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Women's perceptions, knowledge and breastfeeding decision-making

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Summary

General introduction

This doctoral thesis addresses women's perceptions, knowledge, and breastfeeding decision-making. The research project emerged from the way breastfeeding was being discussed in the Netherlands. In 2008, the Dutch Ministry of Health, Welfare, and Sports issued a statement which included the aim of increasing the percentage of women who were still breastfeeding their infants until the age of six months to 40% by 2011. The background to this statement was the discrepancy between the infant feeding recommendations of the World Health Organization (WHO) that infants should be breastfed exclusively until the age of six months, and the high rates of breastfeeding discontinuation in the first month. The biomedical approach was predominant in the Dutch government's involvement in infant feeding. Campaigns that had been launched to increase breastfeeding rates focused on the health benefits of human milk. However, little was known about the reasons that underlie women's breastfeeding decision-making. Our research aimed to understand these reasons from the emic point of view – that is, from the women's own perspectives – using an interpretive paradigm and linking theory to qualitative empirical data. The general objective of the research was to gain insight into the perceptions of women in their decisions to stop or continue breastfeeding in the first month by collecting empirical data and using different theoretical frameworks to analyse the data.

Overall research question

The overall research question was 'What reasons underlie women's decisions to stop or continue breastfeeding in the first month after delivery?'

Theory and qualitative empirical data

The Hutter-Hennink qualitative research cycle was the methodological framework, as described in Chapter 2. This framework guided the cyclical process of research design, data collection, and analysis. Qualitative empirical data were collected by conducting prepartum and postpartum in-depth interviews up to saturation level. Interviews were conducted in 2008 and 2011 in the northern part of the Netherlands among primiparous mothers who intended to breastfeed. The first dataset consisted of 16 transcripts of interviews with 8 women with middle and high socioeconomic status (SES). The second dataset consisted of 10 transcripts of interviews with 5 women with low SES. The research was designed and data

were collected using the theory of planned behaviour as the deductive theoretical framework. In the analysis, the concept of health literacy and the theory of local health care systems were used as sensitising concepts in addition to applying grounded theory. The research was characterised by the combination of deductive and inductive reasoning. Reflecting on the researcher's positionality during data collection was crucial to the research, and this is discussed in the 'Intermezzo' found between Chapter 4 and Chapter 5 of this thesis.

Theory of planned behaviour

Chapter 3 addresses the specific research question 'What are women's perceptions of breastfeeding during the period of intention?' In this study, we used the theory of planned behaviour as the deductive model. Five inductive themes were identified: combining breastfeeding with work, learning about breastfeeding, making arrangements for childbirth, reflecting on the intention, and becoming a mother. During the extended period of intention, the women in our study anticipated breastfeeding, but expressed their intentions cautiously. They felt they had to experience giving birth first, a biological and emotional life event that our analysis identified as the most inductive concept of the study, and thus closest to the women's perceptions: becoming a mother. Although they had access to breastfeeding information, they perceived breastfeeding to be a natural practice and did not start learning about breastfeeding in advance. They usually depended on the support of a maternity assistant. Generally, the women made arrangements for childbirth, but not for breastfeeding. For breastfeeding, the period of intention is relatively long. Rather than recommending an intensification of antenatal breastfeeding education, recommendations must incorporate the awareness that practising breastfeeding should not be considered the continuous outcome of the intention to do so.

Health literacy

Chapter 4 discusses the specific research question 'Can the concept and levels of health literacy be used to understand women's breastfeeding decision-making?' In this study, we used the framework of health literacy as a sensitising concept in the analysis. Health literacy refers to individuals' capacity to obtain, process, and understand health information needed to make health decisions. The three progressive levels of health literacy (as adopted by Nutbeam) are fundamental, interactive, and critical health literacy. We were able to identify all three levels in the decision-making of the women in our four cases. However, a progression from functional to interactive to critical health literacy was not found in all women. Women with low health literacy did not necessarily discontinue breastfeeding, and

women with high health literacy did not necessarily continue breastfeeding. Women are expected to be critically health literate and to make their own decisions so they can exert control over their lives, but are also expected to follow health promotion recommendations, that is, to continue breastfeeding. This discrepancy requires both a reconsideration of the messages delivered by health professionals on breastfeeding and a nuancing of the concept of health literacy.

Theory of local health care systems

Chapter 5 discusses the specific research question ‘What sources do women use to obtain breastfeeding knowledge?’ In this study, data from both datasets were analysed by applying grounded theory, with Kleinman’s theory of local health care systems as a sensitising concept. We identified five inductive themes: the pros and cons of breastfeeding, how breastfeeding works, individual breastfeeding practice, expressing milk, and formula feeding. The women in our study obtained knowledge on these themes from the different sectors of their local health care system. These sectors are the popular sector, the professional sector, and nature (which includes the women’s own maternal intuition). The popular sector comprised significant and anonymous others. Knowledge sharing in the popular sector was limited, and prejudices often predominated. Mothers felt comfortable when they relied on their maternal intuition, especially when this was acknowledged by professionals. The potential of addressing non-professional sources (i.e. the popular sector, the folk sector, and nature) is not fully utilised. Health care professionals could take advantage of these non-professional sources, which might contribute to a supportive environment for breastfeeding women.

Synthesis

Chapter 6 discusses what this research contributes. Our specific application of the Hutter-Hennink qualitative research cycle resulted in three different types of analysis. The potential of applying the model in this way had not been anticipated by its authors. Our research contributed to the scientific body of knowledge by emphasising the importance of the interpretive paradigm when aiming to understand breastfeeding decision-making. There was a change in paradigm over the course of the research project itself, and this is reflected in the application of the different theories. The breastfeeding discourse has been dominated by a biomedical paradigm, and by developing our research using empirical data and theory, we demonstrated 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 gain insight into women’s

perceptions concerning decision-making from an emic perspective. To achieve this will require a change in the breastfeeding discourse.

Implications and recommendations

Learning, knowledge, and information about breastfeeding should once again be linked to the impact of becoming a mother. Breastfeeding should be considered to be a process rather than a product that can be measured in terms of breastfeeding rates. We recommend including breastfeeding education along with information about the impact of becoming a mother, rather than providing this separately. It is important that women be able to make their own informed choices based on information from various sources, including their own maternal intuition. Women should be supported by health professionals who have the skills to listen to this emic perspective.