacted and influenced by multiple layers of their social and ecological environment. Narratives of poor health that focus solely on the individual can lead to stigmatization of Black women, scapegoating of the very individuals who need support, heightened surveillance of Black families, and criminalization (Scott et al., 2019). Blaming Black parents for poor health outcomes minimizes the responsibilities of health systems and healthcare providers, when in fact these systems and individuals should take the lead in addressing the needs of the families they serve (Scott et al., 2019).

Existing Literature Reviews

Literature reviews from Spencer and Grassley (2013), Jones et al. (2015), Johnson et al. (2015), and DeVane-Johnson et al. (2017), explore Black parent's breastfeeding experience and interventions used to promote breastfeeding.

Spencer and Grassley (2013), conducted an integrative review of breastfeeding literature, focusing on "factors that influence breastfeeding intentions, initiation, and duration in the African American population." They identified disparities of information from healthcare professionals, negative family influence, a lack of breastfeeding exposure, experiences of pain, and the challenges of returning to work as reasons for breastfeeding cessation. They found that interventions involving

direct support for mothers as well as hospital implementation of the Ten Steps to Successful Breastfeeding were effective at prolonging the duration of breastfeeding. Spencer and Grassley (2013) also stated that Black women's experiences are not centered in breastfeeding interventions, but they did not specifically discuss the relationship between racism and breastfeeding for Black mothers.

Jones et al.'s (2015) systematic review on the racial and ethnic disparities in breastfeeding included studies with Black, Hispanic, Indigenous, and Asian women. This work lumped all experiences without an analysis by subgroup. They specified that compared to White women, minority women generally encounter more barriers, such as needing to return to work earlier, reliance on free formula through the WIC program, and less and/or compromised education and support from healthcare providers. The review also does not link racism to breastfeeding outcomes.

The Johnson et al. (2015) systematic review focused on breastfeeding rates among Black women by examining interventions aimed at promoting breastfeeding among Black women. The identified interventions are classified using the level of the Social Ecological Model (individual, interpersonal, institutional, and policy level). The review showed that no single intervention addresses the complexity of factors affecting breastfeeding. However, the authors highlighted that racial discrimination is a factor in healthcare delivery that has not been adequately addressed.

DeVane-Johnson et al. (2017) conducted an integrative review examining factors related to breastfeeding in African American women. Identified factors included the social characteristics of women who do not breastfeed, such as education and socioeconomic status, women's perceptions about breastfeeding, and the quality of information that women receive from their healthcare providers. DeVane-Johnson et al. (2017) concluded that health systems needed to develop culturally relevant interventions guided by sociohistorical frameworks and considering historical trauma.

However, they did not discuss the influence of racism on breastfeeding and its role in the production of health disparities.

Study Purpose

Examining the beliefs, experiences, and practices of healthcare providers provides a foundation for understanding how healthcare providers and health systems can more effectively support Black breastfeeding families. Therefore, the focus of this review is to examine literature describing the interactions of Black breastfeeding parents and healthcare providers and systems, from healthcare providers point of view.

Methodology

This integrative review is guided by the work of Wittemore and Knafl (2005) and aims to understand how healthcare providers interact with Black families to influence breastfeeding. Rather than limiting the types of studies included, an integrative review includes both quantitative and qualitative literature to present a broad swath of knowledge produced on the topic.

Literature Search

The search was developed to identify articles that focused on how healthcare providers' perspective on how they interact with Black families around breastfeeding. Articles from a 15-year time frame (2004 – 2019) were evaluated for inclusion. Keywords were chosen to reflect these concepts as broadly as possible, including nurse, nurses, physician, healthcare provider, midwife, lactation consultant, or doula; as well as breastfeeding, breast feeding, infant feeding, lactation, or milk expression; and Black or African American. These terms were used to search five databases including CINAHL, PubMed, Scopus, Embase, and Web of Science. Initial searches returned 204 articles. Duplicates were removed, and titles and abstracts reviewed for relevance to the subject matter. A total of 33 articles were reviewed in full. Of those, only 11 described interactions between

healthcare providers and Black families and considered health providers' beliefs, norms, and behaviors (Figure 2).

Data Evaluation

Studies were evaluated for quality and fit to the aims of the review. To qualify for inclusion, the study must have reported findings or statistics that specifically and explicitly included Black families. For example, studies that included Black families in the sample but did not explain how Black families were affected in the conclusions were excluded. In addition, studies must have discussed interactions between healthcare providers and Black families. Interactions could be from a healthcare provider report or a study that documented interactions as part of an intervention. Studies must also be conducted from the point of view of the healthcare provider or health system in order to be included in this review.

Figure 2: PRISMA Flow Chart (Moher et al., 2009)

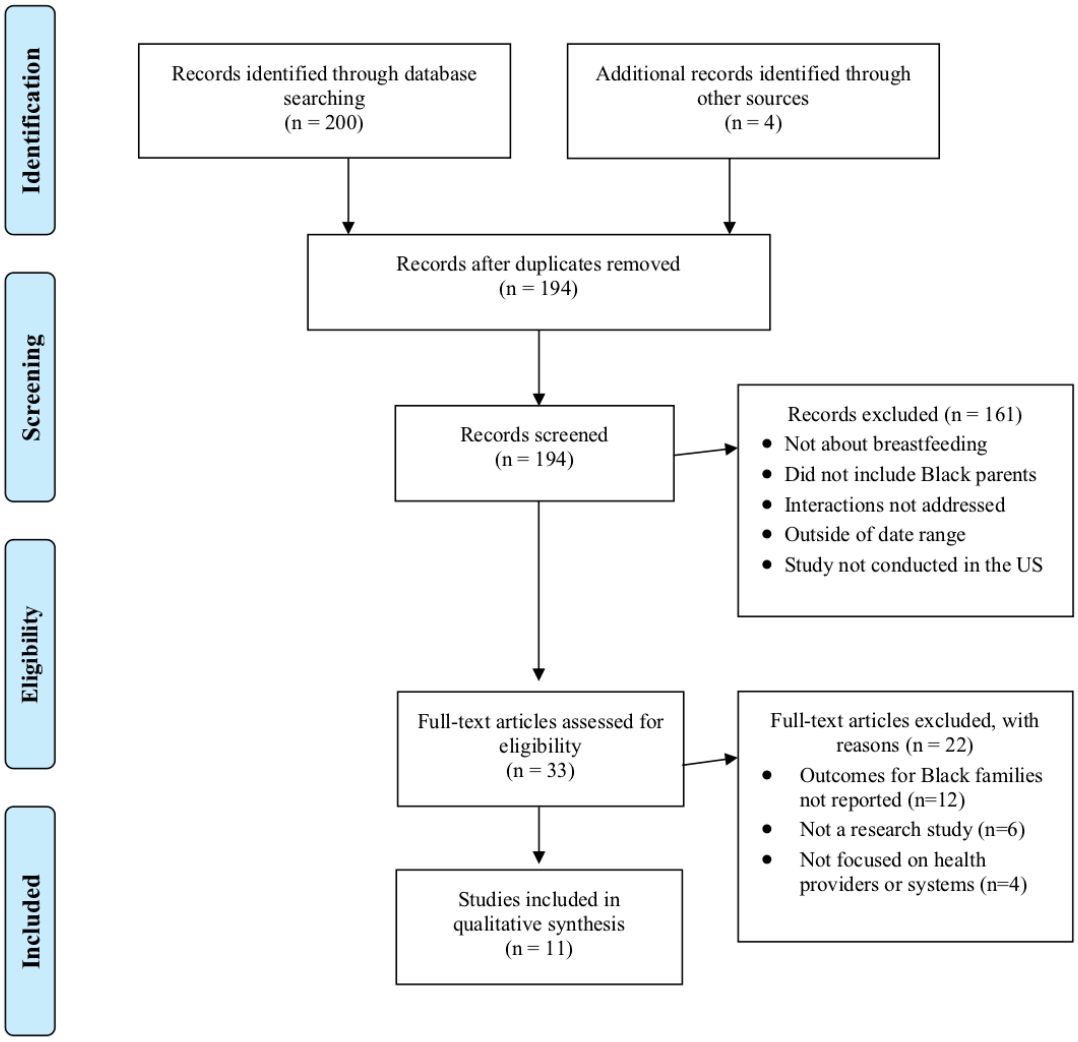


Table 1. Study Characteristics of the 11 studies included in this integrative review

Author(s)	Year	Design Participants	Study Purpose	Outcomes Measured or Investigated	Results, general Results, Black women	Significance
Interpersonal Level						
Meier et al.	2004	Retrospective record review for very low birth weight infants N = 207 hospital records; 44.9% Black (n=93/207)	● Evaluate the effectiveness of a breastfeeding program designed for mothers with VLBW infants ● Program: education about the value of human milk with a neonatologist, early intervention from a dedicated lactation specialist, and provision of pumping supplies and transportation for NICU families, along with direct peer support, both one-on-one and in support groups.	● Lactation initiation rate ● Mean dose of own mother's milk (OMM) ● Days fed with OMM	● Lactation initiation was higher than expected for all mothers ● All mothers were able to provide the majority of the infant's feeding volume through the first 60 days. ● 64% of Black mothers provided OMM ● Low income Black mothers provided OMM at higher rates compared to other reports in the literature at that time	● Demonstrates that this program reached all families. ● Direct outreach, applied equitably to Black families improved breastfeeding practices
Bonuck et al.	2005	Randomized controlled trial	● To determine if an individualized prenatal and postnatal lactation consultant intervention resulted in increased	● Breastfeeding intensity, measured at 13 and 52 weeks ● Breastfeeding intensity measured	● Intervention group had higher breastfeeding intensity, though exclusive breastfeeding was low in both groups.	● Demonstrates that individual support from lactation consultants can increase breastfeeding intensity.

		N = 304 women N = 110 Black women	cumulative intensity of breastfeeding up to 52 weeks ● Intervention: lactation consultant visits with parent prenatally (2), in the hospital, and postnatally (2).	using the Index of Breastfeeding Status, through maternal self-report calculates the percentage of breastmilk received compared with total feedings	● Black women were less likely to have a low breastfeeding intensity than Hispanic women.	
Castrucci et al.	2006	Cross sectional analysis of health records N = 11,525 births (2003) N = 4679 Black (40.6%)	● Compare health facility rates of breastfeeding at hospital discharge for facilities with and without IBCLCs	● Breastfeeding at hospital discharge	● Giving birth in a hospital that employed an IBCLC is associated with 2.28 times overall increase in odds of breastfeeding at discharge. ● 44.3% of Black women who delivered at a hospital with IBCLC were breastfeeding at discharge compared to 28.6% who gave birth at a hospital with no IBCLC	● Demonstrates that access to specialized breastfeeding support can make a difference in the number of families who are breastfeeding at hospital discharge. ● Likelihood of breastfeeding increased most dramatically among Black mothers, low income mothers, mothers without a high school diploma, and mothers with a poor birth outcome or cesarean birth.
Wambach et al.	2001	Randomized controlled trial N = 289 adolescent mothers, majority Black	● To assess the impact of a lactation consultant peer counselor team providing education and counseling intervention on breastfeeding through six months postpartum among adolescent mothers	● Breastfeeding initiation ● Exclusive breastfeeding ● Breastfeeding duration	● Those receiving the intervention were more likely to breastfeed longer ● No effects on initiation or exclusivity	-This intervention had mixed success, with the breastfeeding education and individual support effectively increasing the duration of the breastfeeding relationship but not initiation or exclusivity

Queenan et al.	2012	Cross-sectional Survey N = 290 OB/GYN physicians	● To examine variation in physician practice by assessing their promotion and support for breastfeeding and perceptions about their patients' breastfeeding practices	● Physicians estimates of patient breastfeeding initiation ● Physicians satisfaction with patient breastfeeding ● Physician's self-reported effort to support breastfeeding	● Physician estimates mirrored trends in their state (high, medium, low). ● Physicians were satisfied with their patient's breastfeeding rates. ● Physician effort scores were not associated with the physician's age or patient's race ● Female physicians had higher effort scores than males. ● Physicians with more Black patients were more likely to estimate low rates of breastfeeding, independent of state averages	● Demonstrates that while physicians have a mostly accurate assessment of their patient's likelihood of breastfeed, that assessment may be influenced by the patient's race, and this assessment may influence physicians decisions about breastfeeding support practices
Edwards et al.	2013	Randomized controlled trial N = 248 Black mothers, under 22 years of age	Examine the effect of a community doula home visiting intervention on infant feeding practices among young Black mothers	● Breastfeeding initiation ● Breastfeeding through 4 months ● Introduction of complementary foods	● Doula visits increased breastfeeding initiation (64% vs 50%). ● Doula visits led to breastfeeding beyond 6 weeks (29% vs 17%). ● Doula visits reduced introduction of complementary feeding before 6 weeks (6% vs 18%)	● Doula home visits provides support associated with improved infant feeding practices

Furman & Dickinson	2013	Qualitative, focus group discussions N =17 community health workers (CHW) data on race were not collected	To obtain CHW input in order to prepare for a breastfeeding intervention designed for high-risk Black mothers	● Risk appraisal ● Perceptions ● Relationship and social issues ● Structural and environmental factors	● Support from the hospital was considered inadequate and difficult to access ● CHWs need more education to better support mothers ● CHWs felt that breastfeeding is hard for young Black mothers due to lack of support and resources.	● CHWs were enthusiastic about breastfeeding support but concerned that they did not have enough skill or resources to effectively provide support to their clients
Kozhimannil et al.	2013	Matched cohort study N = 1069 doula clients N = 110 Black clients	To study whether doula support may be associated with breastfeeding initiation among low income diverse women by comparing outcomes to state PRAMS data.	Breastfeeding initiation	● 92.7% of mothers in program initiated breastfeeding compared to 80.8% of mothers in PRAMS data ● Rates for Black women were very high at 97.9% compared to Black women in PRAMS data (70.3%)	• Doula support across the care continuum positively affects breastfeeding initiation

Gross et al.	2015	Qualitative focus groups N = 23 WIC peer counselors N = 10 were Black	To understand the contextual factors influencing breastfeeding decisions of low-income Black women from the perspective of breastfeeding peer counselors	Framed by Social Ecological Theory, asked to discuss individual, interpersonal, community, cultural, and historical factors affecting Black clients	● Breast pumps can give a sense of security ● Black clients don't get support or information about breastfeeding from their healthcare providers ● Associated cultural pressures to be a strong Black woman prevents Black clients from seeking help ● Free formula negatively affects breastfeeding among Black clients ● Not enough baby friendly hospitals are available to Black clients	● Peer counselors are able to identify major areas in which breastfeeding support for Black clients is lacking
Hwang et al.	2016	Stratified, 2 stage, cluster design N = 3297 mothers caring for infants between 2-4 months of age	To determine the prevalence of maternal trust in advice sources on infant care practices, and to investigate the association of maternal and infant characteristics with trust in advice sources on infant care practices	none	● Overall, mothers were most likely to trust doctors for advice on infant health practices, second most trusted source were family members ● Black mothers were less likely to trust advice from doctors and nurses about breastfeeding than were non-Hispanic White mothers	● Highlights mistrust that Black mothers may have for healthcare providers and systems.

		N= 828 were Black mothers			• Black mothers were more likely to trust advice from their families about breastfeeding	
Structural						
Thomas	2018	Qualitative, in-depth one-on-one interviews	To document race-based discrimination against patients in the course of lactation care and link the implicit bias literature to breastfeeding disparities	• Implicit bias • Overt racism • White semantic moves • Institutional inequality	• Less and lower quality breastfeeding support for Black mothers observed • Patients of color are missing health education images, literature, and stories • Black patients often referred to social services or offered sterilization • Overtly racist remarks about patients occur in personnel space (not directly in front of clients) • Hedging language to describe race and racism is used • Noted a lack of professional opportunities for employees of color in the workplace	• Lactation professionals are aware that breastfeeding support for Black patients in the hospital is poorer compared to that offered to Whites • They have witnessed racism in overt and unconscious forms while on the nursing units

Results

Studies examining the ways that healthcare providers interact with Black families around breastfeeding and breastfeeding support are limited. Studies in this review reflect a variety of perspectives and designs and share similar themes. As shown in Table 1, the studies are grouped by levels of the Social Ecological Model. Ten of the 11 studies focused on the interpersonal level. One study focused social structures and explicitly examined racism (Thomas, 2018).

Interpersonal Level

Healthcare Workers Feel Black Clients do not Receive Adequate Support

Many studies indicate that healthcare providers feel that their Black clients do not get the breastfeeding support they need. Furman et al. (2013) presented a qualitative analysis of focus group data gathered from Community Health Workers (CHW) from a prenatal home visiting program incorporated breastfeeding support and promotion along with prenatal and postpartum support and education. CHWs in the focus group acknowledged that there were many barriers to breastfeeding for their clients, but particularly identified that their clients do not get much prenatal education about breastfeeding or get adequate support in the hospital or follow up in the postpartum period. CHWs spoke about the difficulty their patients often have in accessing postpartum breastfeeding support in the hospital and after discharge. Though all CHWs supported breastfeeding, and some were more skilled in providing hands on help due to their own experience, most desired more education themselves in order to more effectively support their clients.

Gross et al. (2015) qualitative study consisted of focus groups done with WIC peer counselors, seeking to understand the peer counselor's perspective on supporting breastfeeding for their Black clients. The peer counselors in this study felt strongly that healthcare providers did not do a good job educating their clients about breastfeeding. They felt that prenatal care providers did not discuss breastfeeding unless the patient brought it up first, particularly if the prenatal care

provider was White. The peer counselors also felt that their clients did not receive regular support from the lactation staff at the hospital, and that formula was pushed on their Black clients.

Black Parents may not Trust Healthcare Providers

Black parents may not trust the advice of physicians for breastfeeding. Hwang et al. (2016) found that while most parents relied on a doctor's advice for infant health practices including breastfeeding, Black parents were more likely to trust advice from their families about infant feeding. These findings highlight the mistrust that Black parents may have for healthcare providers and systems.

Healthcare Providers may make Assumptions about Black Parents

Another theme that emerged was that healthcare providers may be influenced by their assumptions about Black patients. Queenan et al. (2012) surveyed obstetric physicians and found that these physicians had a fairly accurate sense of the likelihood of breastfeeding in their patient populations, which matched the overall breastfeeding trends in their area. Physicians reported that they were fairly satisfied with how much their patients breastfed. Physicians that served a higher proportion of Black parents were more likely to estimate that their clients were unlikely to breastfeed, independent of the trends in the geographic area. Whether or not these assumptions influenced the way physicians cared for their Black patients was not assessed.

Direct Breastfeeding Support is Effective for Black Parents

A consistent theme also emerged from the intervention studies, namely that direct support for Black breastfeeding parents is effective at increasing breastfeeding initiation and continuation. In the Meier et al. (2004) study of parents with babies in the neonatal intensive care unit (NICU), outreach to parents was direct and practical support was prioritized. Neonatologists met with the parent to discuss the lifesaving benefits of human milk, particularly for premature infants. Dedicated lactation specialists were available to parents, with personal support in the postpartum hospital stay as well as

throughout the NICU stay. Lactation peer counselors and support group meetings were coordinated for the parent. Additional practical support was offered as breast pumps were provided and the cost of transportation to and from the hospital for meetings and for baby visits were also covered. When direct support was provided and specific barriers were addressed, Black parents provided milk for their baby at much higher rates than were expected or previously reported.

The Edwards et al. (2013) and Kohimannil et al. (2013) studies showed an increase in breastfeeding initiation among Black parents with doula support. Parents were more likely to initiate breastfeeding, more likely to breastfeed longer than six weeks, and less likely to introduce complementary foods before six weeks (Edwards et al., 2013). Among Black mothers covered by Medicaid, 92.7% of doula-supported parents chose to initiate breastfeeding, compared with 70.3% of the state population reported in the comparison sample of PRAMS data (Kozhimannil et al., (2013).

Studies also demonstrated that access to a lactation support professional in the hospital increased the rate of breastfeeding initiation among Black families. In a randomized controlled trial by Bonuck et al. (2005), the Black women in the intervention group had a significantly reduced risk of low breastfeeding at both 13 and 52 weeks, and in fact were 50% to 60% more likely to have a high intensity of breastfeeding than women who identified as Hispanic. Breastfeeding intensity was determined by the percentage of feedings that consisted only of human milk, and was classified as low, medium, or high. Castrucci et al. (2006) studied how giving birth at a hospital that employed at least one International Board Certified Lactation Consultant (IBCLC) affected the rate of breastfeeding at hospital discharge. IBCLC presence increased rates of breastfeeding at hospital discharge among all women, and Black women were 2.17 times more likely to breastfeed at time of discharge. Interestingly, giving birth at a hospital employing an IBCLC increased the likelihood of breastfeeding at discharge for women receiving Medicaid by 4.13 times. This study does not

measure if parents actually met with the IBCLC, only if they gave birth at a facility that employed an IBCLC.

The randomized controlled trial completed by Wambach, et al (2011) employed an intervention consisting of an education program for adolescent mothers during pregnancy, and counseling from a lactation consultant and peer counselor after birth through the first four weeks postpartum. They found that while intervention group mothers were likely to breastfeed longer than the control group, it did not have a substantial effect on breastfeeding initiation or exclusive breastfeeding.

Racism in Healthcare

Only one study explicitly addresses implicit bias or racism in healthcare. Thomas (2018) interviewed IBCLCs from across the United States to understand their experiences and observations with race and racism in lactation support. IBCLCs who were interviewed described witnessing health care providers including doctors, nurses, and lactation professionals make assumptions about a patient's likelihood to breastfeed based on their race. The subjects discussed that sometimes Black patients were less likely to receive support because the professionals there to support them assumed they didn't want to breastfeed or would not breastfeed for very long. The IBCLCs also reported that parents of color were less likely to be represented on brochures or literature created on their units, which was concerning as it sent a subtle message to parents on the kind of people who were expected to breastfeed. The interviews also revealed that Black patients were more likely to be referred for birth control or have a social service consult made. In addition to the unconscious bias identified, IBCLCs also reported instances of stereotyping and racial slurs being used about patients on their unit, rarely directly to the patient's face, but rather in professional to professional conversation.

Discussion

One of the clearest themes in this review of the literature is that providing support directly to Black breastfeeding parents can effectively increase initiation and duration of breastfeeding. The early days of parenting and breastfeeding are full of changes and challenges and are difficult for every parent from time to time. The most effective interventions met the families at their point of need, such as helping with transportation, equipment, and/or providing scheduled support visits in the home or by telephone based on the family's needs. Every parent can benefit from accurate information, timely intervention, and positive interactions. Every parent needs support, but if that support is not accessible, it's not useful. In this way, the basic needs of Black parents are not essentially different than the needs of White parents. However, the unique needs of the parents must identified and known. Providing a breastfeeding clinic at the hospital to a family without reliable transportation will not be helpful. Support needs to be provided in a way that meets the needs of the family, and if that family has to travel far, make appointments, or spend money on expensive consultations or equipment, the barriers to breastfeeding may be too much to overcome. Health systems are structured to serve institutional needs, and often those are at odds with the needs of parents and families. Meeting the needs of families, as they are, is necessary in order to actually provide effective breastfeeding support.

Clearly, healthcare and health systems in the United States exist in a context of racism and oppression. Unequal treatment in healthcare based on race is a root cause of health inequities for people of color. Racist assumptions lead to biased provision of care, which means that not all parents get what they need or the same level of support. When biased assumptions, routines, and policies permeate health systems, it becomes nearly impossible for even well-meaning and earnest healthcare providers to give unbiased care. The problem is a structural and institutional one, and must be

addressed by eliminating the biased assumptions, routines, and policies that are woven into our health systems.

Racism in Birth Care is a Research Gap

Racism is an integral part of a White supremacist society and is the norm, not the exception (Delgado, 2017). As such, racism is built into our healthcare institutions; we cannot remedy its effects if we ignore it. Academic research investigating and describing racism in healthcare is unfortunately sparse, and research focused on racism in care surrounding birth even more so. Increasing attention is being paid to the issue of inequity and racism in maternity care in the mainstream media and from advocacy groups. Celebrities such as Serena Williams have told their stories of facing life-threatening complications while giving birth and how she was not supported or listened to during the crisis (Salam, 2018; Williams, 2018).

Maternal health advocacy groups such as the Black Mamas Matter Alliance (BMMA, 2018), Reaching Our Sisters Everywhere (Bugg & Bugg, 2013) and the National Perinatal Task Force (Cole, et al., 2018) recommend changes in maternity care delivery to promote equitable care. They recommend centering the voices of black women who are pregnant or giving birth, allowing the healthcare provider to meet the actual needs of women and families, rather than making assumptions that may be based in stereotyping or bias. They advocate for models of care that center the lives, knowledge, choices, and communities of black women to promote equitable and informed maternity care.

Some researchers are focusing more on how health inequities stem from racism. Ghidei, et al (2019) recommends more careful consideration and collection of data surrounding race in research. In a response to this paper, McLemore, et al (2019) provided further recommendations, emphasizing that racism in the provision of healthcare is the risk factor for health problems, not simply race. They also recommended partnering with communities of color when conducting research in order to gain a

more nuanced understanding of how the construction of race affects those communities. Franck et al (2018) outlines an approach to community involvement in maternity health research.

This gap in research is even more glaring when discussing research examining racism in breastfeeding support. Though many studies explore the racial inequities in breastfeeding rates, very few investigate or even mention the impact of racism in this inequity. Further research into the impact of racism in breastfeeding support and maternity care can enhance understanding of the phenomenon as well as lead to interventions to combat its effect.

Recommendations for Research and Practice

Measures to combat racism and unconscious bias begin with the ability to confront and talk about the presence of racism and bias. Framing racism as a universal problem and one that is a barrier to patients receiving equitable care may be helpful in addressing the reluctance to discuss and name racism in personal actions or the actions of others. Identifying racist assumptions and behaviors is the first step to taking measures to combat those assumptions and behaviors.

Combating racism on an individual level is important, but addressing the racism embedded in systems and institutions is more effective. In the context of breastfeeding support from healthcare providers, this can mean standardizing the provision of information about breastfeeding with every patient during prenatal care. Including education at designated points during pregnancy can help minimize the effects of a provider's racist assumptions. In the hospital, policies should also be in place that apply to every patient, like the Ten Steps to Successful Breastfeeding promoted by BFHI. Even hospitals that cannot obtain BFHI certification can institute these steps. When instituting new policies, it is just as important to include procedures to measure and enforce those policies, otherwise they may be easily set aside, or viewed as an ideal that is never met.

Hospitals, community organizations, and insurance providers can also encourage, facilitate, and fund programs that provide direct support to parents, such as covering doula services, or making

sure that every parent has access to breast pumps and infant feeding supplies. Flexible and responsive programs have the value of effecting change in a way that is accessible and meaningful to the parent, rather than being yet another obstacle to overcome.

As researchers are only beginning to focus on how racism and bias impacts birth care and breastfeeding support, there is much to learn about the origins, effects, and remedies for racism in birth care. It is important to continue to examine how racism is embedded in the structures and polices of healthcare systems, as well as how racism and bias is enacted by healthcare providers such as physicians, midwives, nurses, lactation professionals and doulas. Currently, most recommendations for ethical and equitable provision of maternity care come from maternal health advocacy groups. While insights from advocacy groups are important and valuable, more scholarly and academic work needs to be done to facilitate dissemination to the wider scientific community. Academic research partnerships with community organizations may help to provide the best of both worlds.

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"I Find Myself Speaking a Narrative":
Experiences of Nurses Providing Breastfeeding Support to Black Families in the Immediate Postpartum

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Introduction

In the United States and around the world, human milk is recognized as the optimum nutrition source for infants. The provision of human milk reduces acute and chronic illness in infants, protects the gut, reduces risks of ovarian and breast cancer in lactating parent, and reduces financial costs of feeding and healthcare.

Breastfeeding Statistics

In the United States, breastfeeding rates have slowly risen over time, but persistent racial disparities remain. Currently only 79.2% of infants in the United States are ever put to the breast, and only 20% are exclusively breastfeeding at six months. In comparison, only 64.3% of Black non-Hispanic infants are ever breastfed, and only 14% are exclusively breastfeeding at six months of age (Anstey, 2017). These inequities persist even though Black parents are overwhelmingly aware that breastfeeding is healthy for their infant (Munn et al., 2018; Miller et al., 2018; Johnson et al., 2016; Obeng et al., 2015; Gross et al., 2017).

Factors that Influence Breastfeeding

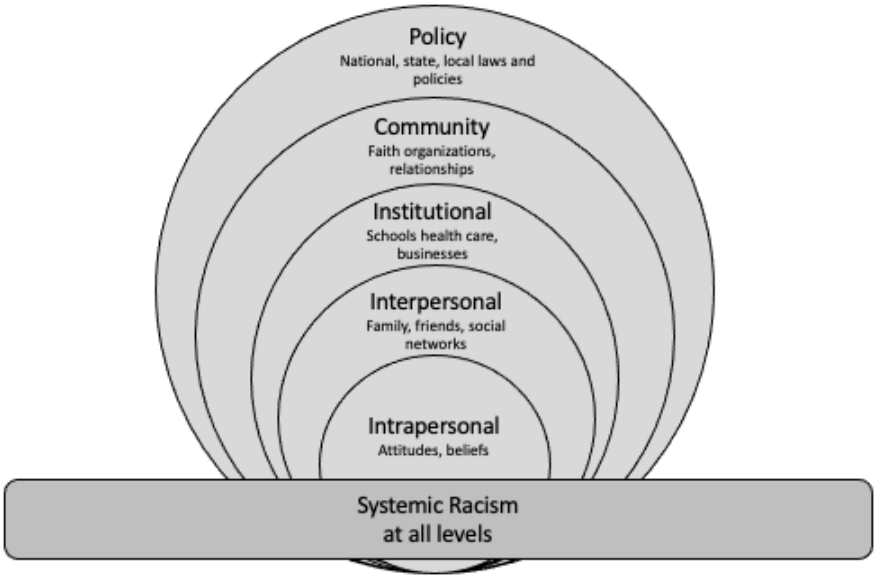
Social Ecological Model

Existing studies have explored factors influencing breastfeeding initiation, exclusivity, and continuation. The adapted Social Ecological Model (figure 3) can be used heuristically to categorize the factors and behaviors by placing the individual at the center of spheres of influence that impact

health decision making while acknowledging that there systemic racism infiltrates each level (McLeroy et al, 1988).

Figure 3

Modified Social Ecological Model



Intrapersonal Level. Intrapersonal level factors influencing the provision of human milk include the lactating parent's health status, their health beliefs, socioeconomic status, education, and age. Intention to breastfeed is necessary for breastfeeding initiation, but not entirely predictive (Corbett, 2000, Meyerink & Marquis, 2002). Though as many as 79% of Black women in one sample (Persad & Mensinger, 2008) intended to breastfeed, most ended up primarily using formula. Persad and Mensinger (2008), found that Black parents who planned to breastfeed had positive feelings about breastfeeding, had support from family and friends, were older, more educated, and wealthier.

Interpersonal Level. Interpersonal level factors influencing Black parents' breastfeeding decisions include family, friends, and health care providers. Black women reported that their own

mothers' opinions and experiences, as well as the opinions of their partner, were influential in their decision (Bentley et al., 1999). Black mothers identify peer and family support, community norms, and exposure to breastfeeding as important influences, along with education and support from healthcare providers (Mickens et al., 2009; Bentley et al., 1999; Robinson, 2009; Racine et al., 2009; McCarter-Spaulding & Gore, 2009; Cricco-Lizza, 2005, 2006). However, Black mothers are less likely than their White counterparts to receive information about breastfeeding from their healthcare providers during their pregnancy, or support for breastfeeding postpartum (Cottrell & Detman, 2013; Robinson, 2009; Robinson & VandeVusse 2011; Cricco-Lizza, 2005).

Black mothers report that their healthcare providers are unlikely to bring up breastfeeding at a prenatal appointment, or may only touch upon the subject, without giving much support or information (Robinson & VandeVusse, 2011; Cottrell & Detman, 2013; Spencer et al., 2015; Hinson et al., 2018). In the hospital, Black mothers report a mixed experience with hospital support staff. Some mothers report a positive experience with nurses and lactation specialists, but others report that they were not given much attention or that they felt dismissed (Gee et al., 2012; Furman et al., 2013; Lutenbacher et al., 2016; Hinson et al., 2018; Miller et al., 2018; Johnson et al., 2016). Black mothers also reported difficulty accessing lactation support after leaving the hospital (Cottrell & Detman, 2013, Cricco-Lizza, 2005).

Organizational Level. Organizational factors include hospital policies, as well as organizations that provide breastfeeding support in the community, such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Prenatal education measures and breastfeeding promotion strategies in the hospital have proven effective at increasing breastfeeding rates for families of all races, including Black families. Hospitals that implemented supportive breastfeeding policies such as those in the Baby Friendly Hospital Initiative (BFHI) found that the greater a facilities' compliance with breastfeeding support practices, the higher the rates of

breastfeeding initiation and duration among their clients, regardless of race (Brenner & Buescher, 2011; Vasquez & Berg, 2012; Digirolamo et al, 2008; Perrine et al, 2012; Hawkins, et al, 2014). The meta-analysis by Rollins et al. (2016) calculated that access to individual counseling or group breastfeeding education, immediate breastfeeding support after delivery, and lactation management services increased exclusive breastfeeding rates by 49%, and any breastfeeding by 66%. Ahluwalia et al. (2012), reports that for Black mothers, breastfeeding within the first hour after birth, not giving baby a pacifier, individualized assistance from hospital staff, and breastfeeding on demand are associated with higher rates of exclusive breastfeeding at six weeks postpartum.

The WIC program is administered through county health departments, and includes access to food, nutrition education, and health care referrals for low income parents and children up to five years of age (USDA, 2020). The program explicitly promotes breastfeeding through peer counseling and assistance, as well as augmented nutrition for lactating parents who are at nutritional risk. Though many Black mothers identify the support from their WIC counselors as extremely important to successful breastfeeding (Robinson, et al, 2016). Beal et al. (2003) surveyed WIC clients in New York and found that Black women reported receiving less information about breastfeeding from their WIC counselors than did White women.

Community Level. Community level factors include breastfeeding support organizations, community norms around breastfeeding in public, and norms in schools and workplaces. Organizations such as La Leche League were formed by middle class White mothers in the 1950s, promoting "good mothering through breastfeeding" (Weiner, 1994). The mother-to-mother support in this organization was instrumental in educating women at a time when breastfeeding rates in the United states were as low as 22%. This low rate was due to decades of physician promotion of formula feeding as the most scientific and most beneficial nutrition for infants, or so they believed. Though the organization has provided education and support to lactating parents for many decades,

its membership has remained largely White and middle class, and geared toward stay at home mothers (Bobel, 2001). Though Black mothers are not explicitly excluded, they may feel effectively unwelcome in the homogenous environment of the organization.

Black women have formed their own support organizations in an effort to find more welcoming spaces and normalize Black breastfeeding. Organizations such as ROSE (Reaching Our Sisters Everywhere), Black Mothers Breastfeeding Alliance, Black Women Do Breastfeed, Normalize Breastfeeding, Breastfeeding Support Group for Black Moms, and the African American Breastfeeding network provide a mix of online, local, and national events and spaces dedicated to breastfeeding support for Black women. These organizations are relatively new, established from 2007-2011 and reflect the grassroots efforts of mothers who recognize that all parents need support that is meaningful and accessible.

Policy Level. Policy factors include local, state, and federal regulations concerning workplace accommodations for lactating parents, breastfeeding in public, and requirements for insurance coverage for breastfeeding supplies and specialists. This can also include health policy guidelines from national organizations and regulatory bodies for healthcare providers and facilities. These policies are not based on race, but workplace policies for hourly workers are usually less accommodating than those for higher paid or salaried employees. Lower income or part-time workers may not be eligible for employer-covered health insurance, and for those who are, the coverage may be less than for higher paid workers. Many individuals do not have insurance provided by their employers or may not be employed, and benefits for people on public health insurance are often less generous than private insurance coverage.

Individuals, and the systems surrounding them, all exist within the context of the larger society. In the United States, we have a strong history of racism, White supremacy, and oppression.

Though the expressions of racism and White supremacy are different today than in the past, and many circumstances have changed for the better, they are still present.

Racial Health Inequities

Racial health inequities in the United States exist within the historical context of racial discrimination and oppression. Williams and Mohammed (2013), described racism as "an organized system premised on the categorization and ranking of social groups into races and devalues, disempowers, and differentially allocates desirable social opportunities to racial groups regarded as inferior." Racism gives rise to negative attitudes and beliefs about oppressed groups, which leads to poorer treatment of those groups (Krieger, 2014; Bailey, et al, 2017). Poor treatment of marginalized groups is seen on many levels, from individuals, to institutions, to governments, and can become so ingrained in attitudes and systems, that the people who perpetrate this unfair treatment are not aware (Dovido & Gaertner, 2004).

Within the literature examining racism and health outcomes, it is clear that non-White patients have poorer health outcomes. From the landmark Institutes of Medicine (IOM) study (Smedley et al., 2002), and confirmed by subsequent studies, clear health inequities persist, even when controlling for variables such as income, education, or social status. Due to antidiscrimination laws and changing social norms, racism and unequal treatment within healthcare today is rarely overt or explicit, but rather implicit and unconscious. However, unconscious racism is no less harmful than overt racism, and racism is evident among healthcare providers within healthcare systems (Wheeler & Bryant, 2017; Zestcott et al., 2016; Paradies, et al, 2014;, Feagin & Bennefield, 2014). Though most studies focus on physician interactions, Haider et al. (2015) found that 85% of the nurses surveyed displayed implicit racial bias, and Sellers et al. (2016), found that nurses commonly use race as a factor in clinical decision making.

Racial Inequities in Breastfeeding Care

Prenatal education measures and breastfeeding promotion strategies in the hospital have proven effective at increasing breastfeeding rates for families of all races, including Black families. Hospitals that implemented supportive breastfeeding policies such as those in the Baby Friendly Hospital Initiative found that the greater a facilities' compliance with breastfeeding support practices, the higher the rates of breastfeeding initiation and duration among their clients, regardless of race (Brenner & Buescher, 2011; Vasquez & Berg, 2012; Digirolamo et al, 2008; Perrine et al, 2012; Hawkins, et al, 2014). Rollins' (2016) meta-analysis calculated that access to individual counseling or group breastfeeding education, immediate breastfeeding support after delivery, and lactation management services increased exclusive breastfeeding rates by 49%, and any breastfeeding by 66%. Ahluwalia et al (2012), reports that for Black mothers, breastfeeding within the first hour after birth, not giving baby a pacifier, individualized assistance from hospital staff, and breastfeeding on demand are associated with higher rates of exclusive breastfeeding at 6 weeks postpartum.

Despite the efficacy of these measures, Black families report receiving prenatal education about breastfeeding less often than White mothers (Beal, et al, 2003, Gee, et al, 2012, Lutenbacher, et al, 2016, Gross, et al, 2017, Obeng, et al, 2015). They also report that their healthcare providers are unlikely to bring up breastfeeding at a prenatal appointment, or may only touch upon the subject, without giving much support or information (Robinson and VandeVusse, 2011, Cottrell and Detman, 2013, Spencer, et al, 2015, Hinson, et al, 2018). In the hospital, Black mothers report a mixed experience with hospital support staff. Some mothers report a positive experience with nurses and lactation support specialists, but others report that they were not given much support or that they felt dismissed (Gee, et al, 2012, Furman, et al, 2013, Lutenbacher, et al, 2016, Hinson, et al, 2018, Miller, et al, 2018, Johnson, et al, 2016).

Decades of research upholds that social and community support of breastfeeding, prenatal education, and direct assistance from healthcare providers and community members during the immediate and extended postpartum periods help breastfeeding families meet their goals. This is true for White families and also holds true for Black families. The needs of Black families are not different, but support from healthcare professionals and systems is unequally applied.

Literature on Racism in Breastfeeding Care

Not much is known from the literature about how racism and bias influence the breastfeeding support that Black families receive in the hospital setting. Thomas (2018) interviewed International Board Certified Lactation Consultants (IBCLC) from across the country about their observations of racism and bias during postpartum care through the lens of Critical Race Theory. The study found that racism influenced the interactions between lactation professionals and breastfeeding families, though most instances were subtle and indirect.

Study Purpose

The purpose of this study is to understand interactions between nurses and breastfeeding families in the immediate postpartum from the perspective of healthcare providers. For mothers who give birth in hospitals, nurses are vital participants in maternal and infant care in the hours and days after birth. Physicians and midwives may plan care, write orders, and offer support, but their contact with postpartum mothers is usually limited to daily rounds. Lactation specialists have a wealth of knowledge and can be important in addressing problems with breastfeeding as they arise, but again, they may have limited contact with the individual patient during the hospital stay or only see a parent if first referred by the nurse, midwife, or physician. Nurses are involved in planning and providing care for both mother and baby and are among the first available to encourage and support breastfeeding. Nurses are at the bedside regularly in the first 24-48 hours after birth and have the most consistent opportunity to provide essential support to the new mother. Nurses are often the

gatekeepers of further intervention as they may make referrals to a lactation specialist based on their clinical judgment of the breastfeeding relationship.

Little is known about the experiences of nurses providing breastfeeding support to Black families in the immediate postpartum period. This study focuses on how nurses experience providing breastfeeding support to Black families in the immediate postpartum, precisely because of the vital role nurses play during this critical period.

Specific Aims

1. To document how postpartum nurses describe their delivery of breastfeeding support for Black mothers.
2. To explore how nurses plan their breastfeeding support for Black mothers.
3. To describe how nurses integrate breastfeeding support for Black mothers into their workflow.

Methods

Study Design

This is a qualitative descriptive study based on in depth one-on-one interviews. Qualitative descriptive analysis has a long tradition of use in nursing and social sciences, particularly to understand phenomena that have not previously been well explored. Concepts and information learned during qualitative descriptive analysis can be used to frame further studies and allow formulation of interventions (Kim et al., 2017). Approval for this study was granted by the Institutional Review Board at the University of Illinois at Chicago. This was a self-funded study.

Sample

Fifteen nurses were interviewed for this study. Purposeful sampling was used to identify nurses, with fliers posted in participating mother baby units and through invitations posted on social media, including Facebook and Instagram. Permission was obtained from participating units, and

fliers were posted including the contact information of the researcher. In addition, some nursing units shared the flyer through email lists and their own social media. The Nashville Breastfeeding Coalition and Nashville Black Nurses Association also shared the flyer through their social media. Inclusion criteria were specified in the invitation. Nurses who care for mothers after the birth of their baby, which includes labor and delivery and postpartum nurses, were targets. The nurses were recruited from a large southeastern city where the study was based. The inclusion criteria were having at least one year of experience in their nursing specialty and having cared for a racially diverse patient population. Nurses who participated in the study also recommended contacting the researcher to other nurses who they thought would be interested in participating in the study. Recruitment and interviews took place over the span of ten months.

Nurses who responded to the fliers universally reported a particular interest in breastfeeding support, and many of them had pursued advanced knowledge and skill in breastfeeding. Many of the nurses who participated in the study had themselves breastfed their own children, and most viewed that as a positive experience. Most of the nurses who responded to the fliers identified as White, which reflects the racial makeup of nurses in the Nashville area. In Davidson and the surrounding counties, more than 80% of registered nurses identify as White (State of Tennessee, 2020).

Sample size

In qualitative research, sample size is not the result of calculations or rules but is determined when the phenomenon being studied is well explained, in that no new themes or data arise from further interviews. This concept is somewhat fluid, and many criteria have been proposed. Patton, (2002) says that the answer to the correct sample size for a qualitative study is "it depends". "The validity, meaningfulness, and insights generated from qualitative inquiry have more to do with the information richness of the cases selected and the observational/analytical capabilities of the researcher than with the sample size (Patton, 2002, p. 245)." In Guest, et al, (2005) analysis of sixty

interviews, they found that data saturation was reached after twelve interviews. Green and Thorogood (2009), propose that most researchers reach saturation somewhere around twenty interviews. In Vasileiou, et al. (2018) review of 214 qualitative studies, they identified sample sizes ranging from 6 to 197.

Tolley, et al. (2005) says that when no new information is coming from the new interviews and observations, and when you are hearing many of the same themes over and over, the researcher begins to know that redundancy and data saturation has been reached. Patton, (2002) further explains that sample size is only one part of determining adequacy, and encourages the researcher to describe, explain and justify their recruitment strategies and sample characteristics as fully as possible for adequate peer review.

As demonstrated by the myriad of advice and opinion on sample adequacy and data saturation, determination of saturation can take a certain amount of expertise and experience. In light of the primary researcher's newness, for this study the researcher periodically reviewed the interviews, themes, and codebook with the committee chair as an expert advisor.

Procedures

When interested participants contacted the principal investigator (PI) about the study, each was screened to evaluate whether or not they met the inclusion criteria. Meetings were arranged for eligible participants to meet in person or by telephone at a time that was convenient. During the initial interaction, written study information was provided. The PI then verbally reviewed study procedures, risks and benefits, and answered any questions about the study to obtain informed consent prior to the interview. Written information about the study purpose, methods, and privacy practices was also provided as a hard copy or an email attachment for the participant's review and reference.

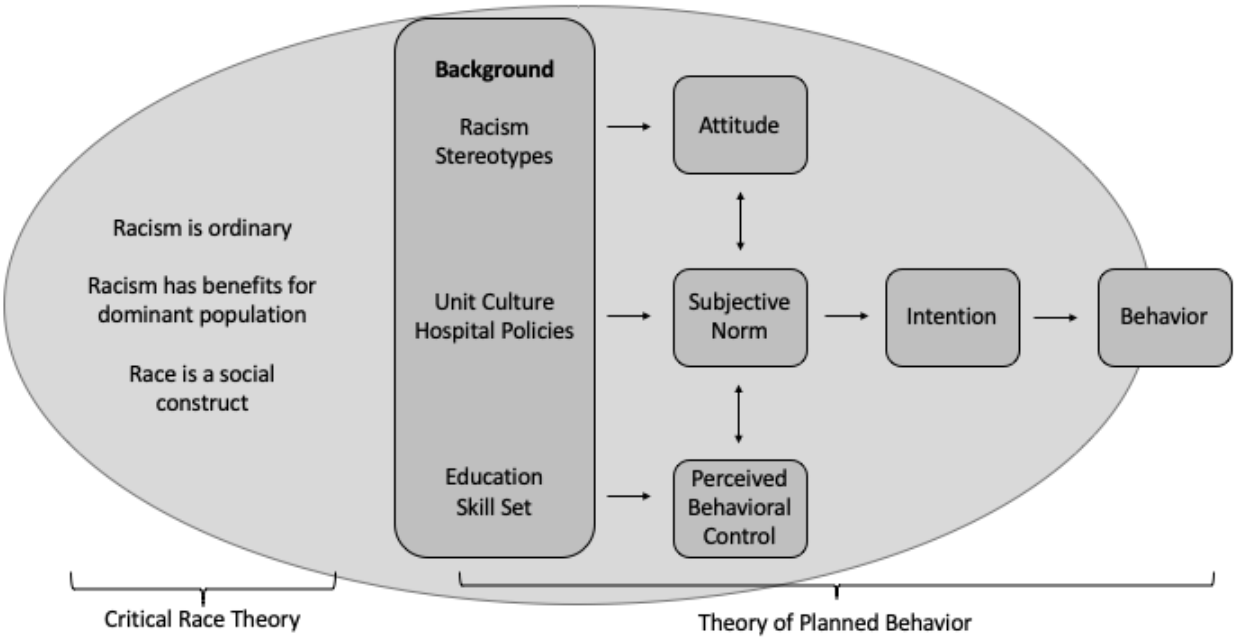
Prior to the interview, demographic information was collected. The demographic questions did not contain identifying information, but asked the nurse's age, race/ethnicity, gender, education, unit type, and years of practice. Interviews were digitally recorded for clarity and veracity as each was transcribed. The PI used field notes and reflexive journaling immediately following the interviews to maintain an audit trail. Interviews were semi-structured, guided by a questionnaire (Table 1), with follow up or exploratory questions as needed. Digital recordings of the interviews were uploaded directly onto a secure server managed by University of Illinois at Chicago (UIC) immediately after completion of the interview. The recordings were transcribed verbatim and de-identified prior to analysis.

Interview

The interview guide (Table 1) was developed with help from the theory of planned behavior and critical race theory. Figure 4 illustrates how these theories work together to guide how the individual's background, attitudes, subjective norms, and perceived behavioral control contribute to intention and behavior. Together these theories show how racism in our larger society underlies and influences all of these factors.

Figure 4

Diagram of Expanded Theory of Planned Behavior and Critical Race Theory



Theory of Planned Behavior

Ajzen's (1991) Theory of Planned Behavior provides a framework for the causes and processes of decision-making, intention, and behavior. In the case of nursing behaviors, this framework can be useful in conceptualizing influences on the nurses' decision-making process, and what actions they take in order to provide breastfeeding support. In this study, the concept of race and the experience of racism give context to understand how nurses provide breastfeeding support for Black mothers.

The Theory of Planned Behavior posits that a person's behavior is a direct result of the intention they have to perform that behavior. As such, the intention is influenced by their own beliefs and attitudes about the behavior, how they think other people will view the behavior, and whether or not they believe they are able to perform the behavior. This framework has been used many times

over to help researchers conceptualize how individuals make decisions about their behavior, and how to influence behavior. In this study, the theory is used to provide understanding of the nursing process and to construct the interview guide.

The Theory of Planned Behavior has been criticized for oversimplifying and overlooking other practical considerations and background influences that also factor into an individual's actions (Sniehotta et al., 2014; Ogden, 2015). However, it can still help to conceptualize phenomena when we wish to understand the motivations and cognitive processes that shape decisions leading to actions (Ajzen, 2015). The Theory of Planned Behavior allows the researcher to conceptualize how attitudes, norms, and perceived control influence the nurse's intention and performance of a particular action, in this case, breastfeeding support. Theory of Planned Behavior has been used effectively in many instances to evaluate nursing behaviors (Jeong & Kim, 2016; Nelson, Cook & Ingram, 2014).

Attitudes include racism and bias, such as the assumptions that nurses make about patients due to their race and the stereotypes they assign. Even well-meaning nurses may assume that Black parents will not initiate or continue breastfeeding, and breastfeeding support measures become reprioritized accordingly. Nurses act as gatekeepers for specialized breastfeeding support choosing when to call for lactation consultants, midwives, or physicians. Because of this role, how the nurses plan and organize postpartum care can have an enormous impact on the education and assistance parents may receive during their hospital stay.

Subjective norms describe unit culture, and what nurses feel is expected of them in their particular practice setting. If other nurses on the unit value and promote breastfeeding, and unit governance and management is vocal in their enthusiasm for breastfeeding education, nurses are more likely to adopt those same norms. However, if nurses are exposed to a unit culture where

breastfeeding is less valued and not supported, the opposite may be true, and they may adopt behaviors modeled to them in the workplace.

Perceived behavioral control refers to how the individual feels about their ability to actually complete the intended behavior. Research that addresses how nurses feel about breastfeeding identifies this area as particularly important. Nurses often have positive attitudes about breastfeeding, believing that it is the optimal feeding choice for infants. However, they express doubts about their abilities to provide support for breastfeeding mothers. Nursing education programs have very little content that covers the practical skills needed to effectively promote breastfeeding, and thus many nurses enter their careers without this knowledge, making them less likely to engage with patients.

Critical Race Theory

Though the Theory of Planned Behavior helps to model the factors within the individual that lead to behavior, it is important to conceptualize the larger social structure in which the individual resides. Critical Race Theory can help to conceptualize how racism is endemic in the larger social structure, influencing the individuals making decisions and enacting behaviors. Tenets of Critical Race Theory outlined by Delgado, (2017) include *racism is ordinary*, *racism benefits the dominant population*, and *race as a social construct*. Considering *racism is ordinary* means that it is an everyday occurrence, rather than aberrational or exceptional. Racism is actually so normalized that it can be difficult to recognize or address except when it appears as particularly blatant or violent. When describing racism as having *benefit to the dominant population*, the authors explain that while the wealthy members of the dominant population materially benefit from racism and inequality, the poor of the dominant population also psychically benefit from a feeling of superiority and supremacy. *Race as a social construct* addresses the perception of race as a biological reality, when it is actually defined by sociopolitical rules and norms. Anthropologists and geneticists have long

discredited the idea of significant biologic or genetic difference between races (Gravlee, 2009), but that remains a widely held belief. *Race as a social construct* is also evidenced by the way that definitions for race are malleable and change over time based on prevailing social norms and stigma associated with specific groups.

Qualitative Descriptive Analysis

The researcher used qualitative description to analyze the collected data. Methods were guided by the work of Sandelowski (1995, 2000, 2010) and Miles et al. (2014). Sandelowski (2000, p 336) describes qualitative descriptive analysis as "not highly interpretive in the sense that a researcher deliberately chooses to describe an event in terms of a conceptual, philosophical, or other highly abstract framework…entails the presentation of the facts of the case in everyday language." The method is described as staying closer to the data, viewing language as a means of direct communication rather than as highly symbolic.

Sandelowski (1995) outlines the recommended procedure for qualitative description to include *data preparation*, *getting a sense of the whole*, *developing a system*, and *data reduction*. This is followed by *data re-presentation* (Sandelowski 2000) which consists of formulating a descriptive summary of the results of data analysis.

During the *data preparation* stage, the researcher took notes during and immediately after interviews, in order to preserve impressions and ideas brought out during the interviews. When transcripts were returned, the researcher then spent time *getting a sense of the whole* by comparing the transcripts with the audio recordings and familiarizing herself again with the words of the interviewees. During this process, the researcher continued taking notes in order to record her memories and ideas about the interviews. Sandelowski (1995) emphasizes that qualitative data analysis is in many ways a simultaneous, iterative, and emergent process, as each stage of data collection and analysis informs the others.

After the first six interviews were transcribed, the researcher began *developing a process*, annotating the transcripts and forming initial codes. These initial codes were reviewed with Dr. Patil for her input and guidance. After the next five interviews were completed, codes were compared and reviewed for the *data reduction* phase. Some codes were expanded, others were regrouped, and a few were collapsed together. A definitive codebook was formulated based on these initial eleven interviews. The final four interviews were completed and coded using the codebook, and though there were some minor changes made to the codebook at that time, no new themes emerged, which caused the researcher to conclude that data saturation had been achieved. *Data re-presentation* is undertaken in organizing and describing the findings while writing this thesis. The researcher organized and analyzed data using Dedoose software to index for clarity.

Trustworthiness Measures for this Project

Measures of trustworthiness are important for any research project, particularly when judging the quality of the work. Quantitative researchers establish *rigor* through measures of *validity* and *reliability*. Lincoln and Guba (1985) propose that qualitative researchers establish *trustworthiness* by focusing on measures of *credibility*, *dependability*, *confirmability*, and *transferability*. Creswell (2013) recommends using triangulation, or the use of multiple methods and sources to establish trustworthiness. Streubert and Carpenter (2011), point out that all of these measures of trustworthiness can work together to show the value and rigor of a given qualitative study, and that there is no single best way to establish trustworthiness.

Credibility

When interpretations of the data produce explanations that make sense and are consistent with the data itself, those interpretations are thought to be credible (Tolley, et al., 2016). For this study, the researcher sought diversity of experience and institution in order to *increase diversity* of the sample and promote credibility. This study recruited nurses from three different hospitals in the

Nashville metro area to get a better idea of how disparate nursing units prioritize breastfeeding support in different ways. Once a codebook was established, two participants who had been identified as key informants were contacted again to engage in *member checking*. Each agreed to meet with the researcher to review the findings and emerging themes and provide feedback on the interpretations based on their own experiences and points of view.

Peer debriefing is another strategy used to establish credibility. The researcher met with a peer group after data collection and analysis to review procedures, codebook, and outcomes. These three peers were nurses and midwives in active practice working with laboring and postpartum mothers. The group members reviewed the study process and outcomes, asked questions of the researcher, and gave feedback to enhance clarity and credibility of the study.

Dependability

Dependability of the study was enhanced by having another PhD student focused on race and health inequities review the data to formulate codes for comparison with the primary researcher. This was done with the initial iteration of the codebook, and the researchers met for comparison and to resolve any differences in coding. The committee chair also reviewed data and gave feedback on the codebook as it was being developed.

Confirmability

To promote confirmability in the study, the researcher employed *journaling* throughout the process of planning, conducting, analyzing, and writing up the study. The researcher also took careful notes during interviews and during data analysis in order to maintain an *audit trail* and to track the development of ideas and concepts and to provide details to reproduce the findings if needed. The researcher used the journal entries, notes, and audit trail to provide transparent and detailed descriptions of the recruitment, data collection, and analysis process.

Transferability

The researcher promoted transferability in the study by keeping detailed notes of procedures and specifics of the study and incorporating full and detailed description in the writing. As noted by Tolley, et al. (2016) qualitative research is often based in the specific context of the study itself and is not usually expected to have a great deal of transferability. The extent to which findings can be generalized to other populations must be determined by the reader or reviewer. The primary responsibility of the qualitative researcher is to provide as much detail as possible about the population, procedures and findings so that readers may have the best information from which to draw their own conclusions.

Statement of Positionality

The PI is a White, cisgender woman, and a professional nurse and midwife. Due to her race she does not have firsthand knowledge about the experience of Black parents breastfeeding. To gain understanding of the patient's perspective, she has relied on immersion in the literature that centers the voices of Black parents, as well as the stories and experiences shared by her Black clients and colleagues.

Her experience as a White nurse and midwife has exposed her to the perspective of other nurses from both the emic and etic perspectives. She has worked closely with maternity care nurses and lactation specialists for many years, and is familiar with the routines, challenges, and language common in this specialty. This professional experience influenced the research focus, as due to her race and relative privilege as a healthcare professional, the researcher might not be uniquely suited to elicit the voices of black parents but may be well positioned to foster candid dialogue with nurses. When speaking with nurses and in organizing and analyzing the data she aimed to foster reflexivity, particularly understanding how her own interactions with nurses have informed her perspective.

Results

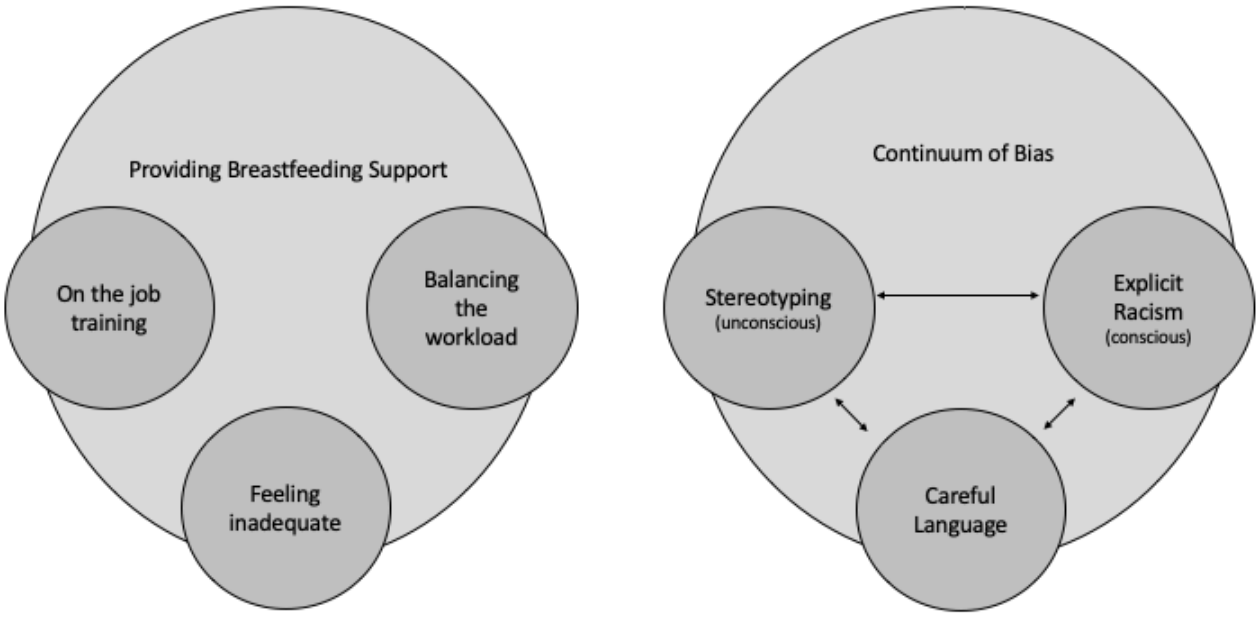
Study Sample and Characteristics

Demographic characteristics of study participants are outlined in Table 3 of this paper. Nurses who volunteered to participate in this study self-identified as interested in breastfeeding and breastfeeding support. Some of the participants had a role that specifically included breastfeeding support, while others were designated as labor and delivery or postpartum nurses only.

Fifteen nurses responded to the invitation and completed interviews. All of the nurses in the studies identified as women, and ages ranged from 26 years to 50 years old, with a mean age of 37. Most of the nurses identified as White, non-Hispanic (11), two as Black, non-Hispanic, one as White, Hispanic, and one as mixed race. All of the nurses interviewed had a bachelor's degree.

Figure 5

Overview of Themes



Themes

One major set of themes that emerged from the data focused on how nurses navigated their jobs when *providing breastfeeding support* (figure 5). Subjects talked about where they learned the information and skills needed to support breastfeeding, which mostly consisted of what they considered to be *on the job training*, with almost all nurses reporting only minimal information or exposure to breastfeeding during their nursing education. Nurses also frequently admitted to *feeling inadequate* when it came to breastfeeding support. Either they felt that they did not always have the skills and clinical knowledge to help their patients, or they felt that cultural misunderstanding and mistrust were barriers to establishing a therapeutic relationship with the patient. Nurses also reported that the many tasks and responsibilities in their jobs posed a challenge when it came to *balancing the workload.* Several nurses disclosed feelings that they sometimes needed to prioritize more urgent tasks over breastfeeding support.

Another set of themes focused on how nurses viewed their non-White patients, and how they perceived their own and other nurses' interactions with non-White patients. These perceptions and resulting interactions occurred on a *continuum of bias*, ranging from *stereotyping* patients all the way to descriptions of *explicit racism*. Nearly all nurses engaged in stereotyping their patients based on race, with some stereotypes being positive and others negative. Most nurses did not seem aware of their stereotyping, though some recognized that they were engaged in stereotyping and attempted to explain their thought process and the ways they combated their own stereotyping. Even in the case of describing explicitly racist practices and interactions, nurses of all races were reluctant or refused to label those actions as racist. All nurses engaged in *careful language* around racism and bias.

Though the themes identified fell into two major categories, the relationship between these themes is evident. When nurses *feel inadequate*, when they are only getting *on the job training*, and when they feel burdened by *balancing the workload*, they must make decisions about who receives

more time, attention, and support and who receives less. Perceptions about their patients, ranging from unconscious *stereotyping* to *explicit racism*, influence that decision-making process, whether nurses realize it or not. At the same time, unit culture and expectations act on nurses so that they use *careful language* or simply avoid the topics of bias and racism altogether.

Providing Breastfeeding Support

On the Job Training. Almost all nurses described feeling unprepared to provide breastfeeding support by their nursing education programs. Many cited personal experiences with breastfeeding, on the job training, or peer mentorship as the main sources of their skill with breastfeeding support. Most nurses described feeling unsure of themselves early in their careers but gained confidence through their work experience. When asked if she felt nursing school prepared her to provide breastfeeding support, one White postpartum nurse with four years of experience said:

> Absolutely not. Oh my goodness. I didn't really actually see myself going into OB. I originally was going to be in the ER or surgery and so I paid attention in my OB classes but most of our OB clinicals were about hemorrhaging and Eclampsia and things wrong with baby and there wasn't much emphasis on breastfeeding. It was, "Here are you options to feed your baby. Breast or bottle? Here are the benefits to both. Here are the risks of both and then let's move on." And there was also never a "how do you support a mom with questions or how do you support a mom when she's struggling and she's chosen to breastfeed?" I think most of that I've learned through my job, through our lactation consultants.

All nurses interviewed expressed a particular interest in breastfeeding support, and most expressed a feeling of fulfillment and accomplishment when helping a parent establish breastfeeding. Many nurses reported finding their job particularly rewarding. One White labor and delivery nurse with 10 years of experience told this story:

> I had this sweet, sweet patient. I went in to help her. And she said, "I feel like I have milk, but I'm not giving any out." I said, "Well, have you tried expressing any?" And she said, "Yes." And I said, "Well, show me what you're doing." And she said, "I'm doing this." And I said, "Uh uh." And I took her hand, and I said, "Do this." And she had so much colostrum. And was like, "Oh my gosh."
> So that was really rewarding ... Yeah, because she did get it. See. Again, I don't know if she's still nursing, but-…We got the baby on, and the baby had a really good latch,

> and she could feel it….Like the light came on. And I thought, "Okay. I think this one's going to make it."

Balancing the Workload. Nurses reported challenges balancing their regular workload and providing breastfeeding support. Nurses disclosed that trying to teach and facilitate breastfeeding, while completing other nursing tasks and meeting the demands of their unit, was overwhelming and made it difficult to devote the time needed for breastfeeding support. A Black labor and delivery nurse with six years of experience explained:

> Yeah, because to do a good teaching, a good foundational teaching, you need a good at least 10 minutes, I think. And sometimes that's the difference between a patient that's coming and another patient that's in pain and you have to give whatever. Excuse me. Also, especially if it's like a baby that I don't [have], because we do couplet care here. So if it's like I have mama but the baby is not my patient, the baby is maybe in special care, which another nurse is taking care of the baby and I'm really busy, I would tend to be like, okay, well this mama's going to have the nursery nurse also helping her and she's also going to have lactation. So I don't have to necessarily really help her right now. So yeah, I think in the totem pole, unfortunately, breastfeeding gets lower, yeah.

Some nurses described utilizing other resources like charge nurses, newborn nurses, or lactation consultants at times, but report that these resources were often not available, particularly on night shift. One White labor and delivery nurse with 10 years stated:

> So we have lactation consultants that we used to come to the bedside at delivery, and they've taken that away. And they put that on a labor nurse….I know our lactation consultants are wonderful. We need more of them…I think they're key over in the postpartum side, but I feel like we really miss a lot in that first hour.

Feeling Inadequate

Most nurses reported that they were aware of racial differences in breastfeeding rates and expressed some distress over the inequity. Some nurses reported a desire to alleviate breastfeeding inequities, and some remarked that they didn’t understand why their black patients did not breastfeed at the same rate as their White patients. Nurses also expressed a sense of inadequacy when faced

with families who don't plan to breastfeed. One mixed race postpartum nurse with eight years of experience disclosed:

> There's formula, I mean, and you can get WIC. They'll give you formula for free and then your gallery over here, the peanut gallery, like, "I got it. I got it 15 years ago and they're giving more now. Girl, just go ahead and do that." Even those moms that don't do WIC, grandma is like, "Why would you do that? Just give the bottle. You can just go and purchase. You can purchase ready-made and you just give that. You can do it in public. It's not a problem. Why would you do that?" So it's hard. I don't know what to do. I don't know how to help people to decide this [breastfeeding] is what they should do.

Continuum of Bias

Throughout the interviews a continuum of bias became evident, ranging from stereotyping and unconscious biases, to examples of explicit racism. All nurses had specific stereotypical beliefs about patients of different races, but many did not recognize this as stereotyping, instead framing it as simply drawing from the nurses' experience.

Stereotyping and Othering. When talking about their experiences working with patients of different races, strong themes of stereotyping emerged, with similar ideas expressed by most of the interview subjects.

Latinx patients were perceived to prefer mixed feeding over exclusive breastfeeding, and nurses verbalized the belief that Latinx parents did not feel that the colostrum (milk produced in the first few days after birth) was enough nutrition to sustain the baby. Nurses described relying on education and demonstration to try and convince their Latinx patients to exclusively breastfeed. A White labor and delivery nurse with four years of experience elaborated:

> And I realized this isn't the population that you're serving. But I try also with the Hispanic population via the interpreter when they first get admitted, if they're not in too much pain, because I found that population doesn't believe that the milk comes in until later. So they often do breast and bottle feeding. So I try to inform them that the milk is in and it's colostrum and talk to them further about that.

Nurses expected needing to encourage their Latinx patients to breastfeed in the first few days, though some also expressed concern about respecting cultural practices and beliefs. A White labor and delivery nurse with 12 years of experience explained:

> Oh 100% I mean, there's no doubt. I mean immediately comes to mind, Hispanic moms, they insist that they have no milk for the first three to five days, none pretty much until their milk comes in. So they want a bottle feed. So trying to educate and so to speak, break tradition of no, you really can breastfeed until your milk comes in and whatever. But trying to be supportive and not rewrite the laws of physics for them too. So that's always a balancing act.

Nurses stereotypes about Black patients were much more negative than those of Latinx patients. Interviewees expressed assumptions that Black parents were less persistent with breastfeeding. Even if they expressed a desire to breastfeed, nurses reported that the Black parents were easily discouraged if any problems or challenges arose. One White labor and delivery nurse with four years of experience revealed:

> I did try to help someone this morning do breastfeeding and it didn't go well for a number of reasons. I think she's just still in the recovery room from having a baby and was in a weird position and didn't really want to move. And so we couldn't get the baby in a good position to latch on either, so. But she didn't want to keep trying. It was just like, "Okay, this is not working, I'm going to be done." Whereas, I feel like sometimes other racial backgrounds maybe would put in a little bit more effort. Granted she did seem like she was a bit uncomfortable. So that's fresh in my mind, just the patient that I saw this morning.

Nurses also disclosed the belief that family was particularly influential for Black mothers and gave examples of grandmothers and female relatives discouraging breastfeeding. Those interviewed felt it was particularly important to include maternal relatives in breastfeeding education efforts. A White labor and delivery nurse with 12 years of experience expressed:

> I had ... You know with thinking about this study, I may be jumping ahead a little bit. I had an experience a couple weeks ago with a young African American woman. She was in her early twenties, and she wanted to breastfeed. And she had a room full of women….And a lot of FaceTime-ing going on, and she had kind of flat nipples, and it was her first baby, and she really didn't know what she was doing, and I was trying to help her. And there was a woman on the phone who was her aunt who was yelling at her through the phone that the baby did not want her titty. The baby wanted the bottle.

> Like yelling this at this patient while she's fumbling trying to get her baby on the breast, and I walked out of that room, and I was so frustrated, because we recently had some communication from our management saying, our patients are telling us we're not helping them enough to breastfeed. And I said, "How can I help this woman breastfeed, when she has a room full of family telling her not to?...And I feel like we do see that a little bit more in the African American sect, where the generation before didn't breastfeed. They bottle fed.

Nurses also verbalized the belief that younger Black mothers were much less likely to breastfeed, even less likely than an equally young White mother. They believe that friends and family of young Black mothers were likely to discourage breastfeeding, and that their influence was particularly strong. A mixed-race postpartum nurse with eight years of experience explained:

> Yeah. I feel like in the African American community more so, in my opinion. And I think that the younger the woman is, the more likely she is to use formula, specifically in the African American community….don't feel like I see that as much even in teen White girls versus teen Black girls. That's speaking from WIC, too. When I worked WIC, a lot of those girls, White girls would come in, and we would make plans to be like, "okay hey, we're going to take our pumps to school. We're going to have times when you're going to be able to pump for the baby." We made plans. But Black girls, it was like, "no, I'm formula-feeding. Don't even start that." A lot of that.

Nurses were particularly pessimistic about the likelihood that poor Black women would breastfeed. There was a tendency to conflate Blackness with poverty. When asked to describe if she had ever seen assumptions about a patient's race affect the patient's care, one White labor and delivery nurse, with four years of experience responding by describing her own experience:

> Sure. I mean you walk into a room and you have someone that just kind of doesn't really seem to care about much or ... I guess it's probably going to sound a little racist, but for me it's going to be those lower class African American women who just kind of seemed to like they rolled in right out of the ghetto and could care less about being at the hospital. I'm probably not going to spend as much time with those people who don't really seem interested than I would with somebody who really seems like they want to breastfeed. If that make[s] sense?

Nurses frequently engaged in othering language, describing White patients as "regular" or "mainstream", while non-White patients were "out of the ordinary". Terms such as "they", "them", and "ladies of other descents" were used to denote patients who were not White. Even nurses of

color engaged in othering language. One Black postpartum nurse with 12 years of experience explained:

> So most of ... As a lactation consultant, most of the folks that I see are Caucasian. I have a handful of Hispanic folk from various and sundry places in the world, Latin America, and I have a handful of Black people. Probably the majority of folk that I see are of the mainstream society, so probably, I don't know, 80% of folk…But I think cultural wise, ladies of other descents, they have just the knowledge deficit of, I don't have any milk right now. And then also the biggest obstacle is about feeding just for convenience.

Many nurses did recognize their own stereotypical beliefs about patients, despite describing how they often go into a room with preconceived notions about how the interaction will go. Some interviewees attributed their preconceptions to their previous clinical experiences and nursing intuition. One mixed-race postpartum nurse with eight years of experience described her interactions with patients:

> I do. I really do feel like I do that. I don't mean to, but I think that I tend to find myself saying the same things in those rooms. Like, depending on the culture. Whatever culture it is, I'll find myself speaking a narrative that I already kind of have. It took a minute to find that narrative, like what narrative works best for which culture, but I do find that I'll end up saying the same things because in those cultures, you tend to have the same problems.

At the same time, many nurses did challenge these stereotypes, citing experiences that counter their assumptions. They also express concern that preconceptions could influence nurse-patient interactions. Some nurses described their process for acknowledging and setting aside their own biases. The same mixed-race postpartum nurse with eight years of experience came back later in the interview to challenge her own biases:

> I do feel like some of that [prejudice] is being broken down. But even in just talking to you, you can already see, you can hear that when I see a Latino woman who's breast- and bottle-fed, I already have these preconceived notions of what's going to happen. Or a young African American. And it sucks, but I never try to bring that energy into the room. I always hope that whatever that notion is is wrong, a negative notion is wrong. And I've been proven wrong several, several times. If I'm walking into who I think is going to be an educated White lady who's got this down pat, she doesn't.

Explicit Racism. More explicit instances of racism were also described. Nurses described educational resources that either simply did not represent their non-White patients or made explicitly racist statements. One nurse described her frustration with some of the standard resource texts for breastfeeding in the context of a conversation with her White colleague, where the colleague was questioning the need for Black breastfeeding week. This Black postpartum nurse with 12 years of experience says:

> So I pull that [resource book] out. Who is on the cover of this book? And then there's another book we have about lactation, professional lactation, blah, blah, blah, I don't remember, and I pull that out. Who is on the cover of this book? So I said, "The reason why things have to be separate is because I don't see myself, and sometimes for me to be successful, I need to see a role model. I need to see someone that looks like me and that's not it." These are books we use every day….Yes. I don't show up in these books and that's why things need to be separate. There was no more conversation about that, but I'm still a little warm about that.

Another mixed-race postpartum nurse with eight years of experience described a nursing resource text encouraging the offer of collard greens to Black patients:

> There are lots out there. I actually ran across a book. It is so wrong. I have a screenshot from it. I ran across a book when I was at work two or three weeks ago that was sitting in the office. I was working the breastfeeding clinic that day. I was like, "oh, I have a couple of minutes." So I started reading through it, and it was just talking about recommendations of dietary recommendations for mothers who are breastfeeding. At one point, it was talking about needing to have more vitamin D or vitamin C in the mother's diet, cause we're finding, and this was published in '95, finding lots of women, we do deplete, and now we don't have enough. Cause we're not in the sun as much as we used to be, blah blah blah…So we're getting our kids more vitamin D, which is why we do supplements for our breast-fed babies. But one of them said, "for example, in the Black community, offer turnip greens." What? What? Wow. Could we get any more racist? I mean, it was amazing. So, that book is fun.

When asked, most nurses acknowledged the presence of bias on their units. The majority of the instances recounted as examples were peer to peer interactions, and nurses felt that other nurses and care providers were more likely to state their true feelings to another professional rather than

directly to the patients. Nurses described instances of hearing or seeing other nurses or lactation professionals make assumptions about whether parents would choose to breastfeed or provide formula based on stereotyping and initial impression. Nurses also recounted instances in which they felt these assumptions impacted the care given to patients, where patients who were not expected to be successful with breastfeeding were not given as much help or support, as the nurse felt this would be a waste of time and resources. When asked about witnessing a time where patients did not receive equitable care based on assumptions about race, one Black labor and delivery nurse with 8 years of experience responded:

> Absolutely. It's probably unconsciously, I would say, you know, just because I'm just going to be honest. I do feel like that most people do say... most people who have worked with breastfeeding or labor moms and that type of thing, in their experience, they probably have noticed that most African American moms aren't as excited about breastfeeding and a lot of them won't do it, or that type of thing. So I feel like they probably have made the assumption that, Oh, I'll just kind of give them a little education because they're not going to do it anyway… And especially for a younger person, so they may not even give them the opportunity to learn more about it or offer the type of support that they would for someone that they felt like is going to do it.

Another White postpartum nurse with five years of experience, when asked about when she had seen nurses make assumptions about patients' breastfeeding goals based on their race, described her own assumptions as well as actions she had seen on her unit:

> Don't we all and I really in my career I'm guilty of it. I would walk in and actually see a Hispanic mom thinking she was going to formula feed and maybe eight out of 10 times they did but having that assumption was probably not the right way to handle that. There are a few consultants and there're a few staff members I can think of that absolutely will not ... I don't want to say force their opinion but go in and if they think it's going to be a struggle and they think they're not going to be successful they automatically advocate for formula, which is to be honest here, "You're not doing it well. You have no patience. You have zero pain tolerance. No one's here to help you. You're telling me you might get formula later on. Let's just do it now," and they just shut down.

Nurses described nurse-patient interactions they observed as being less straightforwardly racist, but still asserted that the assumptions of the nurse or lactation professional affected the sort of support or recommendations that may have been offered to the parent.

Careful Language. Overall, nurses described many instances of biased behavior based on race but were very reluctant to use terms like 'racist'. Nurses tended to use very careful language when describing interactions, even when they observed and described co-workers speaking or acting in a racist or biased manner. Language was often hedged, and there was an extreme reluctance to label actions or interactions as biased or racist, with nurses insisting they could not make such a judgment of their co-workers. When asked if she could recall witnessing unequal treatment of patients based on their race, one White labor and delivery nurse with 15 years of experience asked, "Do you mean other nurses and staff?" as a clarifying question, and appeared physically uncomfortable with the question, having difficulty making eye contact and displaying body tension. She went on to say:

> Maybe some people are still holding on to some stereotypes, yes…I don't see the other nurses talking to patients. I don't see all of that. Maybe the young ones who haven't been pregnant before, or had babies or nursed, I don't know what their ... I don't know, instructions are, or education. It's hard to answer that.

When directly asked to recall an instance of healthcare injustice, she remained cautious and visibly uncomfortable, replying, "No, nothing really sticks out."

Some nurses also skirted the subject of racism and bias by focusing on how their unit had a policy of equal treatment. When asked if she had ever seen a patient getting less breastfeeding support because of assumptions based on race, one White labor and delivery nurse with four years of experience replied:

> So definitely we serve all ranges of socioeconomic status and definitely all types of cultural and race population. So we serve people who don't speak English that are from all over the world to people who were born and raised in Tennessee. We do have a large African American population as well at our hospital and it's really important to our hospital to provide fair and equal care regardless of background.

Discussion

It is important to emphasize that existing breastfeeding support interventions really do work for Black families. Though every community and individual has unique needs, effective support for parents during lactation is remarkably similar. Breastfeeding promotion practices such as skin to skin contact immediately after birth, feeding attempts during the first hour of life, keeping parents and babies together, providing specialized lactation support, and avoiding formula promotion are effective measures no matter the patient's race. Implementing breastfeeding promotion strategies in the hospital does increase breastfeeding rates. Inconsistent application of these strategies based on stereotyping and bias is racist and may be a factor in the consistent racial gap in breastfeeding initiation and continuation. When families are supported in ways that are meaningful to them, breastfeeding is an option. But if parents get a message from their hospital care providers that no one expects them to breastfeed and that breastfeeding isn't for them, if they do not see themselves in breastfeeding promotion literature or if lactation professionals are quick to offer formula, it is not surprising that they may be discouraged. The Social Ecological Model can be a useful way to organize discussion of these results.

Intrapersonal Level

On the individual level, we see that though Black parents are likely to desire breastfeeding and value information about breastfeeding, the perception of nurses is that they are unlikely to initiate breastfeeding or continue breastfeeding. This misconception on the part of nurses may very likely influence how they organize postpartum care and how they prioritize breastfeeding support.

Interpersonal Level

Discussion of the interpersonal level is the most extensive, as this study examines in depth the relationship between nurses and Black families. We find that nurses' belief in and motivation to provide breastfeeding support is consistent with findings reported by other authors. Nurses

consistently report that they do not get adequate information or experience providing breastfeeding support during nursing school. Even nurses who are confident in their skills and are motivated to provide breastfeeding support found themselves overwhelmed at times with all the demands of the nursing role. Some nurses also reported that despite policies promoting breastfeeding in the hospital there were often simply not enough resources to provide adequate support to every family.

In order to provide breastfeeding support, nurses must be familiar with best practices for supporting breastfeeding and have the skills needed to implement these supportive practices. Though the nurses in the study felt confident in their skill set, they reported that confidence came not through their nursing education but rather through their own experience or from training they sought out from peers and colleagues. Nurses must also have the time and resources to engage in supportive breastfeeding practices with every parent who desires to breastfeed. When nurses are overwhelmed or overworked, they have to make decisions about who gets breastfeeding support and who does not. Decisions about how to allocate nursing time and resources are influenced by the internal biases of the nurse making those decisions, and racism is commonly a factor, even if the nurse is not aware of this.

Though few studies examine breastfeeding support in the context of racism and bias, Thomas (2018), interviews IBCLCs and discusses their experiences and observations of breastfeeding support in their practice. Thomas' study identified themes of *implicit bias*, *overt racism*, *White semantic moves*, and *institutional inequality*. Findings regarding racial bias in this study are consistent with other studies examining racism in healthcare. While most bias and racism is found to be unconscious, explicit and intentional racism is still present. Unconscious acts of racism may seem benign, when in fact racism enacted but not acknowledged can be more damaging and difficult to identify. In this study, nurses engaging in stereotyping felt that they were only recounting their own

experiences and relying on their nursing judgment and intuition and used those conceptions to justify their own racist behaviors.

Organizational Level

On an institutional level, when hospital policies mandated supportive breastfeeding practices, nurses identified this as positive. Such policies helped them to prioritize breastfeeding support measures. Some nurses in this study worked in hospitals where breastfeeding supportive practices were part of unit policy while others did not. Due to the small sample we did not attempt to compare units that implemented breastfeeding supportive policies and those that did not, but such comparison would be an area for future research.

One of the most consistent themes in the interviews was the careful and minimizing language used to describe and qualify explicit racist statements and behaviors. Nurses in the study were very reluctant to label themselves or their colleagues as racist, and sometimes exhibited discomfort even answering questions about their observations of racist or biased behavior. However, their stereotyping and bias, whether unconscious or not, is racist, and is just as harmful to a patient as any overt action. Racism is understood by most people as bad behavior, only enacted by bad people. Therefore, if they or their coworkers are good people, they cannot be racist. The desire to avoid any accusation or mention of racism is understandable but dangerous. It is more accurate to recognize that each individual exists within a larger culture that is infused with racism and bias, and that we all carry those beliefs and sometimes enact them.

Implications for Clinical Practice and Policy

Nurses lay the foundation for future practice during their nursing education. Though breastfeeding is ostensibly promoted in nursing education, it is not prioritized in didactic or clinical experiences. This leads to nurses who may have never seen, much less learned how to support a lactating parent by the time they complete their nursing education. Accrediting bodies such as the

Accreditation Commission for Education in Nursing (ACEN) and the Commission on Collegiate Nursing Education (CCNE) should provide more precise and measurable guidelines for breastfeeding support as a core competency. In addition, national licensing exams such as the National Council Licensure Examination (NCLEX) should include more content related to breastfeeding, as nursing schools value and prioritize information that helps their students pass this licensing exam. Ensuring that nurses are well prepared and confident in their skills can help to ensure that support measures are more consistently applied to all patients.

Educational programs are also an ideal setting to engage in conversations and exploration around concepts of racism and implicit bias. Nursing education programs are still overwhelmingly White and female and are themselves often sites where racism and bias are enacted (Waite & Nardi, 2017; Thurman et al., 2019). Racism in healthcare impacts all patients of color, not only pregnant and lactating parents. Helping nurses to understand how racism pervades our culture, how their seemingly benign biases are actually racist, and how these biases impact patients' lives and health is vital.

Hospitals and nursing units should also implement education that destigmatizes discussion and awareness of unconscious bias and racism. It is difficult to make changes in attitudes and behaviors that are so taboo they are not even acknowledged. Nursing units should discuss racism and implicit bias in professional breastfeeding education and provide information on identifying and setting aside personal biases. Nurses should be taught that despite racial inequities in breastfeeding initiation and continuation rates, breastfeeding support measures are effective in reducing these inequities.

Examining racism and bias on the individual level is important, and can be helpful and illuminating, but it is also important to recognize that the larger culture of racism exists in our

policies and institutions. The largest impact on health outcomes stem not from individual change but through structural and organizational change.

On the unit level, mother-baby wards such as labor and delivery and postpartum should ensure that they protect the immediate postpartum period, nurse staffing should be maintained at a level that not only prioritizes patient safety but also provides time to engage in breastfeeding education and support. Providing adequate staffing helps ensure that nurses and lactation support professionals don't have to prioritize one patient over another. Having access to specialized lactation care is an important breastfeeding support measure, but in many parts of the country, access to IBCLCs is inadequate or absent. Consistent application of breastfeeding support practices helps to ensure equal care for all families. When nurses are making choices about where to spend their time based on their unconscious biases, unequal treatment often results.

On the hospital level, policy changes should include clear and measurable standards of postpartum care and breastfeeding support. Implementation of standardized practice bundles, for treatment of hypertension or postpartum hemorrhage, are used to reduce the incidence and mitigate racial disparities in maternal morbidity and mortality (Howell et al., 2016, 2017, 2018). In the same way, use of standardized care for breastfeeding support such as the BFHI has both increased breastfeeding rates and reduced racial disparities. Based on data from births in 2018 (CDC, breastfeeding report card), 26.1% of births in the United States occurred at BFHI facilities, but for many states the percentage was much lower. Seventeen states, mostly rural southern and western states, had rates between 10% and 20%, and an additional eleven states and territories had rates under 10%. The BFHI has improved hospital breastfeeding rates. Participation includes implementation policies and monitoring guidelines, but the cost and arduous nature of the approval process may be out of the reach of some hospitals. Programs to help defray costs and provide mentorship for interested hospitals have been tried in the past with some success. Another approach

might be for hospital credentialing agencies to require implementation of breastfeeding supportive practices as a hospital quality measure, rather than simply tracking breastfeeding statistics.

On a community support level, it is important to provide parenting and breastfeeding support in a way that is meaningful for the actual needs of families and communities. Hospitals and health departments are institutions, and as such tend to implement programs and policies with institutional priorities in mind. However, it is important to remember that serving patients is the first priority, and families should not be required to conform to programs that do not serve their needs or the needs of the community. If families are required to jump through hoops to access supportive programs, the barriers can keep families from reaching out for the help they need. Hospitals and community organizations should focus on responsive, community-based solutions such as doulas, peer counselors, and lactation consultants who are available to families on a flexible basis.

Limitations and Recommendations for Future Research

Sample Composition

Limitations of this study include the small number of non-White nurses sampled. Nurses of color have different perspectives and experiences regarding racism, and inclusion at a higher level could have brought out new themes. When recruiting participants, every effort was made to reach out to a racially diverse sample. This was done with the understanding that an individual's positioning within society impacts the way they see or experience racism and bias. In the sample, non-White nurses brought up their own experiences of racism in a way White nurses did not, but there was not a difference in the way they engaged in stereotyping patients.

Geographic specificity

Because this sample was composed of nurses from one city in the Southeastern United states, there are limits to generalizability. Though racism is certainly not limited to the Southeast or to the United States, different countries and regions have unique cultures and histories that may influence

the manifestation of racism and bias. More research is needed with nurses from different areas to understand how regional differences may impact racism and bias in nursing.

Baby Friendly Hospital Initiative

Studies that compare breastfeeding and racism in hospitals that participate in BFHI compared to those that do not may also be enlightening. It can be theorized that the guidelines required for a hospital to receive Baby Friendly designation should help to ensure that families have access to the same level and quality of breastfeeding support regardless of race. Though there has been some evidence of reduced breastfeeding disparities in Baby Friendly hospitals in previous studies, more work needs to be done that includes awareness of racism as part of the theoretical structure and research design.

Healthcare Providers

Nurses are not the only sources of breastfeeding education and support. It may be valuable to conduct studies that examine how racism affects breastfeeding support from obstetricians, pediatricians, midwives, lactation professionals, and doulas. Breastfeeding support from healthcare professionals ideally starts in the prenatal period and should continue throughout the breastfeeding relationship, so each healthcare provider along the way can have an impact on breastfeeding support.

Conclusion

Overall it is important to closely examine the incidence, impact, and reach of racism in nursing and in birth and postpartum care. Racism should be examined within the nursing profession as well as ways it is enacted in patient care. As researchers and healthcare providers our goal should be to develop education, interventions, and policies to prevent the enactment of racism and mitigate its harm.

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Table 2. Semi Structured Interview Guide with Probes

I am interested in understanding your patient population. Can you tell me about the parents you serve in your hospital?

- As you serve a diverse patient population, what similarities and differences do you see in lactation or breastfeeding initiation of patients of different races?
- Can you tell me about a time that you worked with a black or African American family to support lactation and breastfeeding?

I want you to think back to your nursing education. Did your nursing education adequately prepare you to provide lactation and breastfeeding support?

- Tell me about your confidence level in providing lactation and breastfeeding support.
- Can you tell me about the classroom instruction and clinical experiences during your nursing education that prepared you to provide lactation and breastfeeding support?
- How did your nursing education address racial differences in beliefs and practices surrounding lactation and breastfeeding?
- Which sources of information or experiences have had the most influence on how you provide lactation and breastfeeding support?

Please tell me about the measures that your hospital uses to assess a parent's need for lactation and breastfeeding support.

- What resources are available for specialized lactation and breastfeeding support? (IBCLC, LC, MD?)
- If a parent needs specialized lactation and breastfeeding support, how are those services accessed?

Now I would like to talk about your personal practices to promote and support lactation and breastfeeding. I'm interested in hearing the ways that you are able to provide lactation and breastfeeding support in your everyday practice as well as challenges that might prevent this. How do you incorporate lactation and breastfeeding support into your daily practice?

- Do you talk with every parent about providing mother's milk for their baby?
- Can you talk about a time when you worked with a parent who is unsure or undecided about lactation and breastfeeding?
- Do you have a good sense of which parents will be interested in lactation and breastfeeding and will continue providing milk for their babies for a long time? What indications are you observing and what do you think is the most predictive?
- In what ways do you tailor your lactation education and support techniques to parents according to their race or ethnicity?

Research tells us that even well-meaning healthcare providers can make assumptions about individuals based on their race or ethnicity, and that those assumptions can change the kind of care those individuals receive.

- Have you worked with nurses or lactation support staff who have made assumptions about patients' likelihood of breastfeeding success based on their race?
- How do you think these assumptions impact how nurses and lactation counselors organize their breastfeeding support during the postpartum period.
- Can you tell me about a time you saw this happen with a patient on your unit?

I am curious about any personal experiences you may have with lactation and breastfeeding. Outside of your job, in what ways have you been exposed to lactation and breastfeeding?

- Have those experiences been positive or negative?
- Have you ever breastfed?
- Did someone close to you breastfeed?

As you know, I'm trying to understand how nurses provide lactation support to black families during the first days after birth. Did I miss anything important? What else do you think I should know?

Table 3. Demographic Characteristics of Study Participants

Demographic Characteristics	**Value, n (%)**
Age, mean	37 years
Age, range	26 – 50 years
Gender	
Female	15 (100%)
Male	0
Race/ethnicity	
White, non-Hispanic	11 (73%)
Black, non-Hispanic	2 (13%)
White, Hispanic	1 (7%)
Mixed race	1 (7%)
Level of education	
Bachelor's degree	15 (100%)
Nursing Unit	
Labor and Delivery	7 (46%)
Postpartum	8 (54%)
Years of nursing experience	
1-5	7 (46%)
6-10	4 (27%)
More than 10	4 (27%)

Appendix A

Conditions Required to Secure Approval (Formerly Request for Modification)
Initial Review - Claim of Exemption

February 7, 2019

20190088-120671-1

Holly Houston
Women, Child, & Family Health Science

RE: **Protocol # 2019-0088**
"Understanding Postpartum Nurses' Breastfeeding Support for Black Mothers"

Dear Holly Houston:

Your application was reviewed on February 7, 2019. It was determined that the following issues must be addressed before you may begin your research:

1. As per institutional Information Technology Policy (https://security.publish.uic.edu/files/2014/10/20141007UIC_ITSecurityProgramFull.pdf): The Workforce, including select student employees as identified by a Unit in Policy PER.2 Job Descriptions, Responsibilities, and Training, must use university administered messaging systems (e.g. email, instant messaging, document sharing) to conduct university business. Please revise your research protocol, and especially the recruitment and consent documents, to utilize your UIC email address to conduct this research.
2. Flyers will be placed on nursing units in the Nashville, TN area, inviting nurses to participate in the study. In your cover letter responding to this letter, please document your understanding of the need to prospectively address approval requirements at each of the institution/nursing units in Nashville.

For information on creating a response to this request, please refer to the Research Training Guidelines for OPRS Live before proceeding with the instructions below.

When submitting your response upload the following via OPRS Live:

1. A cover or response letter:
   You may either:
   a. **Unlock** the *Conditions Required to Secure Approval* letter, **OR**
   b. **Copy** the IRB's conditions to a new document.

   Insert your response to each of the IRB's conditions directly beneath that item (i.e., request 1.1, response 1.1; request 1.2, response 1.2, etc.). Save the edits under a new file name and upload it with your response submission packet to the IRB.

2. For conditions that require revisions to previously submitted documents:
   a. **Upload one file** of the revised document(s) **with tracked changes, plus one file without tracked changes but with all of the changes incorporated** into the document(s).
   b. Revise (or insert) a footer on each page of each document that includes:
      1) the next sequential **version number;**

2) the **latest revision date**;
3) a **short descriptor** (to describe each document and differentiate among various documents in the same research protocol); and
4) **page numbers in the X of Y format** (Page 1 of #, Page 2 of #, etc.).

3. **Please note that only new and/or revised documents should be provided.** Previously submitted documents for which no changes have been made do NOT need to be included in the response submission.

Based on your response, the OPRS has the authority to ask further questions, seek additional information, require further modifications, or refer the research for IRB review.

Please note that you ***may not*** implement your research until you receive a ***written notice that an Exemption has been granted***.

If you do not respond to this request within 90 days of this letter, this submission will be withdrawn from the review process and OPRS will not take any further action.

If you have any questions or need further help, please contact the OPRS office at (312) 996-1711 or me at (312) 355-2908. Please send any correspondence about this protocol to OPRS via OPRS Live.

Sincerely,
Charles W. Hoehne, B.S., C.I.P.
Assistant Director, IRB #7
Office for the Protection of Research Subjects

cc: Crystal Patil

Exemption Granted

February 15, 2019

Holly Houston
Women, Child, & Family Health Science

RE: Research Protocol # 2019-0088
"Understanding Postpartum Nurses' Breastfeeding Support for Black Mothers"

Dear Ms. Houston:

Your application was reviewed on **February 15, 2019** and it was determined that your research meets the criteria for exemption as defined in the U.S. Department of Health and Human Services Regulations for the Protection of Human Subjects [45 CFR 46.104(d)]. The specific exemption category under 45 CFR 46.104(d) is: 2. You may now begin your research.

Exemption Granted Date:	February 15, 2019
Sponsor:	None
Institutional Proposal (IP) #:	Not applicable
Grant/Contract No:	Not applicable
Grant/Contract Title:	Not applicable

You are reminded that investigators whose research involving human subjects is determined to be exempt from the federal regulations for the protection of human subjects still have responsibilities for the ethical conduct of the research under state law and UIC policy.

Please remember to:

- ☐ Use your research protocol number (2019-0088) on any documents or correspondence with the IRB concerning your research protocol.
- ☐ Review and comply with the policies of the UIC Human Subjects Protection Program (HSPP) and the guidance ***Investigator Responsibilities***.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact me at (312) 413-8457 or the OPRS office at (312) 996-1711. Please send any correspondence about this protocol to OPRS via OPRS Live.

Sincerely,

Barbara Corpus
Associate Director, IRB # 7
Office for the Protection of Research Subjects

cc: Crystal Patil, Women, Child, & Family Health Science, M/C 802

Holly Houston, MSN, RN, CNM
PhD Student
University of Illinois at Chicago, College of Nursing
Department of Women, Children, and Family Health Science

1032 Horseshoe Drive
Nashville TN 37216
(601) 490-4922
hhoust2@uic.edu

EDUCATION

2013 to present	PhD in Nursing University of Illinois at Chicago College of Nursing, Chicago, Illinois Dissertation: *"I Find Myself Speaking a Narrative": Experiences of Nurses Providing Breastfeeding Support to Black Families in the Immediate Postpartum* Projected graduation, August 2020
2009	Master of Science in Nursing, Nurse-Midwifery concentration Vanderbilt University School of Nursing, Nashville, Tennessee
2006	Bachelor of Science in Nursing William Carey College School of Nursing, Hattiesburg, Mississippi

LICENSURE AND CERTIFICATION

RN LICENSE

2013	Illinois	041.411319	Inactive
2010	Alabama	1-125104	Inactive
2008	Alaska	8372	Inactive
2007	Tennessee	RN0000168649	Active
2006	Mississippi	R873955	Inactive

APN LICENSE

2017	Tennessee	23235	Active
2013	Illinois	209.010843	Inactive
2011	Mississippi	R873955	Inactive
2010	Alabama	1-125104	Inactive

CERTIFICATION

2010	American Midwifery Certification Board	#13276
2009	Neonatal Resuscitation Protocol	Active
2006	Pediatric Advanced Life Support	Inactive
2005	Basic Life Support- Healthcare Provider	Active

PROFESSIONAL EMPLOYMENT

CLINICAL

2017 to present	Connectus Health, Nashville TN, Certified Nurse-Midwife
2014-2017	Gentle Birth Care, Oak Park IL, Certified Nurse-Midwife
2014-2015	Southeast Alabama Medical Center, Dothan AL, Certified Nurse-Midwife
2013-2014	Advocate Illinois Masonic Hospital, Chicago IL, Registered Nurse
2011-2014	Rush Foundation Hospital, Meridian MS, Certified Nurse-Midwife
2010-2011	OBGYN Associates of Montgomery, Montgomery AL, Certified Nurse-Midwife
2008-2009	Monroe Carrell Junior Children's Hospital at Vanderbilt, Nashville TN, Registered Nurse, Pediatric Critical Care
2007-2008	Travel Nursing Agency, Registered Nurse, Pediatric Critical Care University of Virginia Health Systems, Charlottesville VA Providence Alaska Medical Center, Anchorage AK Monroe Carrell Junior Children's Hospital at Vanderbilt, Nashville TN
2006-2007	Blair E Batson Children's Hospital at the University of Mississippi, Jackson, MS, Registered Nurse, Pediatric Critical Care

ACADEMIC

Date	Course	Course Coordinator	Role
2016	NUPR 520: Clinical Synthesis Practicum for the Advanced Generalist Nurse University of Illinois at Chicago College of Nursing	Dr. Jennifer Obrecht	Teaching Assistant
2015	NURS 540: Issues in Advanced Practice Nursing and Policy Implications University of Illinois at Chicago College of Nursing	Dr. Natacha Pierre	Teaching Assistant
2014	NURS 210: Health Assessment University of Illinois at Chicago College of Nursing	Sue Boyer	Teaching Assistant
2014	NURS 401/402: Pathophysiology and Pharmacotherapeutics University of Illinois at Chicago College of Nursing	Dr. Karen Vucovic	Teaching Assistant
2013	NURS 210: Health Assessment University of Illinois at Chicago College of Nursing	Sue Boyer	Teaching Assistant
2013	NURS 345: Clinical Concepts and Processes in Women's and Family Health	Dr. Mary Dawn Koenig	Teaching Assistant

University of Illinois at Chicago
College of Nursing

HONORS AND AWARDS

2005	Sigma Theta Tau International Nursing Honor Society William Carey College chapter (2005) Vanderbilt University chapter (2008) University of Illinois at Chicago chapter (2014)

ABSTRACTS

2020	Experiences of Nurses Providing Breastfeeding Support to Black Families in the Immediate Postpartum. Poster Presentation at Southern Nursing Research Society Conference. New Orleans, Louisiana. Audience: Professional. ** Cancelled due to COVID_19

INVITED PRESENTATIONS

2014	Anatomy and Physiology of the Breast. Oral presentation at the University of Illinois at Chicago, College of Nursing. Chicago, Illinois. Audience: Professional.
2011	Careers in Advanced Practice Nursing. Panel Discussion. Auburn University at Montgomery School of Nursing. Montgomery, Alabama. Audience: Professional.

SERVICE

2020	Tennessee Breastfeeding Coalition – Symposium Planning Committee
2020	Nashville Breastfeeding Coalition- Administrator
2019	Nashville Breastfeeding Coalition – Community Outreach Committee
2011	American College of Nurse-Midwives Alabama Chapter- Vice President

TEACHING

2019	Amber Anderson; CNM preceptorship
2019	Jessica Elliott; CNM preceptorship
2016	Stephanie Martinez; CNM preceptorship
2015	Aimee Clark; CNM preceptorship
2015	Kelly Aten, CNM preceptorship
2011	Summer Bass, FNP preceptorship
2011	Wendy Shaw, CNM preceptorship

PROFESSIONAL MEMBERSHIP

2018	Southern Nursing Research Society
2016	Midwestern Nursing Research Society
2013-2017	American College of Nurse-Midwives Illinois Chapter

2012-2014	Mississippi Nursing Association
2010-2012	American College of Nurse-Midwives Alabama Chapter
2010-2012	Alabama Advanced Practice Nursing Association
2009	American College of Nurse-Midwives