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Black Fathers' Views on Breastfeeding Facilitators, Barriers, and Support Services: Insights From a Qualitative Community-Based Participatory Research Study

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ABSTRACT

Despite the persistence of breastfeeding racial and ethnic disparities in the United States, little is known about Black fathers' perceptions of breastfeeding and breastfeeding support services (e.g., maternity hospital-based care and lactation management care). This qualitative, community-based participatory research study reports Black fathers' perceptions of barriers and facilitators to breastfeeding, including the provision of breastfeeding support services in Connecticut. A focus group guide was co-developed with community partners and adapted from the Barrier Analysis Tool to identify breastfeeding facilitators, barriers, and service improvement areas. Four focus groups were conducted with 30 Black fathers who were Connecticut residents with a child under 3 years old. Qualitative data were analyzed using rapid template analysis involving deductive and inductive coding. We identified factors influencing breastfeeding and fathers' ability to support breastfeeding across all levels of the Socio-Ecological Model. Facilitators included high paternal breastfeeding knowledge, paternal breastfeeding involvement, parents' shared decision-making, extensive maternity hospital discharge support, ongoing breastfeeding support into the postnatal period, availability of community breastfeeding resources, and designated spaces for public breastfeeding. Barriers included low paternal breastfeeding knowledge, familial discouragement, insufficient prenatal breastfeeding education, exclusion of the father from breastfeeding support services, and stigma against breastfeeding in public. Understanding breastfeeding perceptions among members of a mother's support network, including their partners, is key for developing effective person- and family-centered breastfeeding education and counseling services that are well coordinated from the prenatal to postnatal periods with strong direct engagement from fathers.

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Summary

- Black fathers in Connecticut and their partners experience barriers to successful breastfeeding, especially access to effective breastfeeding support across levels of the Socio-Ecological model.
- Lack of paternal knowledge about breastfeeding, familial discouragement, insufficient breastfeeding education, and social stigma were identified by fathers as key barriers to supporting breastfeeding.
- High paternal knowledge about breastfeeding, generational breastfeeding, engagement of the father by breastfeeding education services, and designated spaces to breastfeed in public were identified by fathers as key facilitators to supporting breastfeeding.
- Effective breastfeeding promotion will require a multifaceted approach that addresses barriers to breastfeeding from the individual to community levels, with the inclusion of fathers across the continuum of care.

1 | Introduction

Breastfeeding is widely recommended by health organizations as the optimal infant feeding method due to the constellation of health benefits it offers both mother and child. Breastfed infants have improved cognitive development and a reduced risk of mortality; chronic conditions like asthma and obesity; and acute illnesses like sudden infant death syndrome, upper respiratory tract infections, and diarrheal diseases (Bartick et al. 2017; Li et al. 2022; Pérez-Escamilla et al. 2023). Mothers who breastfeed can lower their risk of hypertension, cardiovascular disease, type 2 diabetes, and ovarian and breast cancer (Binns, Lee, and Low 2016; Tschiderer et al. 2022). However, despite a lack of racial/ethnic disparities in mothers' desire and intent to breastfeed, disparities persist in breastfeeding initiation and retention among non-Hispanic Black mothers (84.0%), when compared to non-Hispanic white mothers (88.4%) or Asian mothers (93.1%) (Hamner et al. 2021).

The lower rate of breastfeeding among Black mothers has been widely researched, revealing several barriers to breastfeeding, including cultural stigma, inaccessible or culturally insensitive lactation support, economic and employment characteristics, medical provider bias, and segregated health resources (Davis et al. 2021; Griswold et al. 2018; Gyamfi et al. 2021; Tran et al. 2023). For Black mothers, schemas of oppression intersect with each other, creating a unique set of barriers resulting from the joint experience of being both Black and a woman, experiences further compounded when individuals also have low socioeconomic status (Davis et al. 2021; Gyamfi et al. 2021; Tran et al. 2023). Conversely, one key facilitator gaining interest but for which there is a dearth of studies is the role of paternal support in breastfeeding (Rempel and Rempel 2011; Tomori et al. 2022).

Research suggests that paternal support during breastfeeding influences overall breastfeeding practices. First-time mothers who receive support in the early postpartum period of breastfeeding from their partners are more likely to continue breastfeeding after leaving the maternity hospital (Hunter and Cattelona 2014). Paternal support perceived to be responsive to the mother's needs was associated with a longer duration of breastfeeding and mothers' higher overall satisfaction with breastfeeding (Rempel et al. 2016). Several intervention-based studies have empirically confirmed the positive influence of father-based education programs, support groups, and peer-to-peer counseling on breastfeeding practices (Baldwin, Bick, and Spiro 2021; Bich, Long, and Hoa 2019; Furman et al. 2016).

A limited number of studies have provided insight into fathers' roles in, knowledge of, and attitudes toward breastfeeding (Ayton and Hansen 2016; Giugliani et al. 1994; Henshaw et al. 2021; Merritt et al. 2019; Tohotoa et al. 2009). However, these efforts have largely overlooked the unique experiences of fathers within the broader context of breastfeeding disparities identified in research. To address this gap, this study employed a community-based participatory approach to explore the perspectives of Black fathers on breastfeeding, breastfeeding support services, and factors influencing their views.

This study involved collaboration between the Community Alliance for Research and Engagement (CARE) and two community organizations dedicated to supporting breastfeeding and parenting in Connecticut, New Haven Healthy Start and Real Dads Forever. CARE is co-housed at Yale University School of Public Health and Southern Connecticut State University. The results of this study will support the development of breastfeeding promotion initiatives by the New Haven Breast/Chest Feeding Task Force to inform efforts at local hospitals and in the community.

1.1 | Study Aims

To support the overall study aim of informing the development of breastfeeding promotion interventions by exploring Black fathers' perceptions of breastfeeding and breastfeeding support services, the researchers sought to: (1) describe Black fathers' experiences with individual, community, and systemic factors influencing breastfeeding; (2) assess perceived influencing factors as either facilitators or barriers to breastfeeding; and (3) outline recommendations to improve statewide breastfeeding support offered by formal support services.

2 | Methods

2.1 | Design

The study design expanded on the methods used in Tran et al. (2023), a prior qualitative study on Black mothers' perspectives on breastfeeding, by integrating practices from community-based participatory research to inform community interventions.

The focus group guide was developed by an interdisciplinary research team, including leaders of community parenting

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organizations. The focus group guide was adapted from an interview guide developed by Tran et al. (2023) and the Barrier Analysis Tool (Kittle 2017). The Barrier Analysis Tool draws from several theories of behavior change to identify determinants associated with a health behavior of interest. Participants were asked questions related to the following breastfeeding determinants: self-efficacy, susceptibility, positive consequences, negative consequences, social acceptability, access, divine will, and policy. The guide was further modified for clarity and cultural relevance after review by a breastfeeding-focused Community Advisory Board of Connecticut residents. The final focus group guide sought to capture fathers' experiences with breastfeeding, factors that influenced views on breastfeeding, and recommendations to improve available breastfeeding support services (see Appendix, Figure 1 for the guide).

This study was deemed exempt by the Institutional Review Board (IRB) at Yale University under (*Category 2*) 45 CFR 46.104(d)(2) exemption by meeting the following criteria: (1) Disclosure of the participants' responses could not reasonably put subjects at risk of liability or damage their financial standing, employability, or reputation; and (2) Information obtained cannot be used to identify participants, either directly or through identifiers.

2.2 | Setting and Relevant Context

This study was conducted in New Haven and Hartford counties in Connecticut, where Black residents represent 17.5% and 18.1% of the population, respectively (U.S. Census Bureau 2020).

2.3 | Participant Recruitment

The following criteria were used for participation in this study: self-identification as a father to a child under 3 years old or expectant father to a child due within the next 6 months, self-identification as Black, Connecticut resident at the time of their child's birth, over 18 years old, and has or had a partner who ever breastfed their infant. Recruitment involved outreach by maternal and child health community-based-organization partners to their membership base of fathers. Depending on availability and relationship with community partners, participants were assigned to one of four focus groups. Traditionally, fathers are difficult to engage in breastfeeding research. Thus, convenience sampling best-facilitated recruitment by leveraging existing relationships between the community organizations and their member base. Based on prior studies, most notably Tran et al. (2023), code and meaning saturation were estimated to be achieved after three or four groups of 6–8 participants.

2.4 | Data Collection

Data were collected via semi-structured focus groups of 5–10 participants, approximately 90 minutes in length, conducted over Zoom. Each focus group was moderated by 1-2 facilitators and 1 notetaker. The facilitators were leaders of community parenting organizations and themselves Black fathers, which encouraged participant engagement and sharing of experiences. Sessions were audio recorded and transcribed. One session was not audio recorded due to researcher error. Instead, verbatim notes recorded by a session notetaker during the focus group and reflective notes from two facilitators recorded immediately after were used in place of a transcript. Participant characteristics including age, parity, and breastfeeding history were recorded through surveys administered before the focus group.

Conducting focus groups via Zoom had benefits including increased accessibility for participants, cost-effectiveness, and the convenience of overcoming geographic limitations. However, challenges related to decreased interaction quality and variable participant engagement were anticipated. To address these concerns, the focus groups opened with informal introductions, participants were encouraged to keep cameras on, and the facilitators actively encouraged discussion throughout the session. Additionally, ground rules were set to establish confidentiality between participants and address how researchers were keeping data from the focus groups secure.

All participants provided verbal informed consent to participate and be audio recorded. No personal identifying information that could be linked to the data was collected. Data were anonymized and stored on a secure password-protected network drive, accessible only to the research team.

2.5 | Data Analysis

Demographic characteristics of the sample were analyzed using SAS 9.4. Qualitative data were analyzed via rapid template analysis and involved both deductive and inductive coding. Microsoft Word 16.2 was used to manage the rapid template analysis (Hamilton 2013). Rapid template analysis was chosen to promptly return results to community partners to inform strategic planning and intervention priority setting to improve facility-based breastfeeding support services (Johnson and Vindrola-Padros 2017).

A templated summary was created after review of the focus group guide to synthesize participants' responses as they corresponded to analytic questions of interest (see Appendix, Figure 2). The summary questions were related to health behavior determinants (e.g., perceived self-efficacy, perceived risk) as adapted from the Barrier Analysis Tool (Kittle 2017). Using the template, research team members independently reviewed each focus group transcript and identified quotes that related to each summary question. The analysis team then met to discuss discrepancies and form a consensus to create a combined template analysis of all focus groups. Next, emergent themes and representative quotes were pulled from the template summary analysis and mapped onto the Socio-Ecological Model, consistent with Tran et al. (Bronfenbrenner 1977; Tran et al. 2023). In the final focus group, themes identified in the prior focus groups were repeatedly represented, indicating adequate data saturation, and no need for further data collection (Saunders et al. 2018). Final themes were agreed upon by the interdisciplinary research team.

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TABLE 1 | Focus group participant characteristics.

Characteristic	*N* (%)
Age (years)	
18–24	2 (6.7)
25–34	19 (63.3)
35–44	7 (23.3)
45–54	2 (6.7)
County of residence	
Hartford County	5 (16.7)
New Haven County	25 (83.3)
Education	
High school graduate	13 (43.3)
At least some college	12 (40.0)
College degree or beyond	5 (16.7)
Marital status	
Married	14 (46.7)
In a domestic partnership	7 (23.3)
Never married	9 (30.0)
Number of children	
0 (Expecting)	1 (3.3)
1-2	19 (63.3)
3-4	9 (30.0)
≥ 5	1 (3.3)
Expecting newborn (in next 6 months)	
Yes	4 (13.3)
No	26 (86.7)
Partner's breastfeeding history	
Successfully breastfed[a]	23 (76.7)
Has not successfully breastfed, plans to	4 (13.3)
Has not successfully breastfed, does not plan to	3 (10.0)

[a]Successful breastfeeding includes *any* breastfeeding that met parents intended feeding plan (e.g., exclusive breastfeeding, combination breast milk and formula).

3 | Results

3.1 | Sample Characteristics

In total, 30 fathers participated in four focus groups (see Table 1 for participant characteristics). Each focus group had 5–10 participants. Per study design, all participants self-identified as Black, fathers or expectant fathers to a child under 3 years old, and residents of Connecticut at the time of their child's birth or expected birth. All except one (an expectant father) had prior experiences with breastfeeding, and some had partners who used a combination of breastfeeding and formula feeding to help mitigate breastfeeding challenges. Additional characteristics are included in Table 1.

Fathers identified various facilitators and barriers to successful breastfeeding at the individual, interpersonal, institutional, and community/policy levels (Figure 1). Identified themes within each domain are explained below, and exemplary quotes from the focus groups are shared in Table 2.

3.2 | Individual–Level Factors

3.2.1 | Knowledge of Breastfeeding Benefits

> *"The more information we got, the better we felt, and the more equipped we were to make our decision."*

Nearly all fathers stated their top considerations in the decision to encourage breastfeeding were the benefits of breastfeeding. Some fathers had detailed knowledge of them, stating that breastfeeding enhances the baby's immune system, promotes digestive health, advances brain development, makes the mother happier, relieves engorgement, and increases the mother–baby bond. Further, several participants described formula as less beneficial than breast milk, citing concerns about constipation, malnutrition, formula recall scares, and adverse reactions to formula.

Although most did not have detailed knowledge about breastfeeding benefits as described above, nearly all participants characterized breastfeeding as healthy, nutritious, and natural. Some fathers identified practical benefits of breastfeeding, like saving time and money. Still, others recognized the benefits for the baby but were not as familiar with the benefits to the mother.

A few participants admitted they did not know much about breastfeeding benefits. One father whose child was formula-fed described uncertainty around the benefits of breastfeeding compared to formula (see Table 2, Barriers—Father has low breastfeeding knowledge).

3.2.2 | Assumed Role in Breastfeeding

> *"No, I didn't think anything like [dads have a role in breastfeeding] … it's more of a role [for] the women, but when the child came that's when I saw it's a role for both genders."*

When asked about their role in breastfeeding, fathers often described providing their partners with a mix of different types of breastfeeding support. Some fathers described direct involvement in breastfeeding as a secondary feeder for the infant. Examples of direct involvement include bottle-feeding expressed milk, taking over nighttime feeding duties to let the mother rest, assisting with breastfeeding tools like pumps, and actively seeking information about breastfeeding through research.

Others acted as a support system by creating a positive environment for the mother to breastfeed, and fathers described this type of paternal support as minimizing the risk for negative consequences like emotional exhaustion, increasing the mother's self-confidence concerning breastfeeding, and expanding the mother's time affluence by taking over household duties.

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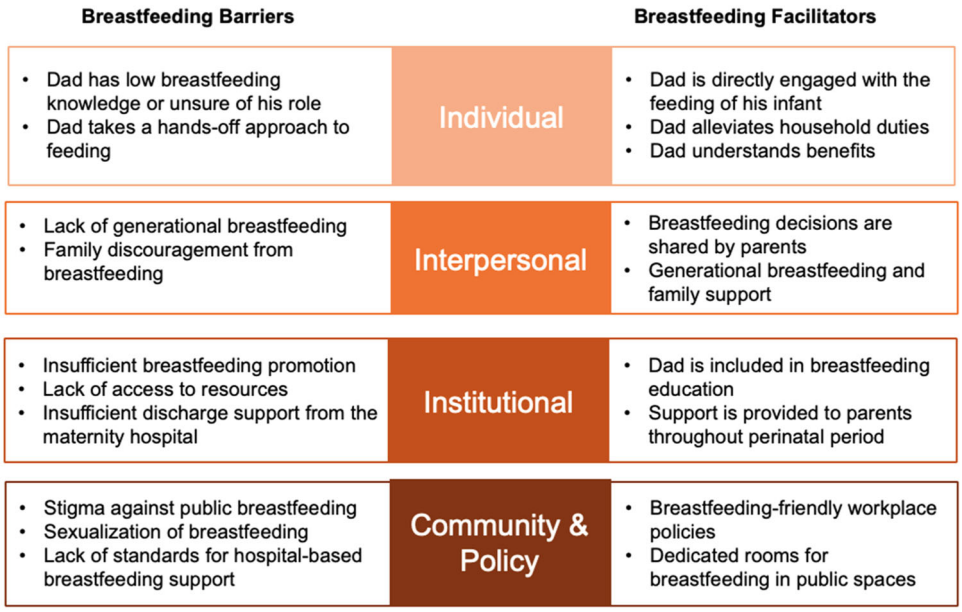


FIGURE 1 | Fathers' identified breastfeeding barriers and facilitators mapped onto the socio-ecological model.

Only one father expressed nonparticipation in breastfeeding, describing breastfeeding as a solely maternal responsibility until his child was born.

3.3 | Interpersonal-Level Factors

3.3.1 | Shared Decision-Making

> *"We both attended classes. We both found stuff on our own time and shared with one another and shared articles. ... We wanted to make the best decision together."*

Participants had a wide range of involvement in the decision to breastfeed. Shared decision-making appeared to influence breastfeeding by pooling both parents' knowledge and attitudes toward breastfeeding. Those who had discussions about the decision to breastfeed before childbirth discussed breastfeeding benefits, plans, and anticipated potential complications to increase readiness and effectiveness against barriers. Other fathers understood breastfeeding as natural and assumed it was the correct action to take despite never explicitly discussing it with their partners. Many felt they had some say in the breastfeeding decision-making process and discussion but highlighted that it was ultimately the mother's decision, as it was her body.

3.3.2 | Familial Support and Generational Breastfeeding

> *"Certain family members didn't really understand the necessity of breastfeeding because they either didn't know what value it had or they just felt uncomfortable."*

Female family members, particularly mothers and mothers-in-law, were identified as primary sources of breastfeeding support for many participants, providing encouragement and remedies for breastfeeding issues to new mothers. Other participants recalled active discouragement from family members who were unaware of the benefits or uncomfortable with breastfeeding. Participants with discouraging familial experiences described these as difficulties or challenges they had to navigate.

The source of most participants' knowledge about breastfeeding before becoming a father was generational breastfeeding (i.e., having a mother or aunt who breastfed). As a result, many fathers described breastfeeding as a natural way to feed infants, positively influencing their desire to breastfeed their children. A few participants were not exposed generationally to breastfeeding in their family growing up, limiting their knowledge of breastfeeding techniques and benefits.

3.4 | Institutional-Level Factors

3.4.1 | Varied Access to Quality Breastfeeding Information and Education

> *"[My wife] had trouble breastfeeding, so she felt like something was wrong with her. But, really what it was, was that no one ever properly showed her how to get the milk out."*

> *"We took classes to see the benefits of breastfeeding. ... That was a lot of the knowledge that we just carried on to each child after that."*

The types of formal breastfeeding support services accessed by parents were numerous, including parenting classes, maternity hospital-based care, and lactation specialty care. Participants' perceptions of these formal breastfeeding support services differed greatly, primarily related to accessing sufficient breastfeeding information and the quality of the support received.

Related to preparedness and planning, participants had a vast range of information and education. Some fathers reported they

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TABLE 2 | Identified breastfeeding facilitators and barriers with exemplary quotes.

Socio-ecological model level	Facilitators	Exemplary quote(s)
Facilitators to breastfeeding		
Individual	Father is knowledgeable about breastfeeding	*It does help with calorie burning for the mom too. It helps get a lot of their baby weight off. I did a lot of, obviously research on all this stuff and it's something that I had to learn because I didn't know any of this stuff either. … And versus formula nutrition wise, if you look up the nutritional value for formula versus breast milk, there's almost an infinite amount of nutritional value in breast milk and there's [much less nutritional value in] formula.* (Participant 07, Focus Group 2) *The more information we got [about breastfeeding], the better we felt, and the more equipped we were to make our decision [to breastfeed].* (Participant 07, Focus Group 2)
	Father is directly involved in breastfeeding	*Because the baby kept on waking up at odd hours … we decided [that] my wife [would] pump milk into … a breast milk bottle. … We scheduled my time for feeding the baby. I fed the baby during the wee hours of the night. … It was my duty to feed the baby at night hours so that my wife [could] get … enough sleep and [be] able to go to work … and … be productive.* (Participant 02, Focus Group 2)
	Father is indirectly involved in breastfeeding	*My role was to tell her [to] drink water. … Encouraging her to do those things. … My advice for other fathers would be [that] it's more of an emotional support. There's nothing physical I think you [can] do [to support breastfeeding] … but it's encouraging the mom to be patient in case there's any issues. And that's what I would say, be encouraging, be helpful, especially in the emotional side of things, if there's issues there.* (Participant 06, Focus Group 2)
Interpersonal	Shared decision-making	*It was both of us. We both attended classes. We both found stuff on our own time and shared with one another and shared articles and stuff like that. Like I said, we wanted to make the best decision together instead of it just be [ing] like, well, you know what, [let's choose] formula. And [formula] really isn't the best thing for [your] baby.* (Participant 07, Focus Group 2) Some fathers had explicit conversations with their partners. These fathers specifically referenced preparation in case of complications like postpartum depression and breastfeeding issues. (Notes, Focus Group 3)
	Familial support	*The biggest support we got was from my mother. She encouraged [my wife] to breastfeed.* (Participant 04, Focus Group 2)
	Generational breastfeeding	*My mother always tell[s] me that I was always … breastfeeding. I was always breastfeeding, not using the formula. So we just learn[ed] from the family background … that we need to give [breast milk] to our children. The best way to get our children to be fit and … healthier is … to [breastfeed] them.* (Participant 10, Focus Group 1)
Institutional	Community breastfeeding support services	*We took classes to see the benefits of breastfeeding. … They showed us the whole chart, everything, so we prepared a lot for our first child. … That was a lot of the knowledge that we just carried on to each child after that.* (Participant 07, Focus Group 2) *My wife … works at [a local organization] and she [is a nurse]. So she's shown me all those things, [that] there's options. There's angles to go around,*

(Continues)

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TABLE 2 | (Continued)

Socio-ecological model level	Facilitators	Exemplary quote(s)
		there's places to get the information, to get the help, to get the support [for breastfeeding]. (Participant 11, Focus Group 1)
	Extensive discharge support	*When we were at the hospital, … they [showed] us the proper way of [breastfeeding], and they were trying to help while we were in the hospital. … Our baby was premature a little bit, like a month or two premature. So, they were trying to help us with his strength and everything and figuring out how he could be on the [breast] most effectively and everything, or most efficiently.* (Participant 27, Focus Group 4)
	Take-home materials	*Just put together packets, hand out a packet or something just to inform. Even if you forget, [nurses] might not want to say it all the time, so a packet, having a packet there in the office or whatever, and we could take it and read for ourselves [would be helpful].* (Participant 24, Focus Group 4)
	Personalized support (e.g., home visits)	Fathers noted several services that helped. It mainly seemed like the availability of lactation support providers like lactation counselors, midwives, and doulas to answer breastfeeding concerns or questions was important to fathers. One father noted being *"able to call [a] lactation counselor at two in the morning to get advice on what to do."* (Notes, Focus Group 3)
	Ongoing support from prenatal to postnatal period	*We had a tough time knowing when to wean the baby off. … We couldn't really understand when we [should] stop, when we [should] give her more solid food. So having more guidance in that area would help too.* (Participant 03, Focus Group 2)
		One father stated that he wished he knew more about transitioning from breast milk to formula because he was unprepared. He said he *"learned the hard way at 12 at night."* (Notes, Focus Group 3)
	Formal support services directly educate/engage the father	*[The hospital] gave me different ways of how I can help relieve the tension [in the breast], the pressure that [breastfeeding] causes. That was one of the major things actually, because … our son stopped breastfeeding himself pretty much. He didn't really want to continue doing it. And so it was just like there was extra pressure [in the breast]. So, trying to help with that, and different things like that. And yeah, support just emotionally and everything too.* (Participant 27, Focus Group 4)
		They stressed the importance of making the dad feel like a part of the process. One dad noted that even though breastfeeding is usually all about the mom, a class should make the dad understand their role in it even if it's a small role. One said that it was even a point of a man's pride, they don't want to feel excluded, especially from their child's life. (Notes, Focus Group 3)
Community/ Policy	Community acceptance of breastfeeding as normal	*Myself, I learned from my background, I was born in Africa and we don't give too much formula to the baby, our parents give birth to 10 children. … They all give them breast milk and they look much healthier. And then they always advise other woman … [to] use the breast milk.* (Participant 10, Focus Group 1)

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TABLE 2 | (Continued)

Socio-ecological model level	Facilitators	Exemplary quote(s)
	Breastfeeding visible in media	*Social media definitely made [breastfeeding] a norm. Girls are breastfeeding in Chuck-E-Cheese, or wherever now, in the mall. But they'll take a picture of it now, and give other women, I guess, confidence to do it now. You can see other mothers doing it. So, all they really have to do, some girls don't even put [a cloth on] no more, they just pop [the breast] right out now. But it's a norm, it's a beautiful thing, know what I mean? Nothing wrong with that.* (Participant 25, Focus Group 4)
	Policies to protect breastfeeding in public and the workplace	*I can't think of what the law was, the actual name of it. I just know that … they cannot discriminate [against] you for breastfeeding your baby in public … because for a while it was even bad for the moms in the workplace to actually pump, [or] be excused to pump. Moms were losing their jobs for that and they're still getting a hard time at some places, but there's laws in place to protect the mom because your body's producing [milk] whether the baby's there or not.* (Participant 07, Focus Group 2)
	Private spaces clearly marked for breastfeeding	*"Something that could make [breastfeeding] easier [that] you don't really see … my girl didn't even know what a mother's room was, no signs, nothing. … So, explaining what a mother's room is …"* One dad added that having these clearly marked spaces for moms to breastfeed would encourage questions from kids. This would expose them early in life to help normalize breastfeeding. (Notes, Focus Group 3)
Barriers to breastfeeding	**Barriers**	
Individual	Father has low breastfeeding knowledge	*I don't know really what [mothers] need when they [are] breastfeeding. And I don't know if they need anything for like their chest or anything like that. Because, don't get [me] wrong, my first daughter, her mom, she breastfed with her and stuff. I was there for it and stuff, but I didn't have to do nothing. I was really just sitting there, but this one is different. … I'm trying to be more involved with everything.* (Participant 08, Focus Group 1) *It was just, I wasn't informed as far as the benefits from it and really wasn't educated enough on what it could bring to my children.* (Participant 07, Focus Group 2)
	Father is not involved with breastfeeding	Facilitator: Before becoming a father, did you think men had a role in deciding to breastfeed or bottle feed? Participant: *No. I didn't even think about it. … I didn't even think about it until [the baby] came. And then I still didn't really know what my place was when it came to breastfeeding.* (Participant 24, Focus Group 4) Participant: *No, I didn't think anything like that. Because it's more of a role [for] the women, but when the child came that's when I saw it's a role for both genders.* (Participant 01, Focus Group 2)
Interpersonal	Lack of generational breastfeeding	*I didn't always think it was normal to breastfeed … until I got a little older … because none of my family never got breastfed or nothing like that.* (Participant 25, Focus Group 4)
	Familial discouragement from breastfeeding	*Only other difficulties was certain family members didn't really understand the necessity of breastfeeding because they either didn't know what value it had or they just felt uncomfortable with that.* (Participant 07, Focus Group 2)

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TABLE 2 | (Continued)

Socio-ecological model level	Facilitators	Exemplary quote(s)
		My wife reminded me that my mother actually discouraged breastfeeding. She said, "Why don't you feed that baby some real food?" And I don't know what kind of food she was talking about, but she discouraged it. So, that was a negative output, that kind of had its time for a minute. (Participant 03, Focus Group 2)
Institutional	Lack of access to breastfeeding resources	*I think that's a problem. It's lack of information and not knowing where to get resources to know about breastfeeding. It's almost like when you become pregnant, your wife and yourself, it's like the only thing you think about is the actual day the baby is due and that's like the end of it. But it would be more helpful if we had more resources to … pull off of so that we're prepared.* (Participant 03, Focus Group 2)
	Insufficient breastfeeding preparation	*Up here in Connecticut is where they gave us some information. But if you were a first time [parent] breastfeeding, it wouldn't be enough to help you make the decision. So … some areas could use work as far as teaching [the] nutritional value of what the breast milk can actually do for mom and baby, or as far as the program here. But they did provide us with pumps or anything else like that we need[ed].* (Participant 07, Focus Group 2)
		We … didn't get [breastfeeding] support [prenatally]. … The [prenatally]. … The gynecologists are more concerned about the baby, just [that] the baby needs to come. And then we g[ot breastfeeding] support from when the baby was born, like in my case, my baby was in the hospital, in the incubator. So they tr[ied] to teach us then. (Participant 10, Focus Group 1)
	Insufficient discharge support	*Some nurse[s] also used to speak to us about [breastfeeding]. Not really the medical doctor, but the nurse; they were busy talking about the importance of … feeding. And then they [gave] us some paper to read and then [went] through it. … But it was in [a] rush. They didn't go through it in detail. … We … learned more from families.* (Participant 10, Focus Group 1)
		I would say [my partner's] experience [after discharge] was more so like soreness, engorgement … And I think because when she first started off, like the first week, … she didn't really know how to do it correctly yet. But when she went to the appointment, they showed her. And when they showed her, I guess she was already kind of like sore from the first couple of days of trying to latch on just naturally knowing how to do it, [so it was more difficult]. (Participant 23, Focus Group 4)
		[My partner] had trouble breastfeeding [our first son], so she kind of felt … like something was wrong with her. But really what it was, was that no one ever properly showed her how to get the milk out. You've got to do it a certain way. (Participant 28, Focus Group 4)
	Lack of breastfeeding promotion	*[Breastfeeding education], it depend[s] on the mood of the nurses, they just do [it] in a rush. … They talk [about] both formula and the breast milk … they don't specify that you need to give the baby [breast milk]. They don't tell us more on [how] the breast milk is the best. I think I'm the one even who [brought up breastfeeding] to them. … Because what they did [after the baby was born], they just start[ed] with the formula themselves. I'm the one who stopped them to say, "No, no, no. My wife can pump the milk. Let me*

(Continues)

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TABLE 2 | (Continued)

Socio-ecological model level	Facilitators	Exemplary quote(s)
		ask her to pump the milk, I'll bring you the breast milk." But the hospital, they don't emphasize giving breast milk. They don't talk about it. (Participant 10, Focus Group 1)
	Father must advocate to be involved in breastfeeding	*I feel like it's usually kind of based on how engaged I am. I take the initiative to ask questions a lot sometimes. I don't know all the questions to ask. And sometimes I actually get frustrated that I didn't know to ask a certain question because then later on when it's something that comes up, I would've wanted to know the answer. But I will say that they are good that, if you ask the questions, then they'll give you the answers. If they don't have the answers, then they have the resources to give to you to find the answers.* (Participant 11, Focus Group 1)
Community/ Policy	Sexualization of breastfeeding	*I just see a lot of bad things happen[ing] to women. It's so important to protect women. … It's just like she could be doing her thing, and then some creep with a phone … you know what I'm saying? Because them type of videos is out there. You know what I'm saying? She just minding her business, trying to feed her kid.* (Participant 23, Focus Group 4) People are sexualizing breastfeeding trying to turn it into something that it's not. (Notes, Focus Group 3)
	Stigma against breastfeeding in public	*But people used to be really offended when they saw my wife breastfeeding. Like, "Does she have to do that out here?" If we're at the mall or somewhere, even with the cover that they you put over the mom and the child, they would still be offended.* (Participant 07, Focus Group 2) *I mean, all right, I totally disagree with the whole public thing. I feel like [breastfeeding] is natural, I do. But doing it in public is like me going to the bathroom in public.* (Participant 23, Focus Group 4)
	Low awareness of policies to protect breastfeeding	*See, [not being able to breastfeed at work is] what make me think that [breastfeeding] wasn't as normal as we might be saying it is. … Breastfeeding, I think growing up, I didn't see it like that. It probably was happening, but I didn't see it like that.* (Participant 30, Focus Group 4) *There should not be any problem about [breastfeeding in the workplace]. Because the baby doesn't know that doing it is some kind of illegal issue.* (Participant 02, Focus Group 2) Breastfeeding is legally protected in all public spaces and workplaces in CT.

were prepared to support breastfeeding because of parenting classes, online research, and having previous children. These fathers had access to information on the benefits of breastfeeding or had a role in breastfeeding before the current child, facilitating a smooth transition into the postnatal period. Others felt underprepared before childbirth and stated they needed more knowledge about breastfeeding to inform their decision to encourage breastfeeding and support their partner in feeding their infant.

Related to breastfeeding promotion, a few fathers laughed about how providers "*push breastfeeding onto you*" by providing breastfeeding pumps and discouraging parents from formula. Others had providers who neglected breastfeeding promotion altogether (see Table 2, Barriers—Lack of breastfeeding promotion). One participant suggested that limited prenatal breastfeeding education leaves parents unequipped with enough information about breastfeeding benefits to decide whether or not to breastfeed.

Related to breastfeeding techniques and troubleshooting, several fathers described receiving clear breastfeeding education at the hospital during prenatal visits and at delivery. However, others found themselves and their partners underinformed about techniques for effective breastfeeding, pump usage, and the importance of breast milk. Participants felt particularly uninformed about potential breastfeeding complications. While most were taught about breastfeeding benefits, few could

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identify adverse breastfeeding outcomes unless their partner had personally experienced them. For those whose partners did face breastfeeding issues like low milk production, many felt helpless to soothe or aid their partner during these distressing experiences. Fathers expressed a desire for formal support services to provide better education on these potential issues so they could be better prepared to resolve them.

Related to breastfeeding support personnel, fathers identified within-system differences, where some healthcare providers were more informative and supportive than others about breastfeeding. Many recognized lactation counselors and alternative birthing attendants like doulas or midwives as supportive and helpful, primarily because of their personal relationships and availability to answer questions. Conversely, some participants noted that maternity hospital breastfeeding services provided by physicians and nurses were not always robust. According to some participants, the usefulness of information given by healthcare providers at the hospital "*depend[ed] on the mood of the nurses*" or the healthcare provider's knowledge (see Table 2, Barriers—Insufficient discharge support).

The variability in access to quality breastfeeding support services was identified as a weak point of breastfeeding care. This sentiment was shared by fathers who identified knowledge gaps because of unstandardized and rushed care delivery.

3.4.2 | Continuum of Breastfeeding Care and Support

> *"We had a tough time knowing when to wean the baby off. … So having more guidance in that area would help too."*

Breastfeeding instruction and support were most commonly delivered by healthcare providers in the period between parturition and discharge from the maternity hospital. Despite the importance of the delivery stay as a critical opportunity for parents to obtain breastfeeding information, the delivery stay period offered diverse experiences for participants.

One father described rushed and unclear instructions on breastfeeding from nurses during their delivery stay. Two other participants described their partners' physical pain from engorgement and emotional distress resulting from the inability to breastfeed successfully in the postpartum period. Both quotes (see Table 2, Barriers—Insufficient discharge support) reveal that the mothers were not adequately instructed on breastfeeding techniques before discharge from the maternity hospital. Other knowledge gaps not adequately addressed during the delivery stay like breast pump usage, balancing a combination of formula and breast milk, and when and how to wean off breast milk were suggested to be addressed through a more robust continuum of breastfeeding education and care.

To offset the pressure resting on quality breastfeeding instruction and support received during the delivery stay, participants favored earlier breastfeeding education and sustained breastfeeding support from the prenatal to postnatal periods. During the prenatal period, participants expressed a desire to learn more about what to expect after the baby is born. Fathers noted that breastfeeding education and support could take the form of classes, appointments, or even reference packets that parents could access throughout infancy. Fathers also requested that support be maintained after childbirth. Participants appreciated the personalized support and accessibility of lactation counselors, doulas, and parenting group leaders.

3.4.3 | Engaging Fathers in Breastfeeding Care

> *"[The hospital] gave me different ways of how I can help relieve the tension [in the breast]…"*

Breastfeeding education and support services as described by study participants focused primarily on the mother and baby. While breastfeeding support providers were responsive to questions from the father, participants indicated they rarely directly engaged fathers in the education or initially included them in the process. Some participants even described an assumption that fathers were uninterested in receiving breastfeeding education. However, all participants described a strong willingness to learn more about breastfeeding and how they could be involved as the father. Several fathers connected their interest in gaining breastfeeding knowledge to a strong desire to be involved in their child's life, referencing factors like a "*man's pride*" and frustration when feeling they were ineffective fathers (see Table 2, Facilitators—Formal support services directly engage the father).

Participants desired clarity on their role in supporting breastfeeding as a father. One participant wanted to know what fathers could do when alone with their infant, especially if the mother works or the father takes on feeding duties at night.

Fathers noted that specifically engaging them in breastfeeding education and support may empower them with the knowledge necessary to be involved in breastfeeding. One father received breastfeeding education specific to his role as a father from a hospital, which included information on relieving breast tension for his wife. Other participants even expressed an interest in a fathers-only educational program. Suggested program content includes information on the benefits of breastfeeding, details of what the mother might experience during breastfeeding, discussion of the father's role in breastfeeding, information about potential risks and remedies to breastfeeding complications, and long-term support to aid in weaning off breast milk.

3.5 | Community-Level Factors

3.5.1 | Normalization of Breastfeeding

> *"Something that could make [breastfeeding] easier [that] you don't really see … my girl didn't even know what a mother's room was, no signs, nothing…"*

> *"People are sexualizing breastfeeding trying to turn it into something that it's not."*

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Most fathers felt their communities viewed breastfeeding as a positive, everyday occurrence due to cultural norms that support and encourage breastfeeding. Still, many fathers described stigma against public breastfeeding in their communities. Judgment against public breastfeeding was received from family members, broader communities, and even held by some participants themselves (see Table 2, Barriers—Stigma against breastfeeding in public). Participants believed that the stigma against breastfeeding in public was due to the sexualization of breasts and general discomfort with exposing the breast without cover in public. Some fathers identified personal concerns over public breastfeeding, suggesting fathers may also benefit from widespread community acceptance of breastfeeding.

At the community/policy level, many participants supported the protection of breastfeeding at work or in public, but most were uninformed about current policies to protect breastfeeding parents. Some participants believed that breastfeeding in public was illegal (see Table 2, Barriers—Low awareness of policies to protect breastfeeding). Per Connecticut General Statutes 46a-64, breastfeeding is legally protected in public spaces and Connecticut General Statutes Section 31-40w protects breastfeeding in workplaces. Only one participant identified policies that prohibited discrimination against breastfeeding.

4 | Discussion

The study's findings revealed several facilitators and barriers to breastfeeding identified by Black fathers. Facilitators included paternal breastfeeding knowledge, paternal involvement in breastfeeding, shared breastfeeding decision-making, and familial support. Barriers included fathers' lack of breastfeeding knowledge, familial discouragement from breastfeeding, and stigma towards breastfeeding. Within formal support services like breastfeeding education during discharge or instruction during prenatal care, fathers appreciated extensive discharge support, take-home materials, and direct paternal engagement by healthcare providers. Conversely, a lack of access to breastfeeding resources, insufficient breastfeeding promotion, and inadequate preparation for addressing breastfeeding challenges contributed as barriers to successful breastfeeding experiences. Overall, this study was unique in its qualitative analysis of Black fathers' experiences with breastfeeding facilitators and barriers from the individual to policy level, with an emphasis on formal support and education services.

Across multiple domains, father involvement and empowerment in breastfeeding were identified as facilitators of successful breastfeeding. The findings suggest that fathers can be essential partners for mothers when deciding if and how long to breastfeed, learning breastfeeding techniques, and helping overcome potential obstacles. Formal support services should thus engage fathers as change agents to promote successful breastfeeding. Research has shown that interventions that specifically aim to engage fathers about breastfeeding improves both maternal breastfeeding outcomes and fathers' involvement (Panahi et al. 2022; Mahesh et al. 2018; Brown 2016). As emphasized in the focus groups, formal support services can bolster paternal attitudes toward breastfeeding and, subsequently, levels of breastfeeding involvement by providing parents with robust information about the benefits of breastfeeding and the consequences of formula feeding. Fathers' suggestions for improved education content included breastfeeding health benefits, practical benefits (e.g., time and cost considerations), and emotional benefits for all family members, including the father. These suggestions align with existing research on educational content that facilitates breastfeeding (Kehinde, O'Donnell, and Grealish 2023; Ogbo et al. 2020; Kornides and Kitsantas 2013).

Participants' comments called for breastfeeding education focused on enhancing the father's self-efficacy to soothe the mother and infant. Based on knowledge gaps from participants, this education might include knowledge of what the mother might be experiencing while breastfeeding, techniques to relieve breast tension, and promotion of skin-to-skin caregiving by fathers to their infants. One meta-analysis found that interventions targeted at engaging fathers with breastfeeding are associated with two times the odds of exclusive breastfeeding at 6 months (Mahesh et al. 2018). Participants were also interested in joining or creating fatherhood groups focused on the father's role in feeding, recognizing their different information needs from mothers. A spouse's specific role in breastfeeding has been identified as a key component of education desired by fathers, and one that improves outcomes (Abbass-Dick et al. 2019; Brown and Davies 2014; Tohotoa et al. 2009.) One intervention by Panahi et al. (2022) provided fathers with targeted education on their critical role in breastfeeding, including techniques, encouraging their partners, and alleviating household duties. This intervention was associated with increased odds of exclusive breastfeeding at 4 months compared to the mother-only control group (Panahi et al. 2022).

In the context of community-wide barriers to breastfeeding like stigma against breastfeeding or a lack of generational breastfeeding, breastfeeding promotion programming should consider culturally tailored interventions. A meta-analysis of breastfeeding interventions involving fathers has found that culturally tailored education has been well received by fathers and positively impacted exclusive breastfeeding rates (Abbass-Dick et al. 2019). At the community level, multimedia strategies such as videos, websites, or social media resources may be useful to increase fathers' exposure to Black fathers involved in breastfeeding. Such multimedia strategies are used to promote narratives of Black mothers breastfeeding but could reasonably be transposed to raise awareness of the possibilities of paternal breastfeeding support as well (Robertson 2014).

Across all levels of the Socio-Ecological Model, participants identified areas for improvement and made suggestions for how current services could be improved. A summary of proposed strategies to improve breastfeeding support as interpreted from the focus groups is included in Table 3.

These strategies are currently being used to inform systems-level changes and interventions to support breastfeeding amongst Black families in Connecticut. More specifically, results of this study have been shared back with focus group participants, as well as presented to the New Haven Breast/Chest Feeding Task Force, a coalition of local breastfeeding

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TABLE 3 | Proposed strategies to improve breastfeeding support as summarized from focus groups.

Suggestions for improving breastfeeding support
• Provide breastfeeding education to fathers tailored to their initial knowledge about breastfeeding and beliefs about their role in breastfeeding.
• Engage fathers as decision-makers in feeding by equipping them with information about the benefits and drawbacks of breastfeeding.
• Create online breastfeeding resources from local community partners or healthcare providers that parents can recognize as reputable.
• Provide take-home materials (e.g., reference packets or instructional videos) for easy reference and to support at-home breastfeeding.
• Ensure transparency from formal breastfeeding support services about risks or potential adverse outcomes of breastfeeding, supplemented with strategies to mitigate these issues.
• Outline standard care objectives for breastfeeding provided to all maternal health providers.
• Teach/show mothers how to breastfeed before leaving the hospital, including instruction on specific breastfeeding skills like positioning, latching, and expressing milk.
• Require that discharge criteria for breastfeeding newborns involve direct observation of at least one effective feeding at the breast.
• Introduce a training protocol or assessment of clinical competency in breastfeeding support/lactation management for healthcare providers (e.g., physicians, nurses).
• Integrate breastfeeding education into prenatal classes and appointments.
• Refer all breastfeeding mothers to lactation specialists available for support after childbirth (rather than just one-time follow-up appointments or phone calls).
• Cater aspects of breastfeeding education or support specifically to fathers to specify ways that fathers can be directly and indirectly involved in breastfeeding.
• Frame messaging for breastfeeding as “natural” by emphasizing the breast as nurturing and breast milk as food for newborns.

advocates and healthcare practitioners, who utilized this study's findings to inform what community-based action to take to reduce local breastfeeding inequities and increase breastfeeding rates, particularly among Black Americans. One key initiative that resulted from this study's findings is a racial equity-focused healthcare provider training. The training is aimed at educating healthcare practitioners about the history, data, and legacy of breastfeeding within Black American communities, as well as the importance of engaging a mother's entire support system, with the goal of cultivating more culturally responsive lactation care by healthcare practitioners and lactation specialists caring for Black families. This strategy directly resulted from fathers' suggestions for improving breastfeeding support, as outlined in Table 3. Simultaneously, New Haven Healthy Start and Real Dads Forever continue to engage and support fathers along their fatherhood and breastfeeding support journeys, even partnering with a father from one of our focus groups to help launch a local lactation space in New Haven.

Since the focus groups were performed, Connecticut hospitals have made improvements in breastfeeding education, but 12% of hospitals still fail to adequately teach specific skills like positioning and latch techniques per the CDC's Maternity Practices in Infant Nutrition & Care (mPINC) survey (Centers for Disease Control and Prevention 2023). Many hospitals utilize discharge criteria for breastfeeding newborns, yet challenges may persist due to complications during childbirth particularly affecting Black mothers, who are more likely to experience cesarean deliveries and associated stress (Chiang et al. 2021). Strategies aligned with literature recommendations include personalized breastfeeding care continuity, assigning dedicated lactation counselors post-discharge, and interventions spanning the prenatal to postnatal periods, all shown to enhance breastfeeding initiation and duration (Segura-Pérez et al. 2021; Tomori et al. 2022; Wouk, Tully, and Labbok 2017).

This study offers valuable insights into Black fathers' perspectives on breastfeeding through a community-based participatory approach, enabling nuanced understandings of their attitudes and experiences. The strengths lie in this study's qualitative nature, which provided detailed insights into facilitators and barriers to breastfeeding and elicited novel ideas for improving breastfeeding care for diverse families. Another strength lies in the community-based participatory nature of the study, which permitted study development and analysis intended to directly inform ongoing strategies and planning for city- and state-wide interventions. Furthermore, by mapping themes onto the Socio-Ecological Model, this study addressed a vast range of interventions possible from the individual to the policy level. However, limitations exist in the recruitment strategy, as the sample primarily comprised of engaged fathers already involved in conversations about fatherhood and breastfeeding. While this strategy leveraged existing community-based relationships to recruit, allowing access to a group that has been traditionally difficult to engage in breastfeeding research, it potentially overlooks groups who have been marginalized with different experiences to our sample. Additionally, one focus group lacked audio recording and relied on session notes, impacting data richness. While the rapid template analysis facilitated efficient theme development, it might have overlooked individual perspectives and minority viewpoints. Future research should explore the identified facilitators' and barriers' impact on breastfeeding outcomes for Black parents. Future studies of tailored interventions specifically involving Black fathers are also warranted.

5 | Conclusion

This study aimed to describe Black fathers' perceptions of breastfeeding using a qualitative, community-based participatory

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approach. Focus groups revealed factors influencing breastfeeding at the individual, interpersonal, institutional, and community/policy levels. Breastfeeding facilitators identified by focus groups include high paternal knowledge and involvement in breastfeeding, generational breastfeeding, personalized prenatal-to-postnatal breastfeeding support services, engagement of the father by breastfeeding support services, community breastfeeding support resources, and designated spaces to breastfeed in public. Breastfeeding barriers perceived by study participants include low paternal knowledge and involvement in breastfeeding, familial discouragement, insufficient support following discharge from the maternity hospital, lack of inclusion of the father in breastfeeding support services, and stigma against breastfeeding in public. These findings underscore the value of understanding breastfeeding perceptions among members of a mother's support network, highlighting key factors influencing the perceptions and support a mother may receive throughout her breastfeeding journey and emphasizing areas for intervention in which breastfeeding support services can better serve breastfeeding families—including fathers.

Author Contributions

Kathleen O'Connor Duffany was the Principal Investigator of this study. Natasha Ray and Doug Edwards initiated the research question, specifically advocating for the inclusion of fathers in breastfeeding research. Jasmine Rios, Natasha Ray, Doug Edwards, Rafael Pérez-Escamilla, and Kathleen O'Connor Duffany designed the research study, including developing the focus group guide and the analysis summary template. Natasha Ray and Doug Edwards recruited all participants. Jasmine Rios, Natasha Ray, and Doug Edwards participated in data collection. Jasmine Rios and Tomeka Frieson analyzed the data. All authors reviewed and developed themes, results, and implications. Jasmine Rios wrote the first draft of the manuscript. All authors were involved in manuscript development and provided substantive comments. All authors read and approved the final manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no data sets were generated or analyzed during the current study.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.

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