Culturally Tailored Support to Improve Breastfeeding Initiation and Duration in Black Birthing Communities

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ABSTRACT

Introduction: Black birthing individuals have lower breastfeeding initiation and duration rates than non-Hispanic White birthing individuals. Breastfeeding provides health benefits for both mothers and infants, and increased access to breastfeeding support may help reduce disparities in infant mortality and chronic disease. Understanding perceptions, motivators, barriers, and knowledge related to breastfeeding in Black birthing communities is vital to improving breastfeeding rates. This study examined how breastfeeding experiences differed between birthing individuals who did and did not receive culturally tailored peer support.

Methods: We used an adapted, validated survey to assess perceptions of breastfeeding, and survey findings informed focus group discussions. We recruited birthing individuals who self-identified as Black and received or declined breastfeeding support within the previous year. Qualitative data were coded to identify themes and compared between groups. t tests were used to compare Likert-scale scores measuring breastfeeding beliefs and barriers between supported and unsupported groups.

Results: Twenty-one Black women (mean [SD] age, 30.1 [6.7]) participated in 3 focus groups; 13 received breastfeeding and birthing support, and 8 reported no formal support. Themes differed by support status, suggesting several benefits associated with support. Participants who received support expressed fewer concerns about pain and reported greater support from family, friends, and employers. Participants also identified opportunities to strengthen breastfeeding support, including addressing workplace barriers, enhancing family and community support, and increasing access to culturally tailored education.

Conclusions: Culturally tailored support was associated with greater breastfeeding knowledge, confidence, and perceived support among Black birthing individuals. These findings highlight the potential value of community-based, culturally tailored interventions in addressing breastfeeding disparities and improving maternal and infant health outcomes.

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INTRODUCTION

Breastfeeding offers benefits for both mothers and infants. For infants, breastfeeding reduces the risk of infections, allergies, and chronic conditions while supporting development.[1,2] For mothers, breastfeeding lowers the risk of postpartum hemorrhage, certain cancers, and type 2 diabetes and supports postpartum weight loss and bonding.[3-5] Black women have lower breastfeeding initiation (75% vs 83%) and duration (49% vs 57% at >6 months) rates than non-Hispanic White women.[6] In Milwaukee County, where 70% of Wisconsin's Black population resides, breastfeeding initiation rates are 78.6%, compared with the national average of 86.1%.[7,8] Across Wisconsin, breastfeeding initiation rates are 54% among Black women and 87% among non-Hispanic White women.[9]

These disparities stem from structural racism and sexism and encompass cultural, sociological, and health-related factors.[10-13] Our community partner addresses these disparities by promoting breastfeeding awareness, building community allies, and reducing reliance on formula.[14] Its mission is to improve maternal health, champion breastfeeding through systems- and policy-level changes, build partnerships with community allies, and provide family-centered health education and support services. These efforts align with initiatives of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). In 2016, these initiatives encouraged participants to initiate and continue exclusive breastfeeding, increased

referrals to WIC for breastfeeding support, and promoted public acceptance and support of breastfeeding.[15] These changes were implemented in response to evidence suggesting that provision of formula vouchers reduced breastfeeding initiation and acceptance among low-income populations nationwide.[16,17]

More than 80% of Black birthing individuals in Wisconsin deliver in southeastern Wisconsin, where our community partner provides services to improve maternal and infant health.[18] Mothers who receive support are significantly more likely to initiate breastfeeding, and fathers who participate in peer-led education have partners with substantially higher rates of exclusive breastfeeding.[19,20] This study examined differences in breastfeeding experiences among women who did and did not receive this level of support.

METHODS

This study employed a mixed-methods design to explore breastfeeding experiences among Black women in southeastern Wisconsin. Quantitative data were collected using an adapted, validated survey assessing perceptions, motivators, barriers, and self-efficacy. Survey findings informed focus group data collection, providing contextual insights into participants' experiences. The mixed-methods approach integrated quantitative trends and qualitative themes to provide a comprehensive understanding of how support influences breastfeeding initiation, duration, and exclusivity.[21]

Recruitment

Participants were recruited through referrals to support services from health care organizations and nonprofit partners. Women who had been referred but did not respond to outreach or participate in support services were classified as "Unsupported." Staff confirmed that these women were not receiving breastfeeding support through any other program. Three focus groups were conducted in Milwaukee, Wisconsin. All participants were less than 1 year postpartum. They were classified as either recipients of breastfeeding support ("Supported") or as women not receiving support from a community- or government-based breastfeeding organization ("Unsupported"). Of 25 invited participants, 21 agreed to participate. The first focus group was designated for Unsupported women, and 7 of 8 attended. The eighth participant was only able to attend the second focus group, which otherwise consisted entirely of Supported participants. The third focus group included only Supported participants.

Facilitation and Data Collection

Two facilitators led community-based focus groups, while a researcher documented participants' affect and nonverbal cues. The research team comprised women and nonbinary individuals, and 3 of the 4 team members self-identified as Black. The focus groups lasted 90 minutes and were audio-recorded and transcribed.

Table 1. Selected Participant Demographic Characteristics, N = 21

Characteristic	n	%	Mean [SD]
Race			
Black	21	100.0	
Sex			
Women	21	100.0	
Age, years			30.1 [6.7]
18–25	6	28.6	
26–35	10	47.6	
36–45	5	23.8	
Relationship status			
Single, no partner	5	23.8	
Partnered, living separately	9	42.9	
Living with partner	7	33.3	
Education			
No high school diploma/GED	3	14.3	
High school diploma/GED	8	38.1	
Some college	6	28.6	
College degree	3	14.3	
Advanced degree	1	4.8	
Household income			
< $50,000/year	18	85.7	
≥ $50,000/year	3	14.3	
Time since last delivery (months)	21		7.2 [2.9]
Any experience breastfeeding			
Yes	11	52.4	
No	10	47.6	
Intend to breastfeed next child			
Yes	15	71.4	
No	0	0	
Unsure	6	28.6	

Staff reviewed survey responses to identify metrics relevant to funding, program improvement, and organizational planning. A previously validated Likert-scale survey developed for Black women to assess perceived risk, benefits, self-efficacy, and barriers related to mammography was adapted for this study because of its accessible language relevant constructs.[21] At the recommendation of the community-based organization, additional questions regarding breastfeeding experiences were added while maintaining the original survey format. For example, participants were asked to rate agreement with the statement, "When I think about breastfeeding, I feel excited, happy, and/or peaceful" (Table 2).

Participants completed the survey before beginning the focus group. Two participants arrived too late to complete the survey and therefore participated only in the focus group. Aggregate survey results were projected on a screen and used to guide focus group discussion.

Quantitative Study Measures and Analysis

Participants' breastfeeding beliefs were assessed using a 5-point Likert scale measuring agreement with statements related to breastfeeding motivations and barriers.

Descriptive statistics were used to summarize responses for variables measuring perceived breastfeeding benefits and self-reported

Table 2. Adapted Survey on Breastfeeding Beliefs

Breastfeeding Questions	Support Mean [SD]	No support Mean (SD)	*P* value
For me, convenience (no need to prepare bottles with formula) is a motivator to breastfeed.	4.29 [1.25]	3.17 [0.75]	.0832
For me, losing weight is a motivator to breastfeed.	3.57 [1.62]	3.00 [1.10]	.4800
For me, the benefits to my baby's health is a motivator to breastfeed.	4.86 [0.38]	4.33 [0.52]	.0586
For me, bonding with my baby is a motivator to breastfeed.	5.00 [0]	4.69 [0.82]	.0522
For me, the benefit to my own health is a motivator to breastfeed.	4.86 [0.38]	3.83 [1.47]	.1018
For me, saving money is a motivator to breastfeed.	4.43 [0.98]	3.83 [1.17]	.3380
For me, cost is a barrier to breastfeeding.	2.29 [1.60]	2.33 [1.03]	.9514
For me, finding time is a barrier to breastfeeding.	1.86 [0.90]	2.83 [1.33]	.1441
For me, inconvenience is a barrier to breastfeeding.	2.29 [0.49]	2.83 [0.75]	.1421
For me, pain is a barrier to breastfeeding.	1.57 [0.53]	2.83 [1.33]	.0408
For me, a lack of support from family and friends is a barrier to breastfeeding.	1.57 [0.53]	3.50 [1.22]	.0030
For me, lack of support from employment or education is a barrier to breastfeeding.	2.29 [0.95]	3.33 [0.52]	.0351
For me, a lack of resources (pump, bag, refrigerated storage) is a barrier to breastfeeding.	2.14 [1.35]	2.67 [1.21]	.4794
When I think about breastfeeding, I feel anxious, depressed, upset, nervous and/or scared.	2.29 [0.49]	3.17 [0.98]	.0597
When I think about breastfeeding, I feel excited, happy and/or peaceful.	5.00 [0]	3.17 [0.98]	.0004

breastfeeding barriers. *t* tests were used to compare mean scores between groups (Stata/MP version18.5 [StataCorp, LLC]). A 2-sided *P* value <.05 was considered statistically significant.

Qualitative Data Analysis

Transcripts were analyzed using ATLAS.ti version v8.4 (ATLAS.ti Scientific Software Development GmbH). Participants were identified using randomized initials. Two research team members independently conducted open coding to identify themes and develop a preliminary codebook. Coding continued until no new codes emerged. A team codebook was then developed by consolidating codes to overarching themes. Discrepancies in coding were resolved through discussion with a third researcher until consensus was reached.

Theme Validation

One month after the focus groups, participants were reconvened for member checking. Themes and conclusions from the analysis were presented, with participants were given opportunities to provide feedback verbally and nonverbally. An executive summary was distributed to accommodate participants who preferred to review the information privately and provide feedback at a later time.

Ethical Considerations and Protection of Human Subjects

All study procedures were approved by the designated Institutional Review Board [Protocol # 00032076]. A waiver of informed consent was granted because the study posed minimal risk. Participants received an informational letter describing the study and their rights as research participants.

RESULTS

Twenty-one Black birthing individuals, all of whom identified as women/female, were included in the analysis. The mean age was 30.1 years [SD, 6.7], and most participants reported household incomes below $50,000 (85.7%). Nearly half had some college education or higher (47.6%), 33.3% lived with a partner, 42.9% were partnered but living separately, and 23.8% were single without a partner. Eleven women (52.4%) had breastfed previously, and 15 (71.4%) intended to breastfeed their next child (Table 1). Among those who had not previously breastfed, 3 had attended only 1 support event, were unsuccessful in their breastfeeding attempts, and subsequently engaged more fully in support programming while preparing for another pregnancy. Only 2 of the 8 women in the Unsupported group reported that they were considering breastfeeding during their next pregnancy.

Survey Results

Table 2 summarizes participants' breastfeeding beliefs. Compared with unsupported women, supported women were significantly less likely to identify pain ($P = .04$) and lack of support from family and friends ($P = .003$) and employers ($P = .04$) as barriers to breastfeeding. Supported women were also more likely to report positive feelings about breastfeeding ($P < .001$). Unsupported women more frequently reported negative emotions, whereas supported women more often identified infant health benefits as a motivator for breastfeeding.

Thematic Analysis

Content analysis identified themes related to barriers and motivators to breastfeeding, sources of advice and information, uncertainty and anxiety, and confidence and knowledge in breastfeeding (Table 3).

Barriers to Breastfeeding: Breastfeeding-related pain was discussed in all groups; however, supported participants generally viewed pain as preventable or manageable. Time- and work-related constraints were also discussed across groups. Workplace barriers included limited opportunities for pumping breaks,

scheduling difficulties, inadequate facilities, and lack of support from supervisors or colleagues. Outside of work, participants identified competing demands on their time, including household responsibilities, caregiving duties, and a desire for personal freedom. They described the need for support with breastfeeding techniques, maintaining milk supply, emotional well-being, and advocacy in personal and professional settings. Supported women typically described insufficient support as a barrier experienced by others rather than themselves.

Table 3. Barriers and Motivators to Breastfeed: Representative Quotes

Barriers	Quote
Pain or fear of pain	"That thing [the pump] hurt, it was almost 19 years ago, I don't know if it was the wrong size or what, but that thing hurt. And I was like, okay, I'm not pumping, I'm just going to feed my baby. I didn't like the pump at all. If I was someone that didn't know about breastfeeding and I thought – the pump, that's how this would feel, I probably wouldn't want to breastfeed." *–JS, Group 3, Supported*
Time constraints or work-related barriers	"We had to set up times and split the room or whatever it was and share the space, but it was a huge barrier for me. And really, I probably would have pumped a little bit longer if I felt like I had more support and freedom at work, to um, continue to do it but, that, that was a barrier for me for sure." *–PL, Group 2, Supported*
Motivators	
Low cost and convenience	"It's like, yeah, it's convenient, it's cost-effective, those are ALL motivators for me, anything that's gonna make my life easier in this transition to being a mom, I'm like, all for it." *—CB, Group 1, Unsupported*
Health and emotional benefits for the baby	"I never knew that. But they can have all the milk they want if it helps me lose some weight. They can have it all." *–LW Group 1, Unsupported*
Support system	"Not just education in the Black community, and within the Black community and support from the Black community to the Black community, but also systems we use. Whether that's stores, public events that we frequent, but systems changing in the medical profession so that they honor our bodies and our decisions to support our babies with our milk." *–RJ Group 3, Supported*
Beautiful and natural process	"it's magical, because, like, my body makes food for my baby, and it didn't have to grow out of the ground, you know, and just I mean all of the science-y stuff behind it, but it's also magical. Like, the oxytocin, and you know, I could be so mad about something, like, girl come get on your booby, and after a few minutes, I'm like, all right, that's fine, everything's fine (laughter)." *–EB, Group 3, Supported*

Motivators to Breastfeed: Unsupported women most commonly identified low cost and convenience as motivations for breastfeeding. Participants perceived the costs associated with formula and supplies for bottle preparation to be substantially greater than those associated with pumping equipment and milk storage. Among supported women, motivations included maternal-infant bonding, nutritional and immune benefits for the infant, and maternal benefits such as weight loss and chronic disease prevention. Many supported women also spoke about the beauty and naturalness of breastfeeding, the importance of celebrating it, and their commitment to breastfeeding despite potential barriers.

Sources of Advice about Breastfeeding: Women in all groups discussed their experiences obtaining breastfeeding information and their perceptions of various sources of information. Unsupported women relied heavily on observations and advice from family members and friends. Participants across groups expressed both positive and negative views of individual health care providers. Some reported strong trust and confidence in their clinicians and relied on them for guidance. However, perceptions of the health care system overall were generally negative. Women frequently shared personal experiences of family members as reasons for general distrust of the health care system (Table 4).

Uncertainty and Anxiety About Breastfeeding: Unsupported women expressed uncertainty regarding breastfeeding techniques, including latching and pumping. They reported concerns about pain, cost, supplies, latching, breastfeeding with piercings, and the potential effects on intimacy with a partner. Although most recognized that breastfeeding was less expensive than formula feeding, many were uncertain about proper breast milk storage and appropriate formula supplementation. Unsupported women generally understood that breastfeeding benefits infants but often could not identify specific benefits. Some were unaware of maternal health benefits associated with breastfeeding. Participants also described employers who failed to provide adequate space, storage, or time for pumping. Although several examples suggested potential violations of workplace protections, unsupported women generally demonstrated limited awareness of their breastfeeding rights.

Confidence and Knowledge About Breastfeeding: In contrast, supported women demonstrated greater knowledge and confidence regarding breastfeeding. They used appropriate terminology for breastfeeding techniques, benefits, and advocacy. Responses regarding cost and preparation were detailed and differentiated between breastfeeding, formula feeding, and pumping. Additionally, they spoke confidently and accurately regarding workplace breastfeeding protections and described advocating for these rights in employment settings. These participants expressed conviction and pride when discussing their commitment to breastfeeding rights, initiation, and exclusivity. Several noted that the maternal-infant bond alone would have motivated them to breastfeed regardless of any other benefits or deterrents (Table 5).

DISCUSSION

This study demonstrates that women who received support expressed greater confidence in breastfeeding. Although participants reported varying levels of support, themes of uncertainty were more common among women who received less support.

While women in all groups indicated that pain was a barrier, only unsupported women expressed fear of pain and identified it as a personal barrier to breastfeeding. These findings were consistent with the quantitative results, in which pain was identified as a significant barrier only among unsupported women ($P = .04$).

It is important to contextualize these findings within broader clinical patterns related to pain and breastfeeding difficulty. Nipple pain is a common reason for breastfeeding cessation. It is often associated with inflammation resulting from to incorrect latching and too much force on the nipple during lactation.[22] Studies indicate that 40% to 70% of mothers experience breastfeeding difficulties, including sore or cracked nipples and pain.[23] These issues have been associated with lower breastfeeding self-efficacy and reduced self-perceived knowledge.[24] Continued, tailored breastfeeding support through professional guidance or community-based programming may be needed to ensure women learn proper latching techniques and feel confident in their breastfeeding abilities.[25]

Unsupported women frequently identified time constraints as a significant barrier to breastfeeding, both at work and at home. One participant worked on construction sites without access to clean, running water. Another worked in food service and could not take breaks. Addressing such barriers will require systems-level changes, including employer education, workplace assessments, and clear standards for breastfeeding accommodations.[26,27] In occupations where breastfeeding is difficult to incorporate into traditional workplace schedules, colleague support has been associated with longer breastfeeding duration and greater exclusivity.[28]

Although supported women report greater confidence in advocating for workplace rights, opportunities remain to improve advocacy on behalf of birthing women. As of 2020, 25 states had enacted workplace breastfeeding legislation that allows mothers to express and store breast

Table 4. Sources of Advice About Breastfeeding: Representative Quotes

Source	Quote
Family and friends	"But my mom and my aunties, they always use Similac. They said that was the best formula, so I was going to go with that. At the end of the day, it is my decision, but I don't really know." *–TM, Group 1, Unsupported*
Government-sponsored programs	"I don't believe the people [government office]. I don't." *–CB, Group 1, Unsupported* "She told me she never breastfed so how you gonna tell me?"*–LW, Group 1, Unsupported*
Community programs	"How she [community partner leader] teaches us breastfeeding, the differences between what formula have [sic] in it, what breastmilk have [sic] in it, the position, all I knew was I was just holding my baby in the cradle, the crosshold, I didn't know all of that. I was just doing it before and now I'm educated." *–HC, Group 2, Supported*
Health care providers (positive)	"I was just gonna say having a good relationship with your doctor is, is important. Um, having a doctor that you can trust, confide in, um, that actually listens to what you're saying, someone you can, I mean, my doctor, I can literally FaceTime her." *–DD, Group 2, Supported*
Health care providers (negative)	"They value business over the people. That's how I look at it, that's been my experence like my parents are on all these types of medications for the same thing, but no one's dealing with the initial issue." *—KS, Group 3, Supported*

Table 5. Uncertainty and Confidence in Breastfeeding: Representative Quotes

Uncertainty/Anxiety	Quote
How to breastfeed:	"I feel like there's a lot of questions like is the baby getting enough food, I don't know. Cuz my sister's baby, when she was breastfeeding, she breastfed him, give him some milk, then he like hungry soon as he got off it, like screaming to the top of his lungs, so I don't know." *—SP, Group 1, Unsupported*
Cost, preparation, and supplies	"They say that babies clench on, and sometimes they don't take it, so if they're not taking it, what do you do if they don't want it? Then how do we know what formula to give them if they don't clench on?" *–ML, Group 1, Unsupported*
Health benefits	"Helps baby not being sick so often and stuff like that…but you're gonna be sick one day in your life, ain't you? They gonna get chicken pox, they gonna be sick, so I mean why is it they gotta suck on you just to not be sick?" *–LW, Group 1, Unsupported*
General unease	"It makes me nervous cuz I don't know what it's gonna feel like, that's the main thing. I don't know how it's gonna work." *–TM, Group 1, Unsupported*
Workplace rights	"At my last job, I went and they told, and I sat there and told them, like you know, about maternity leave. They were like, uh we don't do maternity leave, you just have to leave. Okay, I'll just leave right now if that's how y'all feel like. I'm not gonna work for y'all." *–ML, Group 1, Unsupported*
Confidence/Knowledge	**Quote**
How to breastfeed	"People call me and say, 'my baby, they're forcing me to give him formula, my baby's not gaining weight, they didn't tell me to massage my breasts so that I could integrate the hind milk with the foremilk and my baby can get calorically rich milk'." *—SS, Group 3, Supported*
Cost and preparation:	"When I used to pump, and it wasn't a lot, but it took a lot of energy to make sure that I had enough bottles cleaned. I had to clean the bottles, store milk for her, I had to make sure that the milk was coming correctly, it was just a whole lot of extra stuff that I didn't have to do when I was just breastfeeding. I was just there, no bottles, no fuss." *–EB Group 3, Supported*
Workplace rights	"Then when I got into the workplace, they didn't have any space for me to pump, and so I had to advocate for myself based on the standard with the law that they need to provide me with space to pump, it needs to be private, it needs to have access to running water, I need to be able to pump as many times as I need to and they are not included in my breaks." *–MG, Group 3, Supported*
Positivity and commitment:	"I think it's invigorating because you get that connection with the child, you get that connection with kind of like the world at the same time. You, you're like the tree, and they are like the roots, or you're the roots, and they're the tree. You just grow with your child a little bit more." *–RJ, Group 3, Supported*

milk at work, contributing to improved breastfeeding rates.[29,30] All participants reported work-related barriers. However, supported women appeared more confident about navigating their rights in the workplace. While barriers persist, support may equip women to manage these challenges more effectively ($P = .0351$).

Participants also described limited or no support within their households, competing caregiving responsibilities with other children, and being too tired to devote time to breastfeeding. Nationally, breastfeeding rates are lower among single-parent household and those with lower socioeconomic status.[31,32] Research examining breastfeeding perceptions among women of socioeconomic status has identified positive influences such as shared narratives, improved knowledge, and a supportive social networks, whereas negative influences include lack of guidance, opinions from family and friends, limited support, and conflicting messages from health care professionals.[33]

Unsupported women recognized that breastfeeding benefited infant health but often could not describe specific benefits. In contrast, supported women easily listed the health benefits of breastfeeding and identified their personal motivations with conviction and pride. Notably, only the focus group composed entirely of supported women discussed breast cancer risk reduction as a benefit of breastfeeding. Although greater knowledge does not necessarily translate into stronger motivation, it may help women determine what matters most to them. These findings are consistent with previous research demonstrating that women who are more knowledgeable about the mechanics, benefits, and challenges of breastfeeding are more likely to feel confident in their ability to breastfeed, which is associated with longer breastfeeding duration and greater exclusivity.[34,35]

A notable difference between groups was the extent to which women relied on anecdotal information from their friends and family, with reliance inversely related to support. Unsupported women frequently referenced others' experiences rather than drawing on personal knowledge, whereas supported expressed confidence in their own expertise. In some cases, referencing the experience of friends led to more questions. One unsupported woman referred to friend who claimed that breastfeeding hurt, but she had heard from another source that pain occurred only if breastfeeding was done incorrectly, and she did not know who to believe. Similar studies have shown that social networks play an important role in shaping breastfeeding beliefs and behaviors, particularly among Black women and women with limited access to culturally responsive care.[36,37] When trusted information from health care systems is unavailable or inconsistent, family narratives may fill the gap, even when inaccurate or outdated. Community-based organizations can bridge these gaps by providing accurate, culturally relevant information in trusted settings.

Supported women exhibited clear, confident beliefs and were better equipped to evaluate conflicting information and make informed breastfeeding choices. These findings are consistent with broader evidence demonstrating that breastfeeding self-efficacy is influenced by factors including birth preparedness, socioeconomic conditions, anxiety, and relationship status.[38] Although the Breastfeeding Self-Efficacy Scale was not used in this study, it may be valuable in future research to better tailor breastfeeding support strategies.[39]

Differences in perceptions of health care providers emerged across all focus groups, regardless of support status. Although participants sought information from physicians and other clinicians, distrust of individual providers and the health care system was prevalent. Participants frequently described providers as "disconnected" from the realities of their daily lives. Even women who were happy with their own clinician reported difficulty finding providers with similar values or cultural backgrounds. A previous study of 130 Black mothers similarly identified gaps in breastfeeding education and support throughout pregnancy, childbirth, and the postpartum period and emphasized the importance of trust, continuity of care, and consistent breastfeeding education.[40] While support programs do not replace health care professionals, they may help bridge these gaps by connecting women with individuals who share common experiences and values. Participants also express frustration when breastfeeding guidance came from individuals without personal breastfeeding experience.

Overall, these findings suggest that community-tailored breastfeeding support may improve confidence, knowledge, and attitudes toward breastfeeding. Such support may empower women to make informed decisions, advocate for their needs, and promote breastfeeding within the Black birthing community.

Strengths and Limitations

This study highlights the strengths of a culturally tailored and community-centered approach to breastfeeding support among Black birthing individuals. A key strength was the use of a mixed-methods design, which integrated quantitative trends with qualitative insights to provide a comprehensive understanding of breastfeeding experiences. Partnering with a community-based organization facilitated culturally tailored, person-centered care and enhanced participant trust and engagement. However, the study was limited by its relatively small sample size, which may limit generalizability, and by possible self-selection bias, as supported participants may have been more motivated or had greater access to resources.

Future Directions

Focus groups were conducted in late 2018, and data were analyzed in 2019. Following the onset of COVID-19, our community partner prioritized transitioning to virtual services and ensuring the safety of birth workers. Data from this study have informed multiple funding proposals, and our partner has continued to expand its reach and support services. Future efforts should focus on broad

dissemination of these findings and program successes to support other community-based organizations working to improve breastfeeding initiation, duration, and sustainability.

CONCLUSIONS

This study demonstrates the impact of culturally tailored support on breastfeeding knowledge and intentions among Black/African American birthing individuals. Supported women expressed fewer concerns and demonstrated greater understanding of breastfeeding benefits and breastfeeding-related rights. These findings highlight the importance of community-driven interventions that provide comprehensive, person-centered care. Community-based breastfeeding support programs may offer a replicable approach for reducing breastfeeding disparities and improving maternal and infant health outcomes.

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