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Women's perceptions, knowledge and breastfeeding decision-making

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6 Synthesis

"She should have asked ME instead."

Henriette (participant), August 2008

The quote on the previous page is a subtle reference to the findings of the research project, and addresses the overall research question: ‘What reasons underlie women’s decisions to stop or continue breastfeeding in the first month after delivery?’ “*She should have asked ME instead*” is a quote from the postpartum interview with Henriette, one of the participants in the research. During the interview, Henriette said she had discontinued breastfeeding in the first month after delivery. Her baby was doing well on formula, but she felt guilty she had not managed to continue breastfeeding – she had intended to continue, because she believed that breastfeeding was the best way to feed infants. In the quote, the ‘she’ refers to Henriette herself, and the ‘me’ to one of her clients at work. While Henriette was still on maternity leave, her colleagues and a few clients had been talking about her and the fact that she had stopped breastfeeding. On that occasion, one client (the ‘me’) had commented that Henriette should have asked her – a woman with considerable breastfeeding experience – for advice. When Henriette was told about this conversation between her colleagues and this client, she was disappointed and felt judged. Particularly because of the client’s comment, Henriette felt a lack of acknowledgement for all of her efforts to continue breastfeeding.

This quote illustrates that women such as Henriette might feel judged, as if they had acted inadequately in three ways: first, by having unwisely decided to discontinue breastfeeding, contrary to their intention to continue; second, by apparently not being knowledgeable enough to be able to continue; and third, by not knowing how to ask the right people for advice.

Henriette’s quote refers to the overall research question as well as to the issues that were addressed in the three specific research questions: (1) ‘What are women’s perceptions of breastfeeding during the period of intention?’ (2) ‘Can the concept and levels of health literacy be used to understand women’s breastfeeding decision-making?’ and (3) ‘What sources do women use to obtain breastfeeding knowledge?’ The results of addressing these three separate questions are briefly summarised below.

Research question 1: ‘What are women’s perceptions of breastfeeding during the period of intention?’

The themes that arose with regard to the women’s perceptions of breastfeeding during the period of intention included combining breastfeeding with work, learning about breastfeeding, making arrangements for childbirth, reflecting on the intention, and becoming a mother, as identified by applying grounded theory and the theory of planned behaviour (TPB) as the deductive framework (Ajzen, 1991; Duckett et al., 1998; Fishbein & Ajzen, 1975). The women aimed to combine breastfeeding with work outside the home.

Generally, the women had made arrangements for childbirth but not for breastfeeding or expressing milk at work. They perceived breastfeeding as a natural practice, and generally did not start learning about breastfeeding in advance. While reflecting on their intentions in the prepartum interviews, the women expressed themselves cautiously. They were not sure whether they would succeed, and felt they had to experience giving birth first, a biological and emotional event that our analysis identified as being the most grounded inductive concept of the study, thus closest to the women's own perceptions: becoming a mother. In the postpartum interviews, the mothers indicated that breastfeeding was not as natural as they had expected, and they depended on the support of a maternity assistant. Most women felt they did not have the appropriate knowledge and at the same time felt they could not have anticipated this because they had to become a mother first.

Research question 2: 'Can the concept and levels of health literacy be used to understand women's breastfeeding decision-making?'

The women in our study showed different levels of health literacy in their engagement with breastfeeding information. We assessed this using the three progressive levels of health literacy adopted by Nutbeam (2000): functional, interactive, and critical health literacy. Although we identified all three of these levels of health literacy in the women's stories in our study, we did not find a progression from functional to interactive to critical health literacy for all participants. Women with limited health literacy with regard to breastfeeding did not necessarily discontinue breastfeeding, and mothers with high health literacy did not necessarily continue breastfeeding, which is what health professionals recommend as the preferred choice. We identified a tension between the development of being health literate regarding breastfeeding and adherence to recommendations to continue breastfeeding until the age of six months, in line with global guidelines. This indicates a discrepancy between encouraging women to develop their interactive and critical health literacy skills so they will be able to make their own decisions independently, and at the same time recommending that they make the preferred decision.

Research question 3: 'What sources do women use to obtain breastfeeding knowledge?'

We identified the following themes with regard to the women's breastfeeding knowledge: the pros and cons of breastfeeding, how breastfeeding works, individual breastfeeding practice, expressing milk, and formula feeding. By adopting Kleinman's theory of local health care systems (LHCS) as the deductive framework (Kleinman, 1980), we found that the women obtained knowledge from the professional sector, the popular

sector (while engaging with significant as well as anonymous others), and nature (including their maternal intuition). In our study population in the northern part of the Netherlands, we could not identify a folk sector as indicated in Kleinman's model. While moving back and forth between these different sectors, women encountered support as well as negative comments and prejudices about their breastfeeding practices. We concluded that the popular sector, the folk sector, and nature (including maternal intuition) are non-professional sources that have not been fully utilised until now in the Netherlands, and the potential of these sources should be addressed by health programmes and interventions.

What this research contributes

The Hutter-Hennink qualitative research cycle

Although most qualitative research is cyclic in nature, the Hutter-Hennink qualitative research cycle (HH-QRC) is specific in that it consists of three cycles: design, data collection, and analysis (Hennink et al., 2011). Our application of the HH-QRC as the methodological framework in our research project was even more specific. In the first study, we completed all three cycles. The second and third studies involved the analytic cycle: we analysed the data that had been collected previously, applying different combinations of grounded theory (Glaser & Strauss, 1967) and analytic questioning using sensitising concepts (Bowen, 2006; Thornberg, 2012). As a result, the research consisted of three different cyclic processes and three types of analysis. The potential of applying the model in this way had not been anticipated by Hutter and Hennink.

Another specific characteristic of our research was making inferences, in accordance with the HH-QRC. Making inferences involved both deductive and inductive inferences. Deductive inferences were made from the theory, starting in the design cycle. Inductive inferences were made from the collected data, starting in the data collection cycle and continuing in the analytic cycle. The combination of making deductive and inductive inferences made it possible to achieve a continuous linking of theory and empirical data. This contributed to a refined understanding of the research topic as well as to extending the scope of the theory (Snow et al., 2003).

The empirical data were obtained from in-depth information collected during intensive contact with participants at two time points. Because this in-depth information was rich and abundant, a small sample size was sufficient for reaching information saturation according to the principles of Glaser and Strauss (1967). Saturation was confirmed in the analysis, which contributed to the scientific rigour of the research (Hennink et al., 2011; Mays and Pope, 1995). The coherence (Hennink et al., 2011) between the design, data collection, and analysis also contributed to the scientific rigour.

A necessity in the research has been sensitivity and reflexivity of the researcher. The combination of sensitivity to empirical data and theoretical sensitivity was crucial throughout the entire research process. In addition, reflexivity concerning the researcher's positionality as an anthropologist conducting research in her own culture has been important in the research. This is explained further in the 'Intermezzo' found between Chapter 4 and Chapter 5 of this thesis.

Different paradigms and the emic perspective

This research project contributes to scientific knowledge by showing how breastfeeding is approached from different paradigms. Professionals approach breastfeeding from a particular paradigm, as do women. These approaches can be identical – for example, when they are based on the same biomedical paradigm, as when women act in accordance with campaigns that assert the health benefits of breastfeeding, or with recommendations from professionals.

However, women's breastfeeding practices are not based primarily on the biomedical paradigm, but on their own perceptions, from the emic perspective. Because our research was based on the emic perspective, we could identify these perceptions in the women, which demonstrates that breastfeeding is not a biomedical issue, but a personal one embedded in the sociocultural context (Dykes & Williams, 1999; Maher, 1992; McKinley & Hyde, 2004; Ryan et al., 2001).

Another specific contribution made by our research project is that there was also a change in paradigm during the research itself, related to theoretical pluralism (Wiley, 1992) and induced by the empirical data. The application of the three different theories in our studies reflects this paradigm change in the research project.

The initial paradigm of the research was the biomedical paradigm, which was related to the breastfeeding discourse in the Netherlands that focused on health claims, breastfeeding rates, and breastfeeding interventions based on behavioural factors. Therefore, choosing to use the TPB as the initial theory was the appropriate choice. The contribution made by this part of our research is that, rather than exploring either the intended or actual behaviour, we studied both. In addition, we did so in a qualitative research design, and included the context from the emic perspective. Using the TPB as the deductive framework turned out to be appropriate and useful: the research findings it generated showed that, for breastfeeding behaviour, the period between intention and actual practice is long, and that actual practising breastfeeding is not a continuous outcome of the intention to do so. However, the TPB is oriented toward the intended and actual behaviour, and does not cover all relevant factors in breastfeeding. These findings were also reported by Scavenius et al. (2007), who deliberately did not use the TPB in their research because it would have covered

only one segment (behavioural factors) in the dynamic interaction between the various factors in the breastfeeding process (Scavenius et al., 2007).

During further analysis of the empirical data concerning learning, knowledge, and information, our research confirmed the observation that the TPB does not cover all aspects of breastfeeding. The empirical data prompted us to search for an additional theory regarding these aspects, which we found in the concept of health literacy (Nielsen-Bohlman et al., 2004; WHO, 1998) and its three levels: functional, interactive, and critical health literacy (Nutbeam, 2000). Health literacy researchers developed the health literacy concept in two different ways: from a biomedical and from a public health paradigm (Nutbeam, 2008; Pleasant & Kuruvilla, 2008). From the biomedical paradigm, health literacy refers to patients' or clients' basic health knowledge and compliance with health professionals' recommendations, which corresponds with the functional level of health literacy. From the public health paradigm, health literacy also refers to the social determinants of health, which include health promotion and health education. In this way, health promotion and education can also generate the development of the other levels of health literacy, that is, interactive and critical health literacy (Kickbusch 2002, 2009; Nutbeam, 2000).

We applied the health literacy concept including the emic perspective of the women themselves to be able to explore their functional as well as interactive and critical health literacy. However, the analysis of our empirical data showed a normativity when applying the concept, which was induced by the assumption of a hierarchical progression from the functional to the interactive to the critical level of health literacy. Our interpretation indicated that there is a discrepancy between inviting women to be critically health literate and asking them to comply with recommendations from health professionals at the same time. From this finding, we recommend a nuancing and further development of the concept of health literacy, with the emphasis on critical health literacy. This would encourage conformity with regard to its definitions and applications, something that has also been proposed by others over the past decades (Chinn, 2011, Kickbusch, 2009, 2014). It would also encourage including the emic perspective when applying the concept of health literacy.

We analysed our empirical data further to explore *where* women obtain their breastfeeding knowledge. To do this, we required a conceptual framework that refers to the sources of health information, including societal sources. We found this framework in Kleinman's (1980) theory of local health care systems (LHCS). This theory was developed in the borderland between medicine, psychiatry, and medical anthropology. According to this theory, health care activities are explored based on a medical pluralism paradigm (Leslie, 1980). Medical pluralism exists when different medical systems exist alongside each other and are consulted by community members in their health activities.

Although not as manifest as in the pre-modern cultures in which Kleinman's theory was developed, medical pluralism is also present in the Netherlands. The different sectors indicated in the LHCS are the popular, the professional, and the folk sector. In addition, various sub-sectors can be identified *within* the professional sector in maternity health care, such as the clinical medical care provided by biomedically oriented obstetric clinicians, and the home care provided by midwives and maternity nurses and assistants. However, Dutch maternity care aims for uniformity in its care services, and the women in our study did not perceive medical pluralism within the professional sector. Therefore, we did not identify two distinct sub-sectors from our data.

Although pluralism is thus not explicitly present within Dutch professional maternity health care, it is certainly manifest in the contributions to the breastfeeding discourse made by academics and policymakers. This pluralism is most present in the way breastfeeding is discussed by academics from various disciplines (including biomedical, nursing, nutritional, social, and ethical disciplines) based on different paradigms from these disciplines, and by policymakers engaged in promoting breastfeeding.

From our research we concluded that it is important to integrate the different paradigms. The breastfeeding discourse has been dominated by a biomedical paradigm, and by developing our research using empirical data and theory, we demonstrate that women's decision-making can only be understood if we move from this biomedical paradigm through a public health paradigm and a social science paradigm to an interpretive paradigm where we aim to understand women's decision-making from within, from an emic perspective. To achieve this will require a change in the breastfeeding discourse.

By emphasising global guidelines and breastfeeding rates, the perspectives of women have largely been ignored. Reflecting on the context of this research project when it started in 2008, Esmé Wiegman-van Meppelen Scheppink's resolution in the Dutch parliament in December 2007 (Dutch Parliament, 2007) and the statement issued by the Dutch Ministry of Health, Welfare, and Sport in 2008 were rather ambitious (Dutch Ministry of Health Welfare and Sports, 2008a, 2008b). The aim of increasing the percentage of mothers who were still breastfeeding their infants at the age of six months to 40% by 2011 was based on the global guidelines of the World Health Organization (WHO, 2003). However, breastfeeding rates did not continue to increase after 2008 (Lanting & Rijpstra, 2011; Statistics Netherlands, 2012).

When the focus is on breastfeeding as something that can be measured by initiation and duration rates, breastfeeding is regarded as a product (Scavenius et al., 2007). This is reinforced by the slogan 'breast is best' (Kramer, 2010), generating a moral appeal to women to start and continue breastfeeding. This perspective does not acknowledge that women perceive breastfeeding to be a personal process (Scavenius et al., 2007). This was effectively

summarised by Esterik, who reported that, ‘paradoxically, the more breastfeeding is valued, the more it may become regulated and embedded in rules and patterns of interaction that are not connected to infant feeding’ (Esterik, 2002). By ignoring the emic perspective, breastfeeding easily becomes medicalised (Ryan et al., 2001). As a result, breastfeeding seems to be predominantly in the domain of biomedicine.

Indeed, the majority of breastfeeding research is conducted by researchers in the fields of biomedicine, nutrition, health education, health behaviour, clinical nursing, and public health. Although these disciplines do not traditionally make use of qualitative research methods, they have the greatest influence on policy (Esterik, 2002). The academic disciplines with a research tradition in qualitative designs and emic perspectives (such as anthropology) address breastfeeding as a process (Esterik, 1988; Scavenius et al., 2007) in which the perceptions of women are acknowledged.

When women in the Netherlands discontinue breastfeeding contrary to their original intentions, the focus should be on these perceptions, be it the perception of guilt – such as in Henriette’s case – or relief, or disappointment (Kerkhoff & Wouwe, 2008; Reede, 2011), or the perception that breastfeeding was not what had been expected (Vogel et al., 2009). Interventions to support women in their breastfeeding practice could be more successful if they are based on these perceptions rather than on global guidelines and initiation and duration rates.

Some advances have already been made in this regard, according to a recent study on breastfeeding discontinuation in the Netherlands (Smeets, 2012). Smeets reported that 50% of women who discontinued breastfeeding before their infants were six months of age either felt or had felt guilty. One of the reasons indicated by these women is that breastfeeding is portrayed too positively in the education and campaign material. The Netherlands Nutrition Centre will use these results in the development of future breastfeeding education material (Drongelen, 2014). Our research findings support this recognition of women’s perceptions, and yield the following implications for practice and policy.

Implications for practice and policy

Our first study showed that it is difficult to indicate what is the most appropriate period to learn about breastfeeding. Although it would be challenging to define recommendations for practice and policy with regard to the best time to learn, we concluded that there is no such thing as the most appropriate time. Based on our research findings, we would instead recommend re-establishing the link between learning about breastfeeding and giving birth. This is necessary because, from a biological point of view, but also from the emic point of view of women, giving birth and starting to breastfeed are two parts of the same event, and happen simultaneously when a woman becomes a mother. However, in the breastfeeding

discourse that focuses on health claims and increasing breastfeeding rates, giving birth and starting to breastfeed have been separated into two distinct events.

The need to re-establish the link between giving birth and breastfeeding is clearly reflected in the other conclusion from the first study, that is, that the impact of becoming a mother is crucial. Becoming a mother was our most inductive theme, which was identified by applying grounded theory from the emic perspective. In the women's perceptions, becoming a mother shaped the context of all of the other themes that were identified in the first study, including learning about breastfeeding. Only when learning, knowledge, and information about breastfeeding are once again linked to the impact of becoming a mother, we will gain insight into exactly what it means that breastfeeding is a process that women have to learn rather than a product that can be measured in terms of breastfeeding rates.

If women themselves are more conscious of the impact of becoming a mother, and are acknowledged by others (including health professionals), they will be able to obtain breastfeeding information at a time that is most appropriate for them, and use this information to make their own informed choices in a manner that is connected to their specific way of becoming a mother. Breastfeeding information needs to be adjusted and made part of the individual event of becoming a mother, rather than included in recommendations from a biomedical perspective concerning the appropriate time to learn about breastfeeding and the appropriate decision-making skills related to this. Informed breastfeeding choices need to be related to becoming a mother rather than to breastfeeding themes that are disconnected from motherhood and measured separately, such as pain, not having enough milk, as being difficult to combine with work or as competing with autonomy, and not being what had been expected.

Making informed choices needs to be considered from the emic perspective rather than from the normative perspective of whether women are capable of and have the skills to make the appropriate choices. Because focusing on the health benefits can easily enhance the moralisation of breastfeeding, health professionals need to provide adequate non-moralising breastfeeding information. They need to acknowledge the discrepancy between inviting women to be critically health literate and make their own decisions while at the same time asking them to comply with health recommendations based on health claims. Rather than repeating the same health messages, professionals need to develop skills for listening to the emic perspective and focus on what women need to make their own informed choices. It is within this context that the health literacy of professionals also becomes apparent: professionals who are health literate have the skills to listen to the emic perspective.

To make informed choices, infant feeding information should also include information about formula. Because of the WHO marketing code, formula is ignored as an

acceptable alternative to human milk when discussing infant feeding among professionals and women. Consequently, some parents do not know how to use formula appropriately. We endorse the WHO's achievement in restricting the industry's influence in marketing formula products (Innocenti, 1991; WHO, 1981). However, not discussing formula results in having little knowledge of how to use it when it is needed and how to choose between different types of formulas and materials. This can result in dissatisfaction with this infant feeding practice.

Health care professionals need to acknowledge the variety of information sources that are available. Breastfeeding knowledge is not only the outcome of health education and promotion, it also includes maternal intuition. Women appreciate the support of professionals when using their intuition, and professionals need to take this into account. If the knowledge obtained from intuition or from other sources is inadequate from the perspective of the professionals, they need to thoroughly explain why they believe this is so, and focus on the content of the information without moralising. New campaigns need to be targeted not only at women but also at others in the popular sector (Kukla, 2006). These others can be the carriers of a body of knowledge that contributes to a supportive social environment, enabling women to share their knowledge and advice with others in the community without feeling judged, as in Henriette's case.

Providing support for breastfeeding women therefore includes the following:

1. Women should receive antenatal information about the impact of becoming a mother. Breastfeeding education should not be separated from this, but instead needs to be included in and linked to information about becoming a mother.
2. Women have the right to make their own informed choices based on information from various sources, including maternal intuition. Infant feeding information should also include information about formula.
3. Women should be supported by health professionals who have the skills to listen to the emic perspective, acknowledge the women's informed choices, and recognise that there are different sources of breastfeeding information.

Conclusion

This research project was a journey that began with the breastfeeding discourse in the Netherlands in 2008, involving interdisciplinary academics as well as the lives of many individuals. Because the dominant emphasis among the actors engaged in the breastfeeding discourse is on global guidelines, health claims, and breastfeeding rates, the perceptions of women themselves have largely been ignored. We identified these perceptions by

conducting qualitative research based on an overall interpretive paradigm and collecting in-depth data from the emic perspective. Guided by the Hutter-Hennink qualitative research cycle (HH-QRC) as the methodological model, we linked qualitative empirical data and three theories based on different scientific paradigms. The integration of the biomedical and the social science paradigms while applying the emic perspective, contributes to a better understanding of the reasons that underlie women's decisions to stop or continue breastfeeding in the first month after delivery.

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