Exploring the Lived Experiences of First-time Breastfeeding Women: A Phenomenological Study in Ghana

A thesis submitted to The University of Manchester for the degree of PhD in the Faculty of Biology, Medicine and Health

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Georgina Afoakwah

The School of Health Sciences
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ABSTRACT

The University of Manchester

Georgina Afoakwah, Degree of PhD

Exploring the lived experience of first-time breastfeeding women: A phenomenological study in Ghana

Background: Breastfeeding is globally recognised as a gold standard of nutrition, recommended for the first six months of an infant’s life. Despite its benefits, most women in Ghana do not breastfeed, as recommended by World Health Organization (WHO) and United Nations International Children Emergency Fund (UNICEF).

Aim: To gain in-depth understanding of first-time Ghanaian mother lived experience of breastfeeding.

Design/Method: A longitudinal qualitative design was adopted, underpinned by the hermeneutic phenomenological approach, as described by van Manen (1990). The study explored the lived experiences of thirty first-time women recruited from antenatal clinic. A series of three semi-structured, in-depth interviews were conducted; the first in late pregnancy, the second in the first week following childbirth and the final one between four and six months postpartum.

Findings: Inductive thematic analysis informed by van Manen (1990) and principles of hermeneutic interpretation allowed the emergence of four main themes: the ‘Breastfeeding Assumption,’ Breastfeeding as Women’s Business,’ the Postnatal Breastfeeding Experience and ‘Family as Enabler or Disabler’. Within the context of this study, breastfeeding is expressed as an activity within the family and social environment. The overall phenomenon that emerged was ‘Social Conformity’. This demonstrates an understanding of the breastfeeding experience suffused with emotions as women project an image of themselves as successful breast feeders in order to conform to family and social expectations.

Conclusion: Findings from the study demonstrated the multifactorial dimensions of breastfeeding. Most importantly, it was identified that first-time breastfeeding women use emotion work to cope with their experience of breastfeeding, within the social context. It was suggested that midwives play a pivotal role in helping women develop realistic expectations prior to breastfeeding. Furthermore encouraging family centered education that promotes holistic support for women. The findings therefore suggested the need for better anteatal education based on evidence-based practice. Breastfeeding women require individualised support that assesses their emotional needs and offers encouragement. Developing policies that ensure training of midwives and breastfeeding advocates was recommended. Future research could explore the impact of these interventions on breastfeeding practices, helping first time women to breastfeed effectively.
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Presentations and Conferences


Third Annual Midwifery and Women’s Health Research Showcase – 2012; at the Saint Mary’s Hospital, Manchester, UK

Global Women’s (GLOW) International Research Conference, Liverpool, UK
Acknowledgement

I am grateful to the Lord God Almighty who through His marvelous grace and divine mercies strengthened and guided me throughout this period. My journey of this PhD has been one of hard work and devotion to a dream now come-true, not only on the account of my own effort, but I also wish to express my sincere gratitude and appreciation to these special individuals and organization.

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Dedication

This PhD work is dedicated to my husband whose caring support made this work a reality and our son Jayden who had to sacrifice and endure early separation from me till my work was completed.

I also dedicate my work to my parents and in-laws, for being a great part of my life and taken good care of Jayden whilst I was away studying. Special feelings of gratitude to my loving parents, whose words of encouragement, were timely.

Lastly, I dedicate my thesis to Mr. Albert Acquah, the founder and chancellor of Garden City University College. I will always appreciate your contribution to my career development.
**Glossary Terms**

‘Dasein’: ‘the being of humans and mode of existence’ (Inwood, 1999).

**EBF (Exclusive Breastfeeding)** – feeding infants with ONLY human milk soon after birth to the first six months. No water, juice and herbs or breastmilk substitute needed, except vitamins, minerals and medicine may be given (WHO & UNICEF, 2003).

**Emotional Work:** Hochschild defines it as “the induction or suppression of feelings in order to sustain the outward countenance that produces the proper state of mind in others of being cared for in a convivial safe place” (Hochschild, 1983, p. 7). Building on Hochschild’s concept, emotion work in the context of this study demonstrates participants’ use of emotion work to project an image of themselves as successful breast-feeder. However this experience is heavily dependent on the family and social expectations.

**Hermeneutic circle:** depicts the iterative movements in an attempt to establish the understanding of the whole in reference to its individual parts and vice versa, until the meaning of a given text unfolds (Heidegger, 1927).

**Immediate breastfeeding:** based on the recommendation that early initiation of breastfeeding follows soon after childbirth as the baby is helped to latch to the mother’s breast. It is suggested within the first half an hour of baby’s life (updated WHO & UNICEF, 2015).

**Lived experience:** individual’s unique way of experiencing life events or situation (van Manen, 1990).

**Mixed feeding:** breastfeeding alongside supplementary feeding

**Optimal nutrition:** optimal breastfeeding considers exclusive or total breastfeeding as the golden standard. Optimal breastfeeding practice suggest that received infants nothing but breastmilk for the first six months, followed by adequate and safe complementary feeding whilst breastfeeding continues for up to two years of age or beyond (WHO & UNICEF, 2015).

**Phenomenology:** is the science of phenomena, which focus on the study of consciousness and the objects of direct experience.

**Present-at-hand:** the existence of an objects or equipment in the world is present-at-hand when it stands apart from its intended use. However, our understanding of an object only stem from our prior attitude as we encounter them and since object in a context or world of equipment that is handy or remote. Therefore, we become knowledgeable of the equipment or object as there “in order to do” something (Heidegger, 1962).

**Ready-to-hand:** ready-to-hand, we are able to cease hold of things “close” to us and use it with the intention of achieving something. Unlike present-to-hand where we just know a thing as existing, in ready-to-hand the object is expressed in a very practical way for its purpose (Heidegger, 1962).
Suboptimal breastfeeding: Suboptimal breastfeeding is when total breastfeeding is not practiced and infants are fed along with water, food and formula before they turn six months (WHO, 2010).

Unready-to-hand: Unready-to-hand is when the object we are interested in breaks or something goes wrong, showing itself as something to be repaired or disposed, and therefore demand the totality of our involvement. Breastfeeding was experienced with physical difficulties that need support to help managed it.

List of Abbreviations
AAP – American Academy of Pediatrics
EBF – Exclusive Breastfeeding
PEU – Pediatric Emergency Unit
UNICEF – United Nations of Children Fund
WHO – World Health Organization
Introduction to Study

*To think is to confine yourself to a single thought that one day stands still like a star in the world’s sky,* said Heidegger (1971, p.4)

This research was born out of an ‘abiding concern’ towards the nature of breastfeeding practice in Ghana. This concern was driven by the rising incidence of infant and child morbidity between the ages of 6-18 months. These were encountered during my years of clinical practice as a Registered Nurse at the Paediatric Emergency Unit (PEU), in Ghana. Records from the ‘daily ward state’ and my personal observation showed that about one third of infants admitted to the unit suffered from disease conditions which could be prevented; including pneumonia, diarrhoea, malnourishment and gastrointestinal conditions. Based on my theoretical knowledge of the unequal benefits of optimal and exclusive breastfeeding to infants I was curious to know whether the breastfeeding practices of women could account for or contribute to the rising morbidity.

Upon interaction with a few of the women whose children were on admission, it was clear that the majority were unable to practice exclusive breastfeeding as recommended. Meanwhile, as part of World Breastfeeding Week celebration, a cross section of women in one of the Child Welfare Clinics (CWC) in the city of Kumasi were interviewed about breastfeeding in infants below six months. It was observed that, despite their modest knowledge regarding the health benefits of breastfeeding; of every five women interviewed only two practiced exclusive breastfeeding for the recommended period of six months. The majority of the women demonstrated a lack of consistency with breastfeeding after birth, which suggested a lack of understanding and commitment, among other cultural and social factors that seem to affect breastfeeding practices. Most of the women also found it more convenient introducing water, formula milk and semi-solid foods before six months because of the need to return to work.
The overwhelming negative effect of mixed-feeding practices among mothers (i.e., breastfeeding alongside early introduction of complementary feeding before six months) has been described. This was discussed as part of the talks, during the celebration by a Paediatrician from the Korle-Bu teaching hospital in Accra. The negative effects on infants’ health include increased hospital admissions due to infants’ morbidity and ultimately an increase in mortality. Although in Ghana breastfeeding is generally practiced, the full benefits are not realised due to the high levels of suboptimal breastfeeding practice.

According to Heidegger, embarking on a research journey begins with a concern about something that interests us and therefore drives us to commitment. My initial insight reinforced my belief that a fresh perspective was required to gain understanding of what it means for a Ghanaian woman to breastfeed in Ghana. My motivation for this study was thus to gain further insight into breastfeeding practices to support women to achieve breastfeeding success.

The next chapter will outline the thesis chapters, prior to providing an in-depth account of the theoretical and methodological underpinning, study processes (including ethical considerations), findings, interpretations and recommendations.
Outline of thesis

The thesis has nine chapters. Chapter one provides a general overview of breastfeeding. It focuses on the meaning of breastfeeding and the benefits to both infants and mothers. In addition, it addresses breastfeeding in the Ghanaian context and outlines the purpose of the study.

Chapter two contextualises the study through a narrative review of available literature. This focuses on primary studies that relate to women experiences of breastfeeding across different socioeconomic countries. Chapter three focuses on the methodology of the study. It discusses the theoretical and methodological perspective that underpinned the study. The research process involves the research aims and objectives, description of study area, gaining access and recruitment, sampling strategy, data collection and analysis of data. In chapter four, five, and six the results from analysing the data is presented. Chapter seven demonstrates the overarching theme that is inductively identified. Chapter eight provides a synthesis of the research process and discussion of key themes. Finally, Chapter nine provides the conclusion and recommendations from the study; implications for practice, policy and future research.
Chapter One

Background of Study
Chapter 1: Background of Study

1.1 Introduction
This chapter sets the background to the study. It provides a general overview of the meaning of breastfeeding. It also outlines global recommendations and scientific evidence relating to the benefits of breastfeeding to both mother and infant as the optimal source of nutrition (Riordan & Wambach, 2010; WHO & UNICEF, 2005). Alongside is an overview presentation of breastfeeding in Ghana, looking at previous studies that examined breastfeeding in Ghana. A statement of purpose and summary is finally provided.

1.2 Definitions of Breastfeeding
Labbok and Krasovec (1990, p.227) in their publication: “towards consistency in breastfeeding definition”, recognised the usefulness of defining the term ‘breastfeeding’ in order to ensure accurate interpretation of research findings. According to WHO /UNICEF (2003), breastfeeding is an unequal means of providing nutrition to an infant either directly from breast or through expressed breastmilk. Breastfeeding is advocated to begin following the birth of a newborn baby, within half an hour to one hour (WHO, 2002). In some definitions, early breastfeeding extends to include the first 24 hours after birth (Debes et al., 2013). In principle, the WHO (1996) categorises breastfeeding based on the different practices and what infants received through their mouth. These include:
Table 1.1: Categories of Breastfeeding

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<thead>
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<th>Categories of Breastfeeding</th>
<th>Infant receives:</th>
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<td>‘Exclusive Breastfeeding’</td>
<td>• Breastmilk, expressed or from a wet nurse.</td>
</tr>
<tr>
<td></td>
<td>• Nothing of fluid or solid base food except vitamins and minerals, ORS and medications</td>
</tr>
<tr>
<td>‘Predominant Breastfeeding’</td>
<td>• Main source of food is breastmilk.</td>
</tr>
<tr>
<td>Or ‘Almost breastfeeding,’</td>
<td>• However, infant may receive water and water-based drinks (sweetened and flavored water, teas, infusions etc.); fruit juice; oral rehydration salts solution; drop and syrup forms of vitamins, minerals and medicines; and traditional fluids (in limited quantities).</td>
</tr>
<tr>
<td>‘Full breastfeeding’</td>
<td>• Exclusive breastfeeding plus predominant breastfeeding.</td>
</tr>
<tr>
<td>‘Partial or mixed breastfeeding’</td>
<td>• Breastmilk or breastfeeding, but food such as formula milk or weaning foods are given.</td>
</tr>
<tr>
<td>No breastfeeding</td>
<td>• Formula feeding, no breastmilk</td>
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Although there may be inconsistencies in defining breastfeeding, it is suggested that providing clear definitions allows clear description and understanding of the maternal/child physiological interactions of breastfeeding (Labbok & Krasovec, 1990). Moreover, recent understanding of breastfeeding by experts and researchers in the interpretive field attempt to define breastfeeding based on women’s subjective experiences (Britton & Britton, 2008; Dykes, 2006; Riordan & Wambach, 2010; Renfrew et al., 2006). For instance, in a study that describes maternal perception of breastfeeding success (Leff et al., 1994), breastfeeding is viewed by women as a critical element in their maternal role. Similarly in a narrative review by Afoakwah et al. (2013) the meaning of breastfeeding was identified as a symbolic representation of motherhood. Being symbolic of motherhood, breastfeeding is viewed as the very essence of loving and nurturing an infant.
(Driscoll, 1991). Similarly, breastfeeding is also interpreted as an embodied experience for women who breastfeed (Bottorff, 1990; Schmied & Barclay, 1999).

1.3 Benefits of Breastfeeding

1.3.1 Benefits to Infants

Kakuma (2010) describes breastfeeding as best feeding method for newborn babies. In addition, a number of evidences from research have proven the immense benefits that human breast milk contributes to infants’ wellbeing (Deoni et al., 2013; Horta et al., 2007; Kramer & Kakuma, 2002; Renfrew et al., 2004). These include both short and long term effects on physiological, cognitive, psychological and social development (Heining & Dewey, 1996; Kramer et al., 2008; Renfrew et al. 2004). For instance, scientific evidence has identified over 200 different nutritional components contained in the human breast milk, which makes breast milk the perfect and ideal nourishment for infants (Kramer & Kakuma, 2002; Renfrew et al., 2004; WHO/UNICEF, 2015).

Evidence indicates that early initiation of breastfeeding immediately after birth promotes bonding between a mother and baby. This is reported to enhance the success of breastfeeding; by providing warmth and security for the newborn baby (Horta et al., 2007). Colostrum, which is the first milk, is observed scientifically to be loaded with antibodies and proteins which provide initial immunization making it less likely for infants to develop allergic conditions (e.g., eczema, asthma) (Ip et al., 2007; Kramer & Kakuma, 2002; Renfrew et al., 2004; WHO/UNICEF, 2003). Breastfed infants are also less likely to become obese, maintaining healthy cholesterol compared to non-breastfed infants (Horta et al., 2007; Kramer & Kakuma, 2002). As an added advantage, WHO/UNICEF (2014) reports that early breastfeeding helps stimulate proper growth of a baby’s mouth and jaw. It also enhances secretion of hormones for easy digestion and satiety.

Moreover, evidence of exclusive breastfeeding (EBF) for the first six months is associated with less risk against infectious conditions (e.g., diarrhoea, gastrointestinal and risk of respiratory tract infections) (Lamberti et al., 2011). It
promotes early recovery and hence reduction in morbidity and mortality most commonly in developing countries (Jones, 2008; UNICEF 2014). Evidence also supports that infants who are exclusively breastfed recover early from sicknesses, and have decreased duration and intensity of illness (Birch, 1998). This supports the evidence by Barclay and Murata (2006) in their review, which indicates that exclusive breastfeeding, has 56 percent fewer hospital admissions during the first year of life. UNICEF (2014) also discovered that in developing countries breastfed children were at least 6 times more likely to survive in the early month than non-breastfed children. Consistently, a report in The Lancet (Jones, 2008/2013) estimated that 13 percent of all deaths in children under-five in developing countries are potentially preventable if exclusive breastfeeding is practised.

Breastfeeding is linked to children’s performance and higher IQs (Capsi et al., 2007; Kramer et al., 2008). For instance, a clustered-randomized controlled trial by Kramer et al. (2008) provides strong evidence associating prolonged and exclusive breastfeeding with improved cognitive development in children. In a more recent study, it is demonstrated that exclusive breastfeeding promotes brain development and higher cognitive performance (Deoni et al., 2013). Deoni et al., (2013) further noted that breastfed children have better chances of performing in their educational achievement at aged five and in adolescence than non-breastfed children.

In the developing countries, Bhutta et al., (2013) determined that infants who are exclusively breastfed for the first six months have a greater chance of survival (i.e. 14 times less likely to die) from infections, within the first six months. For instance, in most low income countries, where access to clean and potable water including sanitation is a challenge, effective efforts that promote optimal breastfeeding practice of mothers and their babies is considered essential (Cai et al., 2012). Slater et al., (2010) in a review that considers breastfeeding in HIV positive mothers receiving Antiretroviral Therapy (ART), concluded that exclusive breastfeeding is much safer than mixed feeding (i.e., the supplementation of breastfeeding with other foods).
1.3.2 Benefits to Mothers

Renfrew et al., (2004) established that breastfeeding is not only beneficial for the infants, but their mothers alike. A critical review of epidemiological studies demonstrated the short and long-term effects of breastfeeding to the mother. It was identified that breastfeeding in the early postpartum period promotes early return of the uterus to its pre-pregnancy state through oxytocin release. Early initiation of breastfeeding, soon after baby is born is associated with decreased risk of postpartum haemorrhage (Buckley, 2015). It enhances the release of oxytocin, promoting relaxation and reduced psychological and emotional stress (Buckley 2015). Frequent infant suckling stimulates the release of prolactin, which in turn stimulates milk production and secretion (Buckley, 2015).

In the long term, longer duration of breastfeeding and intensity is significantly associated with potential weight loss while affecting lipid metabolism (Godfrey & Lawrence, 2010; Kramer et al., 2002). In a comparative study on maternal weight loss, significant weight loss was reported among women who practise exclusive breastfeeding for six months compared to three months exclusive breastfeeding (Dewey et al., 1993). Extended breastfeeding is associated with reduced risk of breast, ovarian and endometrial cancer during the premenopausal period. Furthermore, longer duration of breastfeeding shows reduced risk of type-2-diabetes; high blood pressure, increased cholesterol level, breast cancer; uterine and ovarian cancer (Baker et al., 2004; Gwinn et al., 1990). Additionally, research studies have reported frequent night time breastfeeding as an effective natural contraceptive [Lactation Amenorrhea Method]. This has the tendency of delayed menstruation and consequently a well-planned family (Huffman & Lubbok, 1994; Gray et al., 1990). The mother, who is the natural source of lactation, makes breastfeeding inexpensive and readily available compared with formula feeding.

1.4 Overview of Study Context

Ghana is a West African country that benefits from a tropical and equatorial climate. The total land area of Ghana is 2,420 kilometres bordered by Burkina Faso to the North, Ivory Cost to the West and Togo to the East. The country’s economy is dominated by agriculture. Ghana is a democratic country, where the constitution divides powers among the president who is the head, parliament, cabinet, Council
of State, and an independent judiciary. Administratively, Ghana consists of ten regions, with Accra as the capital city as represented in Figure 1.1. Each of these regions has geographical boundaries and is headed by a regional secretary. The level of divisions’ second to the regions consists of 216 districts that serve local and administrative purposes (GhanaDistricts.com, Retrieved 20th March, 2016). At the base of this administrative structure are 16000 unit committees (GhanaDistricts.com, retrieved 20th March, 2016). The Republic of Ghana is populated by 25.9 million (World Bank, 2013) people with multiple ethnic groups, culture and religious beliefs. Besides being a multilingual country, English is considered the official language taught in schools.

Figure 1.1 Map of Ghana
Beside the political administration, Ghana is highly multicultural and divided into multi-ethnic communities. Ghana is a highly multilingual country consisting of about sixty language groups. There are about one hundred ethnic divisions characterised by linguistic and cultural differences. Ghanaians’ worldview is shaped by a variety of religious and traditional beliefs. This is associated with values for culture and traditional beliefs transferred from generations and are associated with respect for the elderly and certain traditional rites. The worldview is also associated with how Ghanaians see themselves as individuals, as part of a community and in their relationship to the spiritual and physical world around them. Although there are economic and cultural differences between the geographic and administrative regions, as well as rural and urban areas, Ghanaians share traits that reflect particular aspects of indigenous culture, for instance within specific ethnic groups. Social groups function within knit kinship systems that affect interpersonal relationships, legal rights to property and social roles and obligations. These regions and districts, however, vary in terms of culture, reflecting its prestigious association with civilisation and social status, its restriction to attitude and behaviour and issues surrounding traditional customs.

Whilst various structures are organised nationally, attention is paid to ethnicity and language groups and the links between the different groups that make up the wider Ghanaian community. Ghanaians regard culture as essential to their lives and future development. For instance beliefs about birth and infant feeding, colostrum and cultural beliefs are unique to specific ethnic community. For example, Tawiah-Agyemang (2008) identified that the Kassena-Nankana District of the Upper East region of Northern Ghana belief that breast milk arrives on the third day after birth was particularly strong in the Northern ethnic groups.

1.4.1 Breastfeeding in the Ghanaian Context
Generally, Ghanaian women practise breastfeeding at some point after childbirth, but the majority do not breastfeed as recommended. Although it appears that women are knowledgeable about the benefits of breastfeeding to their babies, previous studies have identified that most women give-in to suboptimal feeding practices before six months (Aborigo et al., 2010; Seidu, 2013; Fosu-Brefo &
A recent survey shows that the majority of women in Ghana are challenged by a variety of factors, including socio-economic factors that affect infant feeding behaviour, which lead to negative repercussions on infants’ health (Fosu-Brefo & Arthur, 2015). Aborigo et al. (2012) also revealed that traditional beliefs and practices negatively affects early and exclusive breastfeeding, in certain ethnic communities in Ghana.

Although previous breastfeeding in Ghana has recorded increased rates of early and exclusive breastfeeding; an article recently published by the Ghana News Agency (GNA, accessed 24 July 2014), showed a significant percentage decline in exclusive breastfeeding rate from 63.7 percent in 2008 to 46 per cent in 2011. This was determined in a survey by the Multiple Indicator Cluster Survey (MICS), and reported in a statement by Dr Gloria Quansah-Asare, the Deputy Director-General of the Ghana Health Service (GHS). Notwithstanding exclusive breastfeeding rates are reported to also vary by region and within different communities in Ghana (Tampah-Naah & Kumi-Kyeremeh, 2013).

Cai et al. (2012) examined the global trends in exclusive breastfeeding among 140 low-resourced countries within a period between 1995 and 2010. In the findings, where Ghana was used as a case study, it was suggested that the prevalence of exclusive breastfeeding in these countries have only increased by 4 percent from 33 percent in 1995 to 39 percent in 2010. Whilst improvement was observed in West and Central Africa, it was however recognised that the practice of exclusive breastfeeding is not ‘widespread’ (Cai et al., 2012, p.4). Most predominantly was the issue of early cessation and introduction of formula milk and other breastmilk substitutes, liquids such as water and juices. Furthermore, the study reported on the common practices of needless supplementation and poorly timed introduction of solid, semi-solid and soft foods; often of poor quality (Cai et al. 2012; Labbok et al., 2008).

1.4.2 Breastfeeding Policies
In Ghana, policies and guidelines for breastfeeding practice follow that of the global recommendations and interventions by the World Health Organisation and UNICEF. This is an international effort to protect, promote and support exclusive
breastfeeding among infants (WHO & UNICEF, 2003). In Ghana about 325 (21%) of 1527 of maternity facilities are designated as Baby Friendly Hospitals Initiatives (BFHI), which adheres to the ‘Ten steps to successful breastfeeding’ and the International Code of Marketing of breast milk substitutes (UNICEF, 2009). The ten steps provide the basis for health professional practice, especially for midwives to become aware of breastfeeding information, learn skills and provide the necessary support needed for women in order to improve optimal breastfeeding and complementary feeding practices (Merton & Ackermann-Liebrich, 2005; Rosenberg et al., 2008). However, in a current study that re-assessed six selected Baby-Friendly facilities in the capital city of Ghana, Accra, it was observed that there has been poor adherence using the ten steps that support successful breastfeeding (Aryeetey & Antwi, 2013). This was related to a number of factors including trained staff attrition, high client-staff ratio, inadequate in-service training for new staff and inadequate support for monitoring performance (Aryeetey & Antwi, 2013).

Again, under the Ministry of Health, the Ghana Breast-feeding Promotion Regulation 2000 (otherwise known as Legislative Instrument [LI] 1667) was approved as another form of intervention to help promote breastfeeding. The purpose of the LI 1667 was to prevent competitive marketing of breast milk substitutes, and rather promote breastfeeding in the country (Ghana Food and Drug Board, 2006). Formulation and implementation of breastfeeding interventions are all intended to increase exclusive breastfeeding rate in Ghana.

1.4.3 Traditional Beliefs and Practices

Administratively, Ghana is made up of ten regions and sub-districts, which comprises several tribes and ethnic communities. Interestingly, each of these ethnic communities has specific beliefs, values and norms peculiar to its members. These beliefs, values and norms however influence women’s attitudes and perceptions of breastfeeding and infant feeding (Tampah-Naah & Kumi-Kyeremeh, 2013).

Breastfeeding as a common practice among women, is enshrined in historical and traditional beliefs that are handed down from several generations. Women are exposed to traditional and cultural beliefs which influence early and exclusive
breastfeeding practices (Aborigo et al., 2012; Tawiah-Agyemang et al., 2008). In particular, beliefs surrounding breastmilk and colostrum and introduction of water are contrary to the WHO and UNICEF recommendations. These are mediated by traditional beliefs that determine when breastfeeding is best for a newborn baby. There is also the tradition of introducing water before the infant turns six months. In these studies, Aborigo et al., (2012) and Tawiah-Agyemang et al., (2008), reported on a number of issues that serve as barriers to early introduction of breastfeeding.

Furthermore, among other factors that serve as barriers to breastfeeding, Aborigo et al. in a study that examined ‘infant feeding in the first seven days of life’ among women in the Kassena-Nankana district demonstrated their belief about colostrum. Studies reported the notion that colostrum is dirty or contaminated and can be harmful to the newborn baby. It was found that this belief not only delays early breastfeeding, but rather the colostrum may be expressed and discarded. Colostrum is replaced with water, local herbs or gripe-water (Aborigo et al., 2012) giving to the new born baby. Similarly Tawiah-Agyemang et al. (2008) identified the traditional idea that a woman and her baby needs rest after birth, hence the baby not crying for food is a way that delays early initiation of breastfeeding. These practices account for the predominant increase in suboptimal breastfeeding patterns and its effect on the health of infants (Awumbila, 2003; Aborigo et al., 2012; Sika-Bright 2010).

1.4.4 Socio-Demographic Factors
Studies have outlined maternal age, education, and economic status of the household as important factors that affect breastfeeding practices in Ghana (Aidam et al., 2005; Fosu-Brefo & Arthur, 2015; Sika-Bright et al., 2010; Otoo et al., 2009). For instance, Ghanaian women who are affluent and live in their own houses are identified as better able to practise exclusive breastfeeding compared to women living in households with the extended family members or in rented accommodations (Aidam et al., 2005; Fosu-Brefo & Arthur, 2015). Moreover, women in the low-income bracket breastfeed for a relatively shorter period, since they are required to resume work, which is usually their sole source of livelihood (Fosu-Brefo & Arthur, 2015).
According to Aidam (2005), these account for the increased rate of mixed feeding; which usually are poor quality supplementary feeds. In a cross sectional study, findings from the Ghana Demographic and Health Survey (GDHS, 2008) indicated that more than half of the households, 55.02 percent, are considered poor, whilst the middle to high income earners form 16.22 and 28.76 percent respectively (Fosu-Brefo & Arthur, 2015). Other factors noted by the study, to greatly influence the practice of breastfeeding include: maternal health and the economic status of the home. That is, women from wealthy households are more likely to have healthy babies.

Other factors such as maternal age, the level of education, marriage and plans to exclusively breastfeed during the prenatal period have also been identified as contributing to breastfeeding rate in Ghana (Aidam et al., 2005; Sika-Bright et al., 2010). Aidam et al., (2005) identified that older women are more likely to breastfeed for an extended period of time, compared to the teenage mothers. However, this was found to vary in different regions. As per a study conducted in Cape Coast, Sika-Bright et al. (2010) suggest rather that young and teenage mothers breastfeed for a longer time than the older women. Maternal educational background has also been identified to contribute to a woman’s choice to initiate and exclusively breastfeed (Fosu-Brefo & Arthur, 2015; Sika-Bright et al., 2010).

Regarding maternal employment, Danso (2014) examined the practice of exclusive breastfeeding among professional working mothers in the Kumasi Metropolis. She identified that only 48 percent of professional working women were able to combine exclusive breastfeeding and work. Also, it was noted that women working in the informal sector return to work early in order to meet the needs of the family (Fosu-Brefo & Arthur, 2015). The Ghanaian woman is only entitled to three months of official maternity leave. As the mothers return to work, these infants are handled by grandmothers and maid servants who eventually introduce water and formula feeding (Danso, 2014). This contributes to the surge in early introduction of bottle and supplementary feeding leading to an increased risk of infants to infections including diarrhoea and malnutrition (Fosu-Brefo & Arthur, 2015; Sika-Bright et al., 2010).
A fresh perspective that will enhance the understanding of breastfeeding from the view of a breast-feeding Ghanaian woman is considered important. This is intended to gather direct, first-hand information from breastfeeding women, through the daily experience of breastfeeding their babies. This will open a new paradigm of understanding that may change the value of breastfeeding and women’s experiences in Ghana.

1.5 Focus of Study

Evidence from empirical research embrace the knowledge-base of breastfeeding that is women led. It is suggested that breastfeeding is complex and goes beyond the provision of nutrition to an infant. The complex situation includes aspects of sociocultural, physical, psychological and emotional issues. For instance the WHO (2009) standards governing the practice of breastfeeding are identified to be rigid and often contradict women’s subjective experiences. These complexities either positively or negatively impact on a woman’s success of breastfeeding. In an Australian study, “blurring the boundaries“ women identified breastfeeding as two sides of the coin, an experience that either promotes harmony and intimacy or is viewed as disruptive limiting the freedom of women. Specifically, it is frequently argued that the standard rule of six months exclusive breastfeeding is an impossible task for women in both low and high socio-economic countries. In the same study, breastfeeding is also linked to a woman’s maternal identity, thus breastfeeding becomes central to the experience of motherhood (Schmied & Lupton, 2001). Stewart-Glenn, (2013) a study in the Tennessee, Knoxville identified the experience of conflicts in the life of breastfeeding mothers working in the public sections. The study identified the experience of embarrassment that working mothers face breastfeeding at work place.

The phenomenon of breastfeeding therefore suggests a comprehensive look at the nature and process of breastfeeding as it happens in women’s daily life. This study is based on the assumption concerned with eliciting the meaning of the lived experience, and the nature of the phenomenon of breastfeeding as an essentially human experience (van Manen 1990, p.62). The notion of “lived experience“, announces the intent for exploring directly the original or pre-reflective dimensions of human existence.
Investigating “lived experience” possess a special methodological significance in the understanding of a given phenomenon (van Manen, 1990). According to van Manen (1990), what we know is always negotiated through background and the influence it has on person’s perception of the worldview. Dilthey (1985), a German sociologist, defined ‘lived experience’ as that which is immediately given through self-consciousness or awareness. Researching lived experience is significant in human science research, enabling individuals to provide an account of their experiences that “inheres in the temporal structures of life” (p. 223). Therefore, this approach will contribute to enabling the Ghanaian women to become aware of their own breastfeeding experience and enhance a deeper meaning and understanding of what it means to breastfeed. The study therefore aims to extend knowledge around breastfeeding experiences that will improve holistic support. The study will consider the following aims and objectives:

1.5.1 Study Aim and Objectives:
To gain an in-depth understanding of the lived experience of first-time breastfeeding women in Ghana

1. To explore women’s perception of breastfeeding in terms of sufficiency and adequacy of breast milk;
2. To determine the nature of these perceptions and how they have changed over the pregnancy and postnatal period;
3. To gain understanding of the attitudes, values and beliefs that may have contributed to these perceptions;
4. To explore the influence of cultural practice and the role of family on women’s expression of their perception of breast milk; and finally,
5. To reveal women’s self-belief in their ability to exclusively breastfeed.

1.6 Conclusion
In summary, it can be observed that despite breastfeeding being a common to Ghanaian women, majority do not breastfeed as per the WHO/UNICEF (2003) definitions of early and exclusive breastfeeding. Absent from previous studies on breastfeeding in Ghana was the knowledge that expresses women views of what it
means to breastfeed. This study therefore concerned with exploring the first-hand stories of breastfeeding as experienced by the Ghanaian woman.

The next chapter considers a comprehensive review of the literature on women’s breastfeeding experiences from available relevant primary studies. This will enhance insight into previous studies from across the different resource countries.
Chapter Two

Literature Review
Chapter 2: Literature Review

2.1 Introduction
The previous chapter presented background information and overview of breastfeeding practise in Ghana. In an attempt towards an in-depth understanding of how women experience breastfeeding, steps are undertaking to identify, critically examine and synthesis primary qualitative studies with the aim of discovering the views and experiences of breastfeed women.

This chapter presents a review of the literature relevant to women’s experience of breastfeeding. Through critical discussion of qualitative studies will serve as the basis, dispensing ideas for the current research. In order to achieve this, a systematic narrative review is conducted. This approach was appropriate to explore the various aspects that constitute the embodied experiences of breastfeeding and in a manner close to women’s own experiential accounts. Finally, the identification of gaps in the literature is discussed.

2.2 Methodology: Narrative Review Approach
Women’s experience of breastfeeding over the years has been an extensively researched area. Although systematic reviews are deemed superior, the narrative approaches also offer some unique advantages. One of the strengths of a narrative review is the ability to comprehend a broader and diverse range of studies of a given research topic (Green, et al., 2006). In an attempt to link together the differing perspectives across different socio-demographic and economic groups of women, a narrative review was considered vital (Baumeister & Leary, 1997). Although the approach is criticised for being potentially biased, usually with non-specified source and selection criteria (Khan et al., 2003), it is however valuable in reviewing empirical articles and reinterpretation (Baumeister & Leary, 1997). Whilst systematic reviews are acknowledged to be the ‘gold standard,’ their use can be restricting in qualitative studies (Collins and Fauser, 2005). However a narrative literature review allows flexibility and utilises descriptive phrases and metaphors demonstrated by participants within the selected studies, whilst acknowledging
contribution by the reviewer's own experience existing theories and models (Petticrew, 2001; Kirkevold, 1997). Using a systematic approach to the narrative review, however, fits into the interpretive nature of my study. Being a novice researcher, it also serves as a guide to the writing style in the presentation of the actual findings of my study. Whilst the approach is not a systematic review, systematic strategies to literature searching are undertaken. Furthermore, the review is approached in a structured way that ensures clarity and consistency as far as possible (Green et al 2006).

2.3 Deciding What to Include:

2.3.1 Inclusion criteria:
Identification of relevant papers focused on primary papers that used qualitative research methods, and have explored the subjective experiences of breastfeeding women. Articles were included if published in English. Moreover, studies of mixed methodology were considered if they reported strong qualitative findings using qualitative methods (e.g., focus groups discussion, interviews or open-ended surveys).

2.3.2 Exclusion criteria:
Papers were excluded if quantitative approach was adopted. Secondary reviewed papers. Studies of mixed methods were excluded if report did not provide sufficient interpretations of data and qualitative analysis, including closed-ended surveys. Studies not written in the English language were also excluded. The first search took place in 2011, whilst literature was continually updated to include current published articles.

2.3.3 Search Process
A total of nine electronic and peer-reviewed databases were searched manually. The following shows the various databases, their respective date range within which articles were published and the total number of papers identified from each database. Medline (Ovid) provided a total of 703 citations; Psychological Information (PsycINFO), a total of 261 papers; Embase identified 60 papers; CINAHL (Cumulative Index to Nursing and Allied Health Literature), a total of 1350
papers; British Journal of Midwifery online (BJM), total of 105 papers. Citations identified as being potentially relevant to the review were published from 1990 to December 2015. Scopus identified 133 papers and Social Services Abstracts identified 2 articles.

Searches conducted were derived from common phrases and sets of key words based on the following. Results were imported into endnote and duplicates removed before abstract screening. Each search term were either used singly or combined in each database to generate search results:

- ‘Infant feeding’ or ‘Breastfeeding’
- ‘Women’s breastfeeding experience’
- ‘Infant feeding experience’
- ‘Breastfeeding’/‘Qualitative research methods’
- ‘Women’s perception of breastfeeding’
- ‘Family, social and cultural influence of

2.4 Review Processes

2.4.1 Title, Abstract and Full Text Review
An overall total number of 2,614 articles were initially identified from the databases searches. This is followed by reading titles in order to identify their relevance. This exercise excluded majority of the studies (n=2,029) because studies were either not directly related to the objective of the review or quantitative method used. A total of 585 remained after irrelevant and duplicates were removed. The next step involved screening of abstracts (n= 585), which was performed to examined the objectives of study, methodology and process involved in collecting data. This also includes the findings and conclusions reported in the studies. At the end of this exercise an additional (n=389) papers were excluded. The remaining total of 196 papers was examined in full in order to determine their relevance. This led to an additional exclusion of 141 papers on the basis of not meeting the review inclusion criteria. 55 papers remaining were further assessed using the critical appraisal tool (Downe et al., 2007; Walsh & Downe, 2006) to determine their quality. At the end of the appraisal 15 more studies were excluded, since they included insufficient
qualitative data as evidence of lack of trustworthiness and transferability. It remained 40 papers, which were included in the final review. Figure 2 illustrates search and data extraction process, including the countries that the study was conducted in.
Figure 2.1: Illustration of the Flow of Data Search and Extraction Process

**DATABASES (n = 2,614)**

MEDLINE (n=703); PsycINFO (n=261); Embase (n=60); CINAHL (n=1,350); Scopus (n=133); Social Service Abstracts (n=2); BMJ (n=105)

- Titles reviewed Excluded (n=2,029)
- Excluded based on abstracts (n=389)
- Excluded full papers (n=141)
- Excluded based on appraisal (n=15)

Studies based on country split:
Australia (3); Canada (2); China (1); Denmark (1); Ghana (3); New Zealand(2); Nigeria( 1); South Africa(1); Sweden(2); Turkish(1); UK (12); USA(11)
2.4.2 Characteristics of Included Studies
The 40 original studies included in the final review highlighted various aspects of the breastfeeding experiences of different groups of women (i.e., teenage mothers, primiparous, multiparous), from across different countries with varying socio-economic and cultural background. Authors established the socio-demographic characteristics of study participants including age, educational background, and marital status and breastfeeding practices. Individualised studies in the order of highest peer reviewed articles originated from United Kingdom (n=12); United States (n=10); Australia (n=3); Ghana (n=3); Canada (n=2); China (n=2); New Zealand (n=2); Sweden (n=2) South Africa (n=1); Denmark= (n=1); Nigeria (n=1), and Turkey (n=1). Together, studies represent an aggregate data of a total of 1,088 participants. Years in which studies were published range from 1990 to 2015. Studies were exploratory in nature. Not all studies were guided by the different methodological perspective in qualitative research. However, eleven of the papers were underpinned by ‘phenomenological principles’ (Bottorff, 1990; Dykes & Williams, 1999; Leff et al., 1994; Mozingo et al., 2000; McBride-Henry, 2009; Palmér et al., 2010; Phillips, 2010; Risenga & Lebese 2014; Spencer et al., 2010/2015; Williamson et al. 2012). Six studies utilised ‘grounded theory’ (George, 2005; Hauck & Irurita, 2003; Lewallen & Street, 2010; Locklin, 1995; Nelson & Sethi, 2005; Schmied & Barclay, 1999) and, two were ‘ethnography’ studies (Dykes, 2005; Raisler, 2000). Across the studies, data were generated using one or more qualitative method, including in-depth interviews (n=18); focus group discussions (FGD) (n=2), interviews/FGD (n=5), audio and writing diaries/interviews (n=3) and open-ended survey questionnaire (Agunbiade & Ogunleye, 2012; Kronborg et al., 2014). Five studies demonstrated triangulation in the method of data collection. Despite limiting the search to qualitative studies only, variability of the included papers provided in-depth insight into the breastfeeding phenomenon across the different groups of breastfeeding women.

2.4.3 Quality Appraisal

2.4.3.1 Description of the Approach
In order to determine the quality of the included papers, Walsh and Downe (2006) and Downe et al. (2007) framework for appraising the quality of qualitative studies
were adopted. Walsh and Downe’s (2006, pp.108-119) in their article ‘appraising the quality of qualitative studies’ outlined eight procedures for assessing the coherence and appropriateness qualitative studies. Key areas of consideration include the: scope and purpose of the study, design, sampling strategy, analysis, interpretation and reflexivity of researcher, ethical dimensions, relevance and transferability (Walsh & Downe, 2006, p. 114-115). In addition, in a meta-synthesis review study of ‘expert intrapartum maternity care’ Downe et al. (2007, p.132) approach to grading the quality of papers provide a guide to applying score in grading the studies. The approach was not determined by numerical or additive scoring, but was subjective and the extent of trustworthiness checked within the framework proposed by Lincoln and Guba (1985). The various scores are defined as follows:

| A | robust study with attention to all methodological details |
| B | generally good quality study with few omissions |
| C | Relevant study but lacking in detail/has limitations |
| D | study has significant flaws, which are very likely to affect the credibility, transferability, dependability, and/or confirmability of study |

### 2.4.3.2 Results of the Quality Appraisal

Characteristics of included studies are summaries, showing the assessment process and score. These are illustrated in table two of appendix one. Overall, the included papers were determined to be of reasonable quality in terms of clarity, appropriateness, credibility and discussions that consider the bigger picture (i.e., citations of previous knowledge to support discussion), including the author(s) conclusions made based on the research.

With reference to application of the score, none of the 40 papers were identified to be significantly flawed, or rated as D. The quality of individual papers was determined by the application of the appraisal checklist (Walsh & Downe, 2006) and ‘weighting’. ‘Weighting,’ according to Downe et al., (2007) recounts the subjectivity or opinion based by the reviewer. Downe et al. further argued that, subjective nature of qualitative research makes weighting possible, in order to
determine how errors may affect the overall trustworthiness. A combination of this approach identified some studies as having a shortfall of one or more evidence through the application of the checklist. Out of the 40 papers, only ten provide a description of the researcher’s reflexivity (Bottoff, 1990; Dykes & Williams, 1999; Marshall et al., 2007; Palmer et al., 2010; Ryan et al., 2011; Schmied & Barclay, 1999; Spencer et al, 2012 & 2015; Williamson et al., 2012). In three of the studies, ethical considerations were not mentioned (Awumbila, 2003; Bottorff, 1990; Tawiah-Agyemang et al., 2008). The table 2.1 in appendix 2 shows the characteristics of individual studies.

### 2.5 Analysis and Synthesis of Studies

After a review of the abstracts and application of the critical appraisal, studies were approached by engaging in iterative readings to identify recurring and dominant themes across and within the various studies. This process involved repeatedly comparing and contrasting authors’ views on an issue. Authors who arrived at similar or contrasting conclusions were grouped together. The different aspects, including methodology were reviewed for consistency. In addition, exemplary studies were highlighted that identified gaps in the literature. This led to the final iteration and grouping of key themes and subthemes together. By examining the studies in relation to one another made it possible to establish relationships between the included studies with emerging findings. Identified themes from individual studies did not necessarily discredit one another but rather seemed to be directly comparable. Together, five main themes were identified. Table 2.2 highlighted on the emerged themes, their description and studies from which they were identified.
<table>
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<tr>
<th>Themes</th>
<th>Description</th>
<th>Authors</th>
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<tbody>
<tr>
<td>Decision-Making to Breastfeed</td>
<td>- Previous awareness</td>
<td>Bottorff (1990); Lööf-Johanson et al., (2013); George (2005); Marshall et al. (2007); Street &amp; Lewallen, (2013)</td>
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<td></td>
<td>- Gathering</td>
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<td></td>
<td>- Social and cultural discourses influencing beliefs and attitude</td>
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<td>Ideal versus Reality</td>
<td>- Lack of preparation</td>
<td>Dykes &amp; Williams (1999); Lavender et al., (2005); Leff et al. (1994); Hoddinott et al. (2012); Kelleher (2006); Kronborg et al. (2014); Lewallen &amp; Street (2010); Locklin (1995); Mozingo et al. (2000); Palmér et al., (2010); Palmér et al., (2012); Raisler (2000); Schmied &amp; Barclay (1999); Schmied &amp; Lupton (2001); Tawiah-Agyemang et al. (2008); Williamson et al. (2012)</td>
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<td></td>
<td>- Mismatched of the Ideal situation versus reality</td>
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<td></td>
<td>[early breastfeeding as a struggle; continuing breastfeeding and the</td>
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<td>perception of breastmilk]</td>
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<td>Social &amp; cultural context of</td>
<td>- Cultural and social factors affecting breastfeeding</td>
<td>Agunbiade &amp; Ogunleye (2012); Andrew &amp; Harvey (2011); Awumbila (2003); Demirtas et al., (2011); Leeming et al. (2012); Marshall et al. (2007); Street &amp; Lewallen (2013)</td>
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<tr>
<td>breastfeeding</td>
<td>- family’s influence of breastfeeding</td>
<td></td>
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<tr>
<td>Breastfeeding Support</td>
<td>- midwives and nurses, peer and family support</td>
<td>Bottorff (1990); Lavender et al. (2005); Locklin (1995); Mozingo et al., (2000); McFadden &amp; Toole (2006); Thomson et al. (2012)</td>
</tr>
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</table>
2.6 Results
The results from the review process considered the broader picture of the breastfeeding experience, under the themes: ‘decision making to breastfeed’, ‘idealism versus reality,’ which comprise sub-themes; ‘lack of preparation’ and ‘maternal confidence’. Other themes of consideration include ‘breastfeeding support’ and the ‘social and cultural context of breastfeeding’. The discussion also includes direct quotes that add to the understanding of the context being described.

2.6.1 Decision-making to Breastfeed
Bottorff (1990), in a Canadian study that utilised a phenomenological approach, identified that decision-making is the starting point in preparation for breastfeeding. She further described that, “the decision to breastfeed enhance the certainty in an otherwise unknowable future, where one have a goal, prepare and plan for, looks forward to and move towards” (Bottorff, 1990, p.203). Bottorff (1990) pointed out the fact that decision-making leads to a woman’s ability to persist in breastfeeding. Similarly, a number of studies have identified that a woman’s decision-making during the antenatal period are more positive to breastfeed (Lewallen & Street, 2010; Smith, et al., 2012). For every woman, the process in decision-making regarding the choice of infant feeding was made at some point in time. Whilst women decide what is best for their children, this is thought to begin during pregnancy. A clear example of women’s decision-making regarding breastfeeding was clearly demonstrated:

“long before he was born I had made my mind up that I was going to breastfeed no matter what. That was the one thing that I was going to do.” (Bottorff, 1990, p. 203)

The following studies (e.g. Andrew & Harvey, 2011; Bottorff, 1990; Demirtas, et al., 2012; Marshall, et al., 2007; Street et al., 2013) described a number of factors that influence decision-making among a range of women (i.e. from high and low socio-economic and demographic level). These include public health and professional discourses, social and cultural factors and family or historical background of a woman. From the review, it was evident that although women still recognised the health benefits of breastfeeding to be a motivating factor in choosing to breastfeed (Andrew & Harvey, 2011; Leff et al, 1994; Marshall et al.,
2007), in recent studies, it was identified that women are more inclined to the perception that breastfeeding being natural must be the easiest method of infant feeding (Lööf-Johanson et al., 2013; Spencer et al., 2014; Williamson et al., 2012), hence influencing women’s choice to breastfeed. New mothers, in particular, embark on the breastfeeding journey with the belief that breastfeeding is an instinctive practice (Lööf-Johanson et al., 2014). However, most commonly identified were the discourses surrounding breastfeeding as natural and its health implications in the life of both infant and the mother. Most significantly, the knowledge of the health benefits of breastfeeding to the baby and the mother serve as a motivator in women’s choice to breastfeed (Mozingo et al., 2000; Marshall et al., 2007; Andrew & Harvey, 2011). In contrast, the women in Street et al’s (2012) study were identified as not being dissuaded from using formula, despite their knowledge of the benefits of breastfeeding. Moreover, the concept of breastfeeding being the most natural thing on earth was identified in several accounts as contributing to women’s decision to give it a try. Women often demonstrated this through the faith and conviction that breastfeeding is dependent on one’s intuition and something they and their baby would instinctively know (Lööf-Johanson et al., 2012). Breast-milk, being natural, was also associated with being healthy compared with formula milk. This was illustrated in the following statement:

"It’s a natural thing to do so I always thought I would if I ever have children and that’s going a few years back now. I always thought I would." (Bailey et al., 2004, p.243; Deborah, 25, breastfed for two weeks)

More significantly, there were differences in how women from different socio-economic groups and cultural backgrounds made infant feeding decisions (e.g. Bentley, et al., 2003; Marshall, et al., 2007; Andrew & Harvey, 2011). For instance, from some studies (e.g. Dykes, 2005; Marshall, et al., 2007) it was revealed how women in higher socio-economic groups make informed decisions regarding breastfeeding based on the knowledge surrounding breastfeeding and its benefits. In particular, the discourse surrounding the health benefits to the baby and the mother were often mentioned as the motivating factor. On the other hand, in some research (Raisler, 2000; Tawiah-Agyemang et al., 2008; Street et al., 2012), it was
identified that women from low socio-economic backgrounds and among those of African descent demonstrated attitudes and beliefs which were often influenced by the family and the society in which they lived. Street et al. (2012) identified that infant feeding decisions are passed on from family and friends, therefore influencing the expectations of others. In a study by Bentley et al. (2003), which included a group of African-American women, it was identified that single women who live together with their own mothers or relatives are dictated to regarding what and when to introduce complementary foods and liquids (Demirtas et al., 2011; Street et al., 2012). For instance, one young woman demonstrated this by stating:

“it wasn’t me that wanted to breastfeed my child; it was my mother at the time. She breastfed all of us, and she said, it’s only fair that I breastfeed my baby.” (Jensen 1998: 182; 21-year-old pregnant mother of two children)

Additionally, Demirtas et al. (2011) identified women were influenced on religious grounds. Consequently, these factors were identified as affecting early initiation and duration of breastfeeding (Bottorff, 1990; McCarter-Spaulding, 2007).

2.6.2 Idealism versus Reality
First breastfeeding was considered as something eventful in the experience of women (Bottorff, 1990; Dykes & Williams, 1999; Mozingo et al., 2000; Palmer et al., 2010; Williamson et al., 2012). This was often expressed as amazing, fascinating and wonderful feelings (Palmer et al., 2010). However, women described the early experience as extremely distressful and hard (Spencer et al., Thomson et al., 2014; Williamson et al., 2012). In several accounts, women expressed frustration, shock and being overwhelmed with what they thought might be normal and natural (Britton and Britton 2008; Hauck & Irurita, 2003; Mozingo et al., 2000; Spencer et al., 2014; Williamson et al., 2012). There was often thought to be a mismatch between expectations and what women actually experienced. Key findings from the various studies were the physical difficulties of breastfeeding, which was reported by both primiparous and multiparous
women, different socio-economic status, educational and cultural environment (George, 2005; Spencer et al., 2014).

Studies identified how women associate breastfeeding with physical pain, difficulty getting it started, and experience of nipple sores, rather than something thought to be the most natural thing (Hauck & Irurita, 2002; Palmer et al., 2010; Schmied & Barclay, 1999; Williamson et al., 2012). In several studies, the experience of breastfeeding was described as rather ‘awful’ or ‘horrible’ rather than being natural and easy (Mozingo et al., 2000; Hauck & Irurita, 2003). That breastfeeding was a cause of struggle and physical discomfort was expressed in almost all the included studies; for example, Mozingo et al. (2000) and Hoddinott & Pill (1999) identified the theme of ‘idealised expectations’. Similarly, participants in the study of Palmer et al. (2012) experienced what they called ‘shattered expectation’. A narrative of this was well captured by a mother who stated that:

“I just thought it would come naturally, that it was just something that everybody did and there was never any rejection...I just expected it to be automatic...This was like consuming me, you know, this breastfeeding thing.” (Mozingo, 2000)

In a Canadian and US based study that used semi-structured in-depth interviews, Kelleher (2006) described the physical challenges of early breastfeeding experienced by 52 women. Consistently, Williamson et al., (2012) reported on eight British first-time mothers on how they struggle to breastfeed which conflict with their previous expectations that breastfeeding was natural. Palmer et al. (2010) utilised phenomenological research method to interpret the breastfeeding initiating process of eight Swedish women; describing it as ‘overwhelming’, whilst later they attempt to balance the unknown. In a number of studies it became evident that first-time and teenage mothers are those group of women who struggled with getting breastfeeding started. This also included their ability to integrate it into their daily lives (Dykes & Williams, 1999; Mozingo et al., 2000; Raisler, 2000; Lavender et al., 2005; Kelleher, 2006; Williamson et al., 2012). Williamson et al. (2012), in their study, utilised an audio diary to provide succinct accounts of first-time mothers. The study identified that women
struggled to synchronise their body and that of the baby into a better position that made breastfeeding easy. Women were often overwhelmed and expressed shock about the intense nature of breastfeeding in the early days following the birth of their baby, which was experienced as a threat to their maternal identity (Dykes, 2005; Kelleher, 2006; Schmied & Barclay, 1999; Spencer et al., 2014; Williamson et al., 2012). This was clearly demonstrated by a newly breastfeeding woman who expressed how practically difficult it was to get the correct position of the baby into breastfeeding by stating that:

"Try and get him in the right position, try and get his arms out the way.... You're trying to hold and support his head which wobbles and getting him to open his mouth wide, and it's just so much to do. I know it sounds pathetic, it must be, it should be the most natural thing in the world, but...so difficult." (Williamson et al., 2012, p.439; Queenie)

Although women expressed the desire to ‘get it right’ because of the benefits, they seemed not to be in control of breastfeeding within the early days after birth due to the difficulties and stress. Across the studies, this was identified as undermining mothers’ confidence and consequently influencing mothers’ relationships with their infants. For instance, women spoke of being resentful towards their babies and feeling dread about the next feed, which was well demonstrated in the following quote:

"It [breastfeeding] was so hard and so stressful. Like every time he’d wake for a feed I’d think, ‘oh, here we go again’. There was nothing, nothing pleasurable about it at all. I wanted to make it work for all the reasons that you’re taught; that you know, that breastfeeding is good or you and for your baby primarily." (McBride-Henry, 2004, p.183; Sam, int. 12, Para 12 & 20)

Eventually, these women, without the support and supervision desired, fell “by the wayside” (Dykes & Williams, 1999, p.237). Emotional feelings ranged from the women’s inability to quantify their breast-milk, feeding patterns in the early days and the perception that the baby might not be gaining adequate weight (Dykes & Williams, 1999; Mozingo et al., 2000; Palmer et al., 2010). Amidst the insecurity and being overwhelmed with the struggles of breastfeeding.
More importantly, women recounted their need for support and supervision by
the hospital staff that would provide them with the reassurance that they were
doing well (Dykes & Williams, 1999). Women’s need for support was clearly
demonstrated in a study by Lavender et al. (2005) where teenage mothers felt
proud to have their breastfeeding expectations met through peer support and
midwives’ support. Consistently, Dykes (2005) recognised that the hospital
setting and health workers’ practices played a contributing and reinforcing role in
helping women to cope with breastfeeding their baby.

2.6.2.1 The Lack of Preparedness
Adequate preparation of women to breastfeed has been long recognised as a
neglected issue. Following the decision to breastfeed, preparing to breastfeed emerged as a theme across the various studies. Studies indicated how women were prepared during the antenatal and early postpartum period (George, 2005; Hauck et al., 2011; Hoddinott et al., 2012; Lewallen & Street, 2010; Mozingo et al., 2000; Raisler, 2000). Some studies identified family and friends as those providing advice on breastfeeding (Lewallen & Street, 2010). In several of the studies midwives and lactation consultants were identified as providing professional advice and information on breastfeeding (Hoddinott et al., 2012; Raisler, 2000). However, studies often described women’s perception of prenatal education and information received as basically theoretical, rather than practical (Raisler, 2000). In a study by Lewallen & Street (2010), it was identified that, rather than realistic support, participants described a lack of information regarding the benefits and management of breastfeeding. For instance, this was described in the following statement:

“If they would have said, you know, breast-feeding her exclusively would still have met her nutritional needs, I would have continued. I wouldn’t have put her on solids, but because the information I received was that she could eat solids now, I think if they would have stressed that she can, you know breast-feed exclusively, I think I would have, but that information wasn’t passed on in that way, it was more saying, it is time for her to go to cereal and solids.” (Lewallen & Street, 2010, p. 671)
Across the studies, women felt ill prepared and isolated without adequate preparation before going home with a breastfed baby (George, 2005; Mozingo et al., 2000). One woman reported this by stating that:

“They showed me how to put the breast in his mouth, but that’s all they really did. So when I came home I really didn’t know much about it.” (Mozingo et al., 2000)

Particularly newly breastfeeding women felt ill prepared regarding how to manage themselves and their baby, in what they thought might be natural and easy (Williamson et al., 2012). However, advice and assistance received in the early postpartum period from the midwives and other healthcare professionals was reported as prescriptive or “felt to be rigid so much rules that should be strictly adhered to” (Mozingo et al., 2000; Spencer et al., 2014, p.1081). Similarly, women felt the information given was too much to assimilate or that they received inconsistent advice with different healthcare professionals who attended to them (George, 2005; Hauck et al., 2011; Mozingo et al., 2000).

George (2005) described a model showing the effect of lack of preparedness in the new experience of this group of women. This included “unclear role expectations; knowledge deficit; overwhelming responsibility and change in priorities” (George, 2005, p. 254). With the knowledge deficit it was also suggested elsewhere how new mothers struggled and did not know the right kind of questions to ask in order to receive the appropriate support following the birth of their baby. Therefore these women failed in their expectations and felt distressed not knowing what to do in the early postpartum period. Indeed two women put it like this:

“I felt very much like I didn’t know what to do” another said; “There were so many times I didn’t know what to do, I was afraid to do anything.” (George, 2005, p. 254)

Consistently, participants in the study by Palmer et al. (2010) initially felt fascinated at first by the sight of their babies; however they later described the experience with the expression of insecurity, the question of not being able to balance the unknown prospect of breastfeeding. For instance, in a recent study,
Spencer et al. (2014) identified women’s ‘misunderstanding of newborn behaviour, such as crying, wakeful states and cluster feeding’ (p.85). Consequently, inadequate preparation before and following birth was found to have negative impacts on the women’s experience of breastfeeding (George, 2005; Palmer et al., 2010; Spencer et al., 2014). Studies therefore suggested the need for antenatal education to focus on providing realistic practical support, especially for the unique experiences of first-time women (George, 2005; Spencer et al., 2014).

2.6.2.2 Factors Influencing Maternal Confidence
Breastfeeding is considered as part of the biological process, where it is thought to be intuitive and based on the natural instinct of both the mother and her baby. As part of the pregnancy and birthing process, breastfeeding was thought to come naturally. Therefore prior to giving birth, women commonly expressed faith and conviction showing their capability to normally breastfeed their baby (Lööf-Johanson et al., 2013). However as things fell by the wayside due to physical challenges and concerns about insufficient milk, the frustration and the shock of not being able to get things under control undermined women’s confidence (Dykes & Williams, 1999; Hauck & Irurita, 2002; Marshall et al., 2007; Mozingo et al., 2000; Spencer et al., 2014; Williamson et al., 2012). Again, this negatively impacted on women’s self-identity. For example, studies have identified that, in most societies and families, breastfeeding was placed centrally to motherhood and therefore defines who a good mother is (Marshall et al., 2007; Schmied & Lupton, 2001; Thomson et al., 2014; Spencer et al., 2015). Women, however, felt guilty and shameful if they were not successful (Mozingo et al., 2000; Marshall et al., 2007; Thomson et al., 2014, p.37; Wall, 2001). In the study of Williamson et al. (2012), participants expressed guilt and fear that their baby might not get the benefits that breastmilk confers to babies. Consequently, women experienced “feelings of incompetence, inadequacy and inferiority” when their expectations and those of others were not met (Thomson et al., 2014, p 37).

“I was upset that I didn’t carry on like I wanted to – I thought it would come naturally’; ‘They [health professionals] tell you to breastfeed and
they don’t tell you how painful it can be.” (Thomson et al. 2014, p. 38; participant, Angela)

Moreover, women who could achieve breastfeeding success described it as empowering, and a source of pride and satisfaction to have used their body as a source of food for their baby (Dykes, 2005; Leff et al., 1994; Smith, 2008). One woman described how her experience of breastfeeding empowered her as a woman by stating that:

"And I think the best thing I've ever done in my life is breastfeed my children. It was the most empowering feeling thing I have ever experienced as a woman. Absolutely, and we have this miracle fluid that comes through our bodies . . . It's a miracle tissue. It's a miracle." (Smith, 2008, p. 4)

Another woman expressed the satisfaction she felt to have breastfed compared with bottle feeding, when she said:

"It is amazing that you can actually feed somebody else from your own body...I feel much more self-contained and able to look after him than if I was dependent on a bottle. I'd feel like I could be anybody really I wouldn’t, might not be his mother, I could be any old Tom, Dick or Harry.” (Williamson et al. 2012, p. 439; Erica, interview)

In this review, maternal self-identity was particularly evident in women’s desire to be able to manage and cope with breastfeeding, whilst experiencing it as compatible with their daily lifestyle (Andrew & Harvey, 2011; Dykes & Williams, 1999; Leff et al., 1994; Raisler, 2000). The woman’s ability to juggle feeding the baby with housework, shopping and having a perfect body image (Bottorff, 1990; Leff et al., 1994; McBride-Henry, 2004; Palmer et al., 2010). In a study looking at the breastfeeding experiences of ethnic minority women in the UK, many women described breastfeeding as interfering with other household tasks as well as movement outside of the house (Twamley et al., 2011). In a study by McBride-Henry (2004), one woman provided an apt picture of how a perfect breastfeeding mother could be by commenting that:

“The perfect mother can do everything. She can breastfeed while holding down a full time professional job, earning truckloads of money, can
manage a household, drives the perfect car, has great skin every day, lovely shiny hair, and goes to the gym, eats the perfect diet, and does all this and can still be having a good sex life, and be a gourmet chef [laugh]. It's just expectation that we bullied up in ourselves to do with breastfeeding, natural birth, perfect career, and the perfect marriage. I don't know why we do it to ourselves, because we're constantly disappointed.” (McBride-Henry, 2010, p.771; Eva)

However, for several women breastfeeding was more than just providing the baby with breast-milk, rather it was a daily learning process (Andrew & Harvey, 2011; Bottorff, 1990; Nelson & Sethi, 2005). Nelson and Sethi (2005), in their study, identified four processes through the breastfeeding journey. This begins from “one’s decision to breastfeed”, “learning to breastfeed”, “adjusting to breastfeeding”, and finally reaching a decision to “end breastfeeding” (Nelson and Sethi, 2005). Similarly, Ngai et al. (2011) identified the core category of “commitment” that emerged from their studies of essential characteristics of a competent mother.

2.6.3 Socio-Cultural Factors
In this review, mothers commented about how generational beliefs and practices (myths) related to breastfeeding created barriers (Grassley & Eschiti, 2008; Iddrisu, 2012). In a focused study of thirty women, Grassley & Eschiti (2008) found that breastfeeding occurs within the extended family system. They further recognised that support from grandmothers influence decisions to initiate and continue breastfeeding through traditional beliefs and practices. An example of this is illustrated as follows:

“I know my mother-in-law, my husband was born in '62, was taught that breastmilk is bad and it’s not going to be nutritionally enough for your child and that was just how she was raised and how she raised her children.” (Grassley & Eschiti, 2008, p.332; group 2)

In addition, studies from low resourced countries, [e.g. a Ghanaian study, Aborigo et al., (2012) and Dermatis et al., 2007, a study conducted in Turkey] demonstrated the negative effect of traditional culture and religious behaviour held by many generations on early initiation and duration of breastfeeding. Most of these beliefs surrounded the feeding of newborn babies with colostrum, which
provides nourishment following birth (Aborigo et al., 2012; Demirtas et al., 2011). In a study carried out in Ghana, Tawiah-Agyemang et al. (2008) identified the influence of Traditional Birth Attendants (TBAs) and the performance of birth rites for new mothers which delayed initiating breastfeeding early. The authors in a study carried out in Turkey identified how religious beliefs cause a delay in early breastfeeding for an extended duration of 16 hours (Dermatis et al., 2011). Breastfeeding was only initiated after three calls for prayers, whilst denying the newborn baby any nourishment. One mother commented on how she ignorantly delayed breastfeeding of her two children based on religious grounds.

“...My mother and mother-in-law told me that it was better to breastfeed after three calls for prayer...so that the baby does not have bad breath. I breastfed my first two babies after three calls for prayer ...I learned the benefits of first milk from nurses and comprehended its significance....I did not know about it when I had my first two children.... At my third birth, I wanted to start breastfeeding immediately.” (Demirtas et al., 2011, p.114; 40-year-old secondary school graduate with a 14-month-old boy)

Commonly identified in this review was the social construct that surrounded public breastfeeding, and the ambivalent feelings about exposing the lactating breast in front of others (Lewallen & Street, 2010; Leeming et al., 2012; Raisler, 2000). For instance, among the Turkish women who participated in a descriptive qualitative study, it was reported to be a cultural taboo for women to breastfeed in the presence of the male family members (Demirtas et al., 2011). Similarly, among the western culture, breastfeeding in public places is counted as perverseness and insensitive on the part of women (Andrew & Harvey, 2011; Leeming et al., 2012; Lewallen & Street, 2010; Raisler, 2000). These restrictions, however, have become a contributing factor where woman choose to stop breastfeeding or are not willing to give it a try (Andrew & Harvey, 2011). Women, however, resolved concerns about public feeding by using private spaces. Studies further identified how mothers withdrew from breastfeeding whilst in the public, but rather preferred using bottles of formula or expressed milk. Lewallen & Street, (2010) on the other hand commented on mothers
adopting measures, like discreet feeding, as a way of managing their lactating body in front of others:

“I found it again really difficult [breastfeeding] because there were a lot of men in there [a restaurant] ... so I went down to the toilets ... and found myself sitting on the loo giving him a top-up ... and I was worried about the germs ... I found myself sweating and rushing back to the car in the rain having got lost ... trying to get back to the car, just desperate so that I can give him a feed” (Leeming et al., 2012, p.461; Robin, Phase 2 diary)

Women welcomed the support of others; acceptance and approval led to positive and confident feelings about breastfeeding. This was commented upon by one woman who felt encouraged to breastfeed in front of family members, by stating that:

“He [father-in-law] was absolutely great and didn’t think anything of it [breastfeeding in front of him], even when they were leaving and I was feeding her he gave me a hug while I was there feeding her and it was a really, really positive feeling.” (Leeming et al., 2012, p.462; Louise, Phase 1 interview)

The women’s experiences in relation to public breastfeeding emerged as a barrier to successful breastfeeding. Women repeatedly expressed inconvenience and disapproval in the presence of others. For instance, a woman said: ‘I was made aware of “their” disapproval through critical facial expressions being directed toward me’ (McBride-Henry, 2010, p.771). Similarly, Bottorff (1990) noted that breastfeeding challenges a mother’s position in relation to the world, and thus, acceptance is extremely beneficial. Dykes (2005) further described ‘sexuality issues’, relating to maternal feeling for exposing their breasts in public settings. Breastfeeding women in both industrialised and low socio-economic communities found this as a challenge and found breastfeeding outside the home difficult. Studies therefore recognised the need for support and building infrastructures that ensure privacy to enable mothers to breastfeed.

2.6.4 Breastfeeding Support
Information, advice and support for mothers were expressed as crucial to their success at all levels of breastfeeding (Andrew and Harvey, 2011; Bottorff, 1990;
Locklin, 1995; Dykes, 2005; Grassley & Eschiti, 2008). For instance, mothers valued support based on "practical guidance, encouragement and the reassurance of doing it right" (Dykes 2005). The first postpartum weeks were often identified across the studies as the most crucial period for women and their babies; this is the period in which they needed active support. Rather than breastfeeding support being prescriptive and according to standard, Grassley and Eschiti (2008) identified five components as part of their participants’ suggestions for the right kind of support services that would enable them achieve breastfeeding success. These include: “information about breastfeeding and what to expect, practical help with positioning the baby to breastfeed, effective advice and suggestions, acknowledgement of mother’s experiences and feelings and reassurance and encouragement” (pp.181-183).

“I don’t think that women are aware of just how painful breastfeeding can be. In the leaflets it says all the encouraging things like it’s good for the baby. It would be more helpful if they were realistic and also pointed out that you have to be dedicated to keep it up. You are tied to your baby and get little space for yourself, which can be very exhausting for the first few weeks. If I had been more aware of this in advance, I could have prepared myself a bit more. Giving women a full picture may discourage breastfeeding, but it’s up to us to make the decision based on ‘true’ information.” (Grassley & Eschiti, 2008)

Undoubtedly, mothers’ experience of breastfeeding occurs within the family context. Support from the family and friends were expressed as strongly influential to a mother’s confidence to continue breastfeeding (Andrew & Harvey, 2011; Dykes & Williams, 1999; McBride-Henry, 2010; Street & Lewallen, 2013). In both the nuclear and extended family system, the mother’s own mother was reported as the one either approving or disapproving of their grandchildren’s feeding pattern (Andrew & Harvey, 2011; Dykes & Williams, 1999; Grassley & Eschiti, 2008; Thomson et al., 2013). Whilst some mothers viewed support from their own mothers as giving them confidence, others rather felt influenced by their mothers’ own feeding experiences (Dykes & Williams, 1999). This was clearly demonstrated by a newly breastfeeding mother, who stated that:
“I think my Mum could have pointed out the problems, but she didn’t mention any, she just said ‘oh I fed all three of you’ and I was fine… I just assumed that Mum had done it so could I, just as simple as that really.” (Dykes & Williams, 1999, p.239; Isabel)

Another mother commented on the fact that she felt under obligation to use bottles that enabled others to care for the baby:

“I like having the bottles because it gives her a chance to bond with … my partner and … her grandma and her great granny … feeding her is one of the most beneficial ways of bonding with a baby because you are so close.” (Samantha, Phase 1 diary)

Similarly, in a New Zealand study, Manhire et al. (2007) identified the attitude, beliefs and the family members’ knowledge base on the benefits of breastfeeding as a contributing factor to earlier cessation of breastfeeding than they would have chosen. Family members’ desire to be part of the feeding and bonding with the baby, however, increases pressure for early introduction of either formula feed or the mother having to express breastmilk in a bottle (Manhire et al., 2007; Grassley & Eschiti, 2008).

In most studies, concerns regarding the role of male partners in the support of breastfeeding vary (Bailey, 2007 Andrew & Harvey, 2011). For instance, in a study in Ghana (Aborigo et al., 2012), it was found that male involvement in the support of breastfeeding was limited, with the perception that breastfeeding is solely the responsibility of the woman. On the contrary, in countries such as the UK, fathers’ involvement has been reported to have a positive effect on the initiation and duration of breastfeeding (Raisler, 2000). Studies have also indicated that women highly value the joint decision with their partners regarding the decision to breastfeed (Andrew & Harvey, 2011). Moreover, male partners do want to be actively involved in the support and care of their baby’s mother (Dermatis et al., 2011; McBride-Henry, 2010), having the capacity to “protect and defend” their decision to breastfeed (Tohotoa et al., 2009, p.6). Support for breastfeeding was recognised to cut across women with varied socio-economic status, ethnicity and age.
2.7 Summary of Review
The narrative review of the literature was conducted to broadly examine the experience of breastfeeding from high and low resourced countries with women from different socio-economic background. In general, studies have demonstrated women’s decision-making, preparation and experience of breastfeeding. Across the various studies, the experience of breastfeeding was identified as comprehensive; however the majority of women reported inconsistencies between expectations and the actual experience. Physical and cognitive challenges such as position of the baby, sore nipples and painful breastfeeding were frequently cited. Moreover, new mothers were identified as the group of women who were most vulnerable; falling by the wayside as they negotiated their new status. There is also evidence of women’s need for support, especially during the early stages of breastfeeding. Frequent sources of support cited are the social group and family members. However, most studies revealed the support from health professionals as discouraging, rather commending peer support where they get the best help to keep them motivated.

2.8 Identified Gap
Most studies identified were retrospective in nature, reporting on experiences after women had ended breastfeeding or expressing views that they have already lived. In most cases authors identified potential of recall bias. There were also limited studies in Africa [e.g. Ghana (n=3); Nigeria (n=1) and South Africa (n=1)] that focus on the experiences of breastfeeding women. Individual studies from Ghana observed specific aspects of Ghanaian women experience of breastfeeding, for example, aspects of early and exclusive breastfeeding (e.g., Aborigo et al., 2012; Otoo et al., 2009; Tawiah-Agyemang et al., 2008); rather than women understanding and interpretations of their embodied experiences.

This current study therefore aimed to extend the understanding of the lived experience of breastfeeding by focusing on a group of first-time mothers in their late pregnancy to early and six months postpartum period. The aims of this thesis relate to the literature in a number of ways, most notably through the inclusion of the phenomenological qualitative method, and semi-structured interviews. This enabled experiences of breastfeeding to be explored as they were lived as a
subjective account. It also aimed to consider the women’s experience of breastfeeding within the cultural context of breastfeeding and motherhood in Ghana. It is therefore assumed that the findings will add to the understanding of breastfeeding and provide strategies that enable women to breastfeed successfully.

2.9 Conclusion
The principal aim, the objectives and the intended deliverables of this research are in line with the themes identified in the review process. Most (90 per-cent) of the studies included in the review were conducted in the high resourced countries, addressing the different dimensions that make-up women’s experience of breastfeeding. In Ghana, studies identified used qualitative methods but focused on specific areas (i.e., early breastfeeding or exclusivity of breastfeeding). This is the first research that would consider the holistic or totality of the Ghanaian women’s experiences, whilst enabling women to make sense of their own experience of breastfeeding and events happening in their daily lives.

The identified gap through the review process demonstrates the relevance of this study, in a way that empowers women to breastfeed as recommended. This might further establish any differences in the experiences of women in developed countries. In addition the theoretical and methodological base, that is, using phenomenological perspectives, semi-structured interviews to explore the views of women, was found to be consistent in most studies. This gives an indication that the phenomenological approach adopted in my research will yield the right kind of data that informs the study. The next chapter therefore provides an in-depth description of the theoretical and methodological stance that underpins this research.
Chapter Three
Methodology & Method
Chapter 3: Research Methodology and Method

3.1 Introduction
This chapter presents the methodology and method used to address the aims and objectives of this study. The intention is to demonstrate an appropriate method that promotes an in-depth understanding of the phenomenon being investigated. The chapter is structured into two main sections. The first begins by outlining the research aims and objectives, and the conceptual framework of interpretivist/constructivist research paradigms. Drawing primarily on the perspective of Heidegger’s hermeneutic phenomenology, informed by van Manen (1990/1997), has provided the appropriate methodological approach for considering the concept of breastfeeding. This takes into consideration the study context and individual participants’ experiences. The second section demonstrates the techniques and practical approach to gathering data. Details of the research methods employed, research area, sampling technique and process of interpretive data analysis are presented. Finally, the approaches suggested by Sandelowski (1986), which are used to enhance the rigour of the research process, are described.

3.2 Aims and Objectives
This study aims to gain an in-depth understanding of the lived experience of breastfeeding for Ghanaian first-time mothers.

Objectives
1. To explore women’s perception of breastfeeding in terms of the sufficiency and adequacy of breast milk;
2. To determine the nature of these perceptions and how they changed over the pregnancy and postnatal period;
3. To gain an understanding of the attitudes, values and beliefs that may have contributed to these perceptions;
4. To explore the influence of cultural practice and the role of family on women’s expression of their perception of breast milk; and finally,
5. To reveal women’s self-belief in their ability to exclusively breastfeed.
3.3 Theoretical Framework
As an enquiry that seeks to gain an in-depth understanding of the essence of lived experience from breastfeeding women, a qualitative exploratory approach is considered appropriate (Bowling, 2014; Holloway & Wheeler, 2010; Mertens, 2015). Qualitative research is generally associated with the philosophical tradition of the interpretivist approach, which involves social inquiry that attempts to make sense of people’s experiences and the world in which they live (Holloway & Wheeler, 2010; Polit & Beck, 2013). In the literature, qualitative research is distinguished from a quantitative approach to investigation (Neuman, 2014). Generally, quantitative research is associated with positivist philosophies, whilst qualitative research is commonly associated with interpretivist techniques.

There are different approaches to qualitative (interpretive) research (e.g., ethnography, grounded theory and phenomenology), and this is observed in the data collection and analysis. However, there are common features that make it distinct from quantitative or positivist research (Holloway & Wheeler, 2013, pp.3–4). In qualitative research, theory is not predetermined, as in the case of the quantitative method, but is inductively derived from the data. In addition, researchers are part of the on-going research process and are therefore sensitive to the context of the investigation. Researchers in the qualitative field focus on the views, meanings and interpretations provided by the actors or participants involved (Morse, 1994). Analysis and interpretation of data involves thick description. However, according to Koch (1995), this goes beyond participants’ constructions to include the researcher’s pre-understanding and knowledge of the subject being investigated. There is also intersubjective interaction, where the researcher and the researched are at an equal level. Lastly, researchers in this field of inquiry make their stance on the subject under investigation explicit through reflexivity.

This study is placed within the interpretivist/constructivist research paradigm, which acknowledges multiple constructions, the changing nature of reality and the confining/defining power of language (Miles & Huberman, 1994; Charmaz, 2000; Schwandt, 2000). According to Guba and Lincoln (1994, p.107), the research paradigm is a belief system and entails an understanding of the worldview ‘that
guides the researcher’s choice of epistemology, ontology, and methodology of investigation’. Alternatively, Cohen and Manion (2013, p.22) defined the research ‘paradigm’ as ‘the philosophical intent or motivation for undertaking a study’. In the literature, claims of what constitute the basic beliefs of the research paradigm have been highly contested. For instance, Guba and Lincoln’s (1994/2005) definition of ‘paradigm’ identifies four elements: axiology (the nature of ethics), epistemology (the nature of knowledge and the relationship between the knower and what can be known), ontology (the nature of reality) and methodology (how the knower goes about obtaining the desired knowledge and understanding). However, Laverty (2008), in her discussion of the philosophical and methodological tenets of phenomenology and hermeneutics, considered the following three elements: epistemology, ontology and methodology. Hence, the beliefs and philosophical assumptions of this research study are based on the epistemology, ontology and methodological premise.

Essentially, the interpretivist views reality as something that is constructed by humans, who use language to put forward concepts, models and schemes to make sense of experience, and modify these constructions or meanings in the light of new experience (Schwandt, 2000). An individual’s understanding is therefore limited by the words and concepts available to them within their particular culture, and may develop and change as new words and concepts become available through intercultural and intracultural exchanges. The constructivist outlook is highly compatible with a realist approach that seeks to understand how interventions operate in the contexts in which they are placed, as different individuals’ understandings of the actions performed in a particular environment are central to this process. The qualitative approach and constructivist perspective employed in this primary investigation influenced the choice of research participants, the extent to which the findings were seen as a ‘true’ rendition of the research subjects’ lives, and the steps taken to reduce or expose the researcher’s influence on the findings. These issues are discussed below.
3.4 Philosophical Underpinnings of Phenomenology

The term ‘phenomenology’ is the study of phenomena or ‘towards the things themselves’ (Van Manen, 1990, p.62). According to Langdridge (2007), phenomenology is a discipline that focuses ‘on people’s views of the world in which they live and what it means to them; a focus on people’s lived experience’ (p.4). She further highlighted that phenomenology, as a method of qualitative research, is a focus on the human experience as a theme or topic in its own right. It is concerned with meaning and the way in which meaning arises in experience.

Phenomenology is commonly identified as a philosophy and method. Spiegelberg (1982) referred to the philosophical traditions of phenomenology as a movement, rather than existing only within a given time. This, however, portrays the evolving and dynamic nature, as well as the significance of understanding, the various philosophical perspectives. Phenomenology can be seen as located within the positivist perspective Husserl, (1963), the interpretivist perspective Heidegger, (1962), or a combination of both interpretivist and constructivist Gadamer, (1972). However, others have only described the philosophical foundations based on descriptive and interpretive concepts of phenomenology. The specific context of their differences and similarities are examined below in detail, whilst considering their application to the current study.

3.4.1 Phenomenology according to Husserl

Edmund Husserl (1859–1938), a German mathematician, is often credited as the ‘father’ of phenomenology (Koch, 1996). However, Husserl’s descriptive phenomenology emerged from a project initiated by his mentor, Franz Brentano (Glendenning, 2007). Husserl sought principles and foundations on which science could be built. He urged researchers to search for reality, ‘the things themselves’ (Husserl, 1970, p.252). For Husserl (1970), the aim of phenomenology is the rigorous and unbiased study of things as they appear in order to arrive at an essential understanding of human consciousness and experience. In order to hold subjective perspectives and theoretical constructs in abeyance and facilitate the emergence of the essence of the phenomenon, Husserl (1970) devised the approach of phenomenological reduction and argued that the ‘Lifeworld’
(Lebenswelt) should be understood based on what individuals experience pre-reflexively 'before we have applied ways of understanding or explaining it. It is experience as it is before we have thought about it' (Crotty, 1998, p.95), without interpretation. Husserl advocated ‘putting aside’ any assumptions about the subject matter ('bracketing'), thereby allowing the essence of the phenomenon itself to emerge. This approach places the researcher as a detached, unemotional observer (Paley, 1997). For instance, nurse researchers viewed the issue of bracketing as a detachment from patients’ emotional feelings and world whilst attempting to reach an objective understanding (LeVasseur, 2003).

3.4.2 Hermeneutic Phenomenology
Hermeneutics is a discipline of study that relates to the philosophy and science of interpretations (Koch, 1995). Thus, it is both a philosophy and a method (Cohen et al., 2000). Fundamental to hermeneutics is the need to properly interpret and understand the meaning of daily occurrences or experiences in life. Human experiences are interpreted historically and contextually (Koch, 1995). This means that interpreting human experience is based on our understanding of the culture and background in which the situation occurs. Heidegger (1929) asserted that human beings are no different from what their culture and society offers them. For example, in order to understand the phenomenon of breastfeeding, it is important to understand the social and cultural context in which breastfeeding occurs for the study participants, and how it influences perceptions. Interpreting an experience contextually also involves consideration of the context of parts of the text in an attempt to determine the meaning of the whole, and vice versa (van Manen, 1990). The hermeneutic phenomenological methodology is based on phenomenological philosophy (Cohen et al., 2000). The discussion on hermeneutic phenomenology in this study will significantly focus on Heidegger’s and Gadamer’s tenets.

3.4.2.1 Heidegger’s Hermeneutic Philosophical Tenets
Martin Heidegger (1889–1976) was also a German philosopher, a student and successor of Husserl. Despite his relationship with Husserl, Heidegger’s philosophical idea in examining the lifeworld differs significantly from that of Husserl. Heidegger conceives the hermeneutic (interpretive) phenomenology, claiming that there is nothing such as an ‘uninterpretive’ texts or thoughts
Heidegger’s primary focus of phenomenology was based on his interpretation of ‘Dasein’. In his ‘Being and Time’, Heidegger explains that, it is through interpretation that ‘the authentic meaning of being’ (Heidegger 1962, p.62).

The ontological understanding of ‘Dasein’ is a central theme of Heidegger’s thought (Cohen et al., 1994). This is expressed in his attempt to make known the “basic structures of being” in which dasein possesses (Heidegger, 1962, pp. 37-38). It also shows Dasein’s peculiarities as a being in the world. To begin with, Dasein essentially refers to ‘human being’ and a type of being, having peculiar existential characteristics (Heidegger, 1962).

In his Being and Time, Heidegger disputed Husserl’s epistemological knowledge of phenomena, stating that phenomenology is based on understanding the existential meaning of ‘being’ (i.e., based on ontological concepts) of human experiences (Dowling, 2007; Laverty, 2003). According to Heidegger, ontology is concerned with the nature of existence and the structure of reality, providing the basis for epistemology (Taylor, 1994). In other words we exist before ‘we know what we know’ (Koch, 1995). In other words, the path to understanding ‘what it means to be human’ (Koch, 1995, p.832) does not lie in examining how we gain knowledge, but rather in an enquiry into the nature of being.

In his attempt to explain the nature of dasein, Heidegger opposes the Cartesian dualism notion that portrays human being as separate entities constituting mind, body and spirit (Heidegger, 1962). He belief that dasein, (‘being-in-the-world’) exist as an embodied being (i.e., the mind, body and spirit are inseparable). He emphasised that the task of ontology is to ‘explain the being itself and to make the being of entities stand out in full relief’ (Heidegger, 1962, p.49).

In his Being and Time, Heidegger explores the world by considering the entities or substances within it and the way dasein relates to them. This is influenced by the way people view and understand these entities through experiences in the world. Most significantly, dasein’s nature is seen in the different modes in which it exist (Inwood, 1990). Heidegger defines these entities in relation to how dasein makes
substances intelligible. The nature is the understanding *dasein* as always already presence in the world, or ‘*being there*’ (Heidegger, 1962, p.27; Laverty, 2003). This is translated in German as *da ‘there’*; *sein ‘being’,* which indicates how dasein interacts, engages or relates with his/her surroundings. Secondly, dasein demonstrates its possibilities of being by acting either authentic or inauthentic (p.68). Heidegger also revealed other aspects in terms to how dasein relates with objects or equipment’s in the world, by using the terms ‘*present-at-hand*,’ ‘*ready-to-hand*’ and ‘*unready-to-hand*’. Present-at-hand is something that we only have knowledge of and are independent of our lives (Blattner, 2006). An example of this pertains is substances or objects in the world that is as self-sufficient, such as the sun or trees. ‘*Ready-to-hand*’ refers to instrumental objects, such as equipment that has in practical usefulness. Using the hammer as an example, Heidegger pointed out that:

*The less we just stare at the hammer, or seize hold of and use it, the more primordial does our relationship to it becomes. And the more unveiled it (object) appears to us.* (Heidegger 1962, p.98)

The term ‘*unready-to-hand,*’ according to Blattner (2006), describes the ‘*unavailability of something for use in human practice*’ (p. 65). An object which remains as unready-to-hand is either breakdown or malfunction, and therefore becomes the focus of our attention. In addition Heidegger (1962) described objects in the unready-to-hand mode as something that only pertains to being missing or unsuitability, but also concerns us greatly and requires our attention.

Spiegelberg (1982) emphasised on Heidegger’s ideas of hermeneutic phenomenology as to provide interpretations of phenomena, within the context of socio-cultural and historical background in which the situation occur, “with results as startling as they were original” (p.7). This process involves the understanding of the phenomenon itself as they appear and, secondly, the attempt to understand how it is we about understanding the world, presented through the stories told by people living the experience (through gathering and analysis of data).
Heidegger contested the issues surrounding Husserl’s concept of bracketing. Bracketing suggests suspending prior knowledge so that fresh perceptions about phenomena can develop without any interference in the interpretive process (LeVasseur, 2003). According to Heidegger (1962), the attempt to uncover meaning regarding the worldview does not sit outside human consciousness. His approach posits that the experiences of others are viewed within a given socio-cultural context, and that the individual and the world closely linked together (Dykes & Williams, 1999; Koch, 1995).

Researchers who have adopted the Heideggerian hermeneutic method have acknowledged their own worldview as important in the entire approach and interpretation, where it is believe that bracketing of outside influences is neither possible nor desirable (Anderson, 1991; Cohen & Omery, 1994; Fleming et al., 2003). Fleming et al. (2003) highlighted the difficulties of laying aside one’s pre-understanding or foreknowledge; the current researcher also recognises these issues and it is for this reasons that a descriptive phenomenology was not applicable in this study. Anderson (1991) also noted that questions asked in hermeneutic research ‘reflect the way in which the researcher views the world’ (p.29), in which ‘meaning is constructed through a dialectical process’ (p.32). He reaffirmed that what is understood through Heidegger’s hermeneutic methodological approach is not the meaning of a thing, but our understanding of ‘being’ which can only take place through dasein’s intelligibility’ structured through the process of the hermeneutic circle (Heidegger, 1962).

In table 3.2 provide the main distinctions between Husserl descriptive phenomenology and Heidegger/Gadamer hermeneutic ideas, suggested by Koch (1995).
**Table 3.1: Comparisons between Husserl’s and Heidegger’s Phenomenological Approach**

<table>
<thead>
<tr>
<th>Husserlian Phenomenology</th>
<th>Heideggerian Phenomenology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transcendental</td>
<td>Philosophical hermeneutics</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>Hermeneutic phenomenology</td>
</tr>
<tr>
<td>Epistemological</td>
<td>Existential-ontological</td>
</tr>
<tr>
<td>Epistemological questions of knowing</td>
<td>Questions of experiencing and understanding</td>
</tr>
<tr>
<td>How do we know what we know?</td>
<td>What does it mean to be a person?</td>
</tr>
<tr>
<td>Cartesian duality mind-body split</td>
<td>‘Dasein’</td>
</tr>
<tr>
<td>A mechanistic view of the person</td>
<td>Person as self-interpreting being</td>
</tr>
<tr>
<td>Mind-body person lives in a world of objects</td>
<td>Person exists as a ‘being’ in and of the world</td>
</tr>
<tr>
<td>Ahistorical</td>
<td>Historical</td>
</tr>
<tr>
<td>Unit of analysis is the meaning giving subject</td>
<td>Unit of analysis is the transaction between the situation and the person</td>
</tr>
<tr>
<td>What is shared is the essence of the conscious mind</td>
<td>What is shared is culture, history, practice, language</td>
</tr>
<tr>
<td>Starts with a reflection of mental states</td>
<td>We are already in the world in our pre-reflective selves</td>
</tr>
<tr>
<td>Meaning is unsullied by the interpreter’s own normative goals or view of the world</td>
<td>Interpreters participate in making data</td>
</tr>
<tr>
<td>Participants’ meanings can be reconstituted in interpretive work by insisting that data speak for themselves</td>
<td>Within the fore-structure of understanding interpretation can only make explicit what is already understood</td>
</tr>
<tr>
<td>Claim that adequate techniques and procedures guarantee validity of interpretation</td>
<td>Establish own criteria for trustworthiness of research</td>
</tr>
<tr>
<td>Bracketing defends the validity or objectivity of the interpretation against self-interest</td>
<td>The hermeneutic circle (background, co-constitution pre-understanding)</td>
</tr>
</tbody>
</table>

(Koch, 1995, p. 832)
3.4.2.2 Gadamer’s Hermeneutic Tenets

Gadamer (1900–2002) is credited with contributing to the development of contemporary hermeneutic philosophy (Pascoe, 1996). As a student of Heidegger, Gadamer built on Heidegger’s philosophical insights, especially his understanding of the meaning of Dasein. In his Truth and Method, Gadamer (1989) placed the philosophical debate of hermeneutics within two central positions (Dowling, 2004). These constitute what he labelled ‘prejudices’, or horizons or preconceptions of meaning involved in a linguistic experience that makes understanding possible (Ray, 1994). His second claim focused on ‘universality’, or that which goes beyond the intersubjective account but involves understanding that is made possible through the human consciousness (Ray, 1994).

Linge (1976) identified the notion of prejudice as one of the most debatable features of his philosophy. However, Gadamer maintained that pre-judgements or prejudices have a special significance in interpretation, and therefore should not or cannot be disposed of (Pascoe, 1996). Further, our past (culture and historicity) has a profoundly pervasive power in contributing to the understanding of phenomena. Gadamer emphasised that the work of hermeneutics is to illuminate the circumstances under which understanding takes place, rather than to develop a process for understanding (Cohen & Omery, 1994).

Gadamer mentioned that people have a ‘historically effected consciousness’ as a result of existing in the particular history and culture that shaped them. As a result, interpreting a text involves a ‘fusion of horizons’ (Horizontverschmelzung), where the researcher finds ways in which the text's history is coherent with their own background. In Gadamer’s concept of philosophical hermeneutics, understanding is derived from personal involvement by the researcher in a reciprocal process of interpretation, which is inextricably linked with one’s being in the world (Spence, 2001). According to Koch (1995), the application of Gadamer’s hermeneutical concept involves more dialogue, rather than individual phenomenology, and interpretation permeates every activity, with the researcher considers the social, cultural and gender implications.
Gadamer placed a stronger emphasis on language than Heidegger did, and affirmed the position of the hermeneutic circle as the fusion of horizons, which is circular in process. He argued that we remain open to, and also embrace, the meaning held by another person (or text). Dowling (2004) explicated Gadamer’s assumption that what is essential throughout this process is that we are aware of our biases in order for the text to portray its uniqueness against our own fore-meanings (Gadamer, 1989). Therefore, the hermeneutic process becomes a dialogical method whereby the horizon of the interpreter and the thing being studied are combined.

In gathering hermeneutic data, Gadamer (1993) suggested that researchers use the term ‘gaining understanding’, rather than data collection. According to Gadamer, the aim of data collection is to reach an understanding through a fusion of horizon of meaning between the researcher and the participants. He further indicted that in spite of acknowledging foreknowledge, the inquirer must remain open to the subject and the views expressed by the other. For Gadamer, the significance of conversation in hermeneutic philosophical research is to allow immersing into the phenomenon being investigated. This therefore makes language the primary method of understanding; a universal medium in which understanding occurs (Moran, 2000). Finally, Gadamer (2004) expressed the idea that ‘human language must be thought of as a special and unique life process since in a linguistic communication, that “world” is disclosed’ (p.443).

### 3.5 ‘Researching Lived Experience’ (van Manen)

The tenets of the Canadian phenomenologist Max van Manen (1990), outlined in his book *Researching the lived experience: A human science for an action sensitive pedagogy*, provide a good grounding on which to better understand phenomenology as means of conducting human science research. Van Manen (1997) offered a practical guide to conducting phenomenological study, with concrete examples based on the experiences of parenting/teaching/notions of pedagogy. His approach to phenomenology has, however, gained acceptance among educationists, nurses and midwives who are interested in phenomenology as a philosophy, but also as a unique way to understand human existence (Benner, 1981).
According to van Manen (1997), the approach of phenomenology inquiry is rooted in the everyday lived experience of human beings. His method entails both descriptive and interpretive phenomenology, in which researchers attempt to grasp the essential meaning of the experience being studied (van Manen, 1997). Like Heidegger, van Manen (1990) referred to Husserl’s concept of bracketing, commenting that: ‘if we simply try to forget or ignore what we already know we might find that the presuppositions persistently creep back into our reflections’ (p.47). He further suggested that researchers using the phenomenological method acknowledge their previous experience, knowledge and beliefs, and how these may influence research in all phases of data collection, analysis and interpretation.

Furthermore, van Manen’s (1997) stance on the hermeneutic approach to phenomenology follows Gadamer’s philosophical principles, where language reveals being (or existence) within some historical and cultural contexts. Language, for example that used in interviews, gives meaning to the data. The researcher therefore moves in an ‘hermeneutic circle’ between part of the text and the whole, in order to establish truth by making sense of phenomena and interpreting them (Langdridge, 2007). This circle is defined as the process of understanding a text by reference to the individual parts, along with the researcher’s understanding of each individual part, and then referencing the whole dataset.

In this study, a qualitative hermeneutic approach, as described by van Manen (1997), was used. Hermeneutic phenomenology is applicable when the research question asks for meanings of a phenomenon with the purpose of understanding the human experience (Crist & Tanner, 2003). It aims at understanding the unique nature of each human situation of everyday experiences, rather than relying on abstract generalisations and theories (van Manen, 1997). The reason for adopting Heidegger’s hermeneutic method as outlined by van Manen (1990/1997) is that it keeps a strong connection to the phenomenon and is easily applicable to grasping the meaning of the lived experience of breastfeeding from the views of women who breastfeed. The literature review identified researchers that have successfully utilised the hermeneutic phenomenological method to explore women’s perception and experiences of breastfeeding (Bottorff, 1990; Dykes & Williams, 1999; Spencer et al., 2012/2015).
In summary, van Manen’s (1990) practical approach to researching the lived experience of a phenomenon helped to navigate the research methods. This involves the operationalisation of the phenomenological approach in a more pragmatic way, particularly in the data analysis. Van Manen’s (1990) phenomenological approach integrates both description and interpretations in uncovering thematic aspects of the breastfeeding experience (i.e., identifying and interpreting the meaning of the phenomenon). He described three distinct stages to thematic data analysis, which include the ‘holistic approach’, whereby the researcher reads the text as a whole, the ‘selective approach’, in which the researcher uncover the essential statements, and the ‘detailed approach’ or line by line, is whereby every sentences in the data is analysed (van Manen 1990, pp. ). The researcher engages in a reflective process by returning data to participants for validation (Polit & Beck, 2005).
**Table 3.2: van Manen’s Guidelines to Researching the lived experience**

| Step 1: Turning to the nature of lived experience: |
| The main phenomenon of interest in this study is to understand the meaning of the lived experience of breastfeeding from the perspective of first-time breastfeeding women. My pre-understanding and assumptions of breastfeeding were not bracketed out. They were rather written down and constituted in the reflection process. |

| Step 2: Exploring the experience as we live it: |
| The essence of the breastfeeding experience was obtained through semi-structured in-depth interviews with 28 breastfeeding women. Interviews followed a longitudinal approach beginning from the antenatal period, the first week after the baby was born, and the fourth and sixth month postpartum. Interview questions were influenced by the literature and the baseline interview with participants informed subsequent interviews. |

| Step 3: Reflecting on essential themes – Hermeneutic phenomenological reflection: |
| Repeated reading of interview transcripts and repeated listening to the audiotapes were used to isolate thematic statements. For each interview the themes that emerged as ‘there’ after initial readings and listening were identified (sententious approach). These were modified after the second round of several readings in more detail (highlighting approach). Finally the transcripts were read and re-read line-by-line and the themes that emerged in this step were used again to adjust and complete the themes that were isolated earlier (line-by-line approach). To complete the process of thematic analysis, the transcripts were re-read to ensure the accuracy of the themes. This is partially a step-by-step, but mainly a circular movement (hermeneutic circle). |

| Step 4: Describing the phenomenon through the art of writing and re-writing: |
| Through the writing and re-writing the meaning that the women brought to their experience of breastfeeding was made visible. Both the development of the themes and the themes themselves are accurately described. |

| Step 5: Maintaining a strong and oriented relation to the phenomenon: |
| The research aims and objectives were the main guide through the entire research process: interviewing, analysis and writing. These were repeatedly asked by the researcher in order to maintain a focused and oriented relationship to the views of breastfeeding women. Besides, van Manen’s thematic approach follows an inductive process, allowing themes to emerge as one dwells with the phenomenon or experience. |

| Step 6: Balancing the research context by considering parts and the whole: |
| In this study there was a continuous iterative movement (back-and-forth) between the research question, data and the final analysis to ensure a clear focus on what it is like to be a breastfeeding woman. |
3.6. Guiding Principles Underlying the Study

Heidegger and Gadamer are the two philosophers, whose hermeneutic philosophical tenets underpin this study, influencing the hermeneutic approach I took (Gadamer, 1989, Heidegger, 1962). In both perspectives, the focus of phenomenology is directed at understanding and making sense of the others’ experience in the world (Freeman, 2011). Heidegger claimed that the understanding of ‘Dasein’ is within the perspective of a lived experience (Moran, 2001). This therefore reflects on the need to understand the ‘lifeworld’ of the samples of the breastfeeding women in this study, on the basis of their lived experience, which constitutes substantially their perception and experiences of breastfeeding.

Furthermore, both Heidegger and Gadamer share the common view that emphasises on interpretation, viewing the individual as a being-in-the-world, who view and experience a situation within socio-cultural contexts. The interpretive approach is therefore, an attempt to unveil the ‘taken for granted’ (Heidegger, 1962). In using the Heideggerian approach, one acknowledged that her own world view mainly influences her approach and interpretations, where bracketing of outside influences is considered not feasible or desirable (Ray 1994; Koch, 1995). The researcher therefore has a responsibility of seeking for the hidden truth or meaning by engaging in interviews, reading and writing (Wilson & Hutchinson, 1991). The question ask therefore reflects the way in which the researcher views the world and meaning is constructed through a dialectical process (Anderson 1991, p.23). Gadamer (1989) acknowledged ‘language’ as a means of shaping both the experience and interpretations of texts, being the means in which understanding is made possible. In the light of this, conversational style of interviews was adopted to obtain in-depth accounts of the participants’ experience of breastfeeding.

3.6.1 Hermeneutic Circle

The hermeneutic circle simply refers to the process of understanding and interpretation of text (Gadamer, 1997; Heidegger, 1962). Understanding in this process is achieved through repeated circular movements between the whole (i.e., in terms of the reality situated in the detailed experience of everyday existence) by reference to understanding of the individual parts, and vice versa (Cohen et al.,
2000). According to Heidegger, understanding is developed on the basis of fore-structures (Heidegger, 1962, p. 195), so that rigorous interpretation can be achieved (Moran, 2000). Moran explained that the focus of the hermeneutic circle is not to get out of the circle, ‘but coming into it in the right way’, which is essential (Moran, 2000, p. 195). A clear understanding of a text in this process is dependent on the researcher’s ability to establish real relationships between reader, text and context (Ramberg et al., 2005). In the current study, understanding and interpretation of the data were developed based on my foreknowledge of the practice of breastfeeding in Ghana, and a review of the literature. This was augmented by exploring the narratives of participants, but with an open stance.

Within the hermeneutic phenomenological tenets, the hermeneutic circle is also reflexive (Koch & Harrington, 1998), in a way that enables the researcher to turn a critical view on themselves and how their opinions may have influenced the research process (Finlay, 2003). The interpretive process is however un-ending as it is always tentative, following the assumption that no single correct interpretation exists (Denzin & Lincoln, 2005).

This involve a continuous examination of the whole and parts of the transcript or texts (e.g., repeatedly listening to the audio-recorded interviews with participants) and ensuring that the interpretations are reflected in the findings (Diekelmann, 2001). This guided the research process, in the interpretation of text, which begin during the data collection and analysis, enabling a grasp to the essential meanings of the data (van Manen, 1990).
3.6.2 Reflexivity

The concept of reflexivity indicates a thoughtful, self-awareness of the ways in which ‘researcher’s personal assumptions, positions, values and social background impact on the dynamics of the research process [i.e., collection and analysis of data], (Finlay & Gough, 2003; Lipson, 1991). According to Rolfe (2006) reflexivity enhances the trustworthiness of the research, by extending the understanding on how personal positions and interest have impacted through all stages of the research.

Within the various literature, the approach to reflexivity is being debated (Freshwater & Rolfe, 2001; Finlay, 2002; Finlay & Gough, 2003; Taylor, 2006), with each expressing the challenges and strengths for the researcher. Finlay (2003) offers a map of five variants of a reflexive journey: ‘introspection’, ‘intersubjective reflection’, ‘mutual collaboration’, ‘social critique’ and ‘ironic deconstruction’. With introspection, research originates with the data of the researcher’s experience ‘by accepting his/her own humanness as the basis for psychological understanding’ (Walsh 1995, p.335). This approach address the researcher’s own reflections, intuitions and thoughts used as the core evidence (Moustakes, 1994). Moustakes (1994) further describes this process in terms of the formulation on the research question. In the case of this study is: ‘exploring an in-depth understanding of the lived experiences of breastfeeding women’. Formulation of research questions are developed through the prior review of the literature and theoretical understanding of breastfeeding. This also dismiss the concept of bracketing by Husserl (1970), which is intended for the research to bracket out pre-understandings, in order to enter into the lived experience of the participants and appreciate their narratives.

‘Intersubjective reflection’ as part of the multifaceted of reflexivity focus on the mutual meanings involved within the research relationship (Finlay, 2003, p.8). According to Lipp (2007), it is the self-reflective consciousness on the part of the researcher in relation to those being researched (Lipp, 2007). Employing this variant of reflexivity, has to do with turning a critical gaze towards the emotional
investment that both the researcher and participants have in the research relationship. Hammersley and Atkinson, (2007) pointed out about any associated features that will have a bearing on the way people react to the researcher. For example being mindful of the dress code during visits to the participants homes was important, in order to establish a good rapport between participants.

In addressing the issue of reflexivity, Parahoo (2014) noted that not only is it hard to carry out, but that it is not always possible to reflect and examine the effects of one’s preconceptions, since it is possible that we may not readily be aware of them. As a novice researcher, the application of reflexivity was challenging. However, in order to become aware of them, a field journal was used throughout the research process, to reflect on my personal observations and interpretations soon after returning from the field. However, in keeping with the hermeneutic method, rather than bracketing, my priori understanding was however acknowledged as part of the methodological processes, where decisions and dilemmas of the fieldwork experience became part of the research process.

In this study, stance on ‘reflexivity shows a dynamic process of continuously reflecting on the interpretations of my personal experiences and the phenomena being studied so as to move beyond the partiality of my previous understandings’ (Finlay 2008, p.108). Throughout the research, I became aware of my personal influence, which served as an integral part in promoting my understanding of the phenomenon being considered and my role as a researcher. Practical aspects on reflection and reflexivity undertaking in this study are highlighted at different stages of the research process.

In summary, in my orientation to the phenomenon of study, I have explored the participants’ and my own historical and cultural horizons, in my attempt to be open and make them explicit. I have been mindful and open to the phenomenon of breastfeeding as it has emerged through the participants' narratives. To achieve this, I have adopted a position of making this explicit by assessing my pre-understandings through the background information provided in (Chapter One), and acknowledging my understandings of breastfeeding as a Ghanaian. I have immersed myself in the narratives in order to allow the meaning and interpretations
within the text to emerge through the voice of my own presuppositions and understanding. In addition, I repeatedly returned to the texts in an attempt to be owned by the text, and in doing so allowing the text to speak. I was also immersed in a continuous process of questioning any interpretations that have emerged. This is as a result of dialogue with the transcripts of the participants’ narrative accounts of their breastfeeding experience led to a fusion of the mothers’ horizon and that of mine. Through this process, findings that emerged were put into a perspective that enhanced understanding of the phenomenon of breastfeeding in Ghana. Openness to the phenomenon was key involving reflective processes (i.e., being quiet and allowing interpretations to come); no matter how long it might take.

3.6.3 Ethical Consideration

The essence of ethical consideration is to safeguard the interests of research participants (Eide & Kahn, 2008; Hollow & Wheeler, 2010) and entails how well researchers treat participants (Ritchie et al., 2013). Ritchie et al. (2013) described ethical practice as the heart of research that uses human beings as subjects of investigation. Ethical issues were addressed based on the four main ethical principles of respect for autonomy (Beauchamp & Childress, 2009). Autonomy refers to respect for an individual participant’s right to voluntary participation. This is also related to their capacity to make informed choices and provide consent. Beneficence and non-maleficence relates to the researcher’s making every effort to promote the benefits of the study to participants, whilst minimising potential harm. Justice is concerned with fairness and equal treatment without discrimination. In this research study, ethical practices were considered before, during and after data collection (Graham et al., 2007).

In planning and carrying out data collection, an effort was made to avoid any form of perceived coercion. The research participants were entirely free to make a choice about their participation. All participants approached were provided with information sheets (Appendix section 2), and were given time and space for both reflection and further discussion regarding their participation. The information sheets explained details of the research objectives, duration, and reasons for participants’ involvement and option for them to withdraw at any time without any
negative effect. Written consent (Appendix 3) was then obtained from interested participants.

During the data collection, participants were reminded of their right not to answer a question or to say more than they wanted to. Verbal consent was renegotiated prior to the beginning of the interviews. Flexibility was ensured in the way questions were asked. A good rapport and relationship established throughout the data collection enhanced participants’ feelings of comfort and respect. In addition, conducting interviews at individual participants’ homes built their confidence, while preventing any form of intimidation. The right to confidentiality and anonymity were respected, whilst data was only made available to supervisors. Confidentiality was maintained by using pseudonyms to identify participants. In addition, unbiased and accurate reporting of participants’ stories was provided in the discussion of findings (Graham et al., 2007). As per the Data Protection Act (1998), all data generated, including transcripts and computer-generated data, were stored in secure files protected by a password. Access to information was limited to the researcher and supervisors involved in the study. All interviews were personally transcribed and each transcript was anonymised. The chapters that explore the interpretations contain portions of narratives, which are identifiable only through a pseudonym and interview number. Ethical approval was granted by the University of Manchester and permission received from Ghana Health Services (GHS) (Appendices 3 and 4).

3.7 Research Design
A prospective longitudinal research design was used to meet the aims and objectives set for this study. This utilised qualitative research methods or techniques to generate data from the participants taking part in the study (Pope & May, 2006). In keeping with hermeneutic phenomenology, this method was designed to help interpret the meaning of lived experiences of the women relating their experiences of breastfeeding. The longitudinal approach enabled a continuous discussion with the participants in a way that helped to identify changes over time (Coden & Miller, 2007; Holland et al., 2006), as part of the transition process.
The following topics are outlined: description of the study area, inclusion and exclusion criteria for selecting participants, access and recruitment, sample size and sampling technique, data collection, analysis and interpretation of data, and finally rigour of study.

3.8 Description of Study Area

The study was located in the Ashanti region in central Ghana. The Ashanti region is mainly made up of the Asante group of people; however, approximately 11% of people from other ethnic groups make up the total population (Ghana Population and Housing Census, 2000). Over half of the population in the Ashanti Region lives in urban areas (51% in 2000). Manhyia Government Hospital is one of the district hospitals within the urban city of Kumasi. Participants were identified and recruited from an Antenatal Clinic (ANC) of the hospital. The hospital serves 10 communities within the Kumasi Metropolis. The diversity of the population at the hospital made it an ideal study site. The diversity is described in terms of different socio-demographic characteristics and economic status. One of the main landmarks close to the hospital is the Manhyia Palace, the seat of the Ashanti king. (See Appendix 2 for a picture of Manhyia Hospital.)

The hospital is located about 30 kilometres away from the main city centre, on the north side of Kumasi. It has facilities that provide both outpatient and inpatient wards for conditions that relate to medical, surgical and maternity care, among other services. The maternity unit, from which participants were identified and recruited, runs ANCs, delivery suites and maternity wards for postpartum women. It also runs child welfare clinics and counselling sessions for mothers and their babies.

The Maternal Unit is a recognised Baby Friendly Initiative hospital. Whilst the delivery unit runs in-patient facilities every day, the ANC runs on weekdays only. As one of the most vibrant district hospitals within the metropolitan assembly, daily records show close to 200 women attending antenatal care every day. The mean number of births occurring at the hospital in a year stands at 1,300, with 600 of these women giving birth for the first time. Attending women range between 18 and 36 years of age (Manhyia Government Hospital Annual report, 2010). On
average, a total of 100 pregnant women attended the ANC on a daily basis, of which about 15 were eligible for this study based on the inclusion criteria.

The Maternal Unit of the study site runs an ANC along with family planning, skilled delivery care and emergency obstetric care. Attendance of expectant women at the ANC adheres to the World Health Organization (WHO) guidelines. The WHO’s (2011) new model of ANC for low-income countries can be observed to have moved away from the traditional model. The updated model, also called ‘focused’ ANC, promotes at least four visits by pregnant woman to a health facility during an uncomplicated pregnancy (WHO, 2002).

All the women in this study were recruited through the ANC at the hospital within Kumasi Metropolis; most women lived within the general geographical area. This area spans a 20km radius to suburban areas. An additional seven women lived in other areas at the outskirts of the hospital. Most women accessing the clinic travelled for about 10 to 25 minutes to the health facilities for their ANC. The women often used taxis or minibuses, but those who lived within shorter distances from the health centre walked there for up to 10 minutes. The maternity clinic is held in an open space with a mass of women seated and awaiting their turn. The clinic begins at 8am in the morning. Routine activities are covered by midwives and health care assistants and include a health talk and routine monitoring. On average, an individual woman spends three hours or more at the clinic, due to the small midwives-to-women ratio. Pregnant women attending the study site varied in terms of socio-demographics (e.g. different ethnic groups and socio-economic status). This shows that various groups of women representative of the larger Ghana population.

3.9 Inclusion and Exclusion Criteria
Dilthey (1985) suggested that the most basic form of lived experience involves our immediate, pre-reflective consciousness of life. This means that ‘[…] the lived experience is there-for-me because I have a reflexive awareness of it, because I possess it immediately as belonging to me in some sense’ (p.223). Therefore, in keeping with hermeneutic phenomenology, this requires that selected participants
might have lived through or are living through the experience or the phenomenon in question, in a way that they are capable or willing to provide access to it (van Manen, 1990). In this study, participants were selected primarily because they had knowledge of the phenomena. This was found to be consistent with a similar phenomenological study of 22 participants in the UK (Spencer et al., 2015). In addition, specific characteristics were considered for including or excluding participants based on the following criteria:

**Inclusion Criteria**
- Women intending to breastfeeding
- Primiparous women
- Women in their third trimester (≥36 weeks)
- Women aged 18 years or over
- Women able to provide informed consent

**Exclusion Criteria**
- Multiparous women
- Women unable to speak or understand the Twi language

### 3.10 Gaining Access and Recruitment

Shenton and Hayter (2004) noted that one of the most basic tasks that relates to undertaking fieldwork for qualitative research is gaining access, which is the process of entry into a research site and to potential participants. According to Creswell (2007), it requires a combination of strategic procedures to be followed. In their book, *Gaining access: A practical and theoretical guide for qualitative researchers*, Feldman et al. (2003) presented a useful conceptual guide that recognises gaining access as a process of building relationships. Processes also require researchers to identify those who can help them gain access, learn the art of self-presentation and nurture relationships once they are established.

The starting point in gaining entry, according to Given (2008, pp.3–4), is the first and most important step of obtaining ethical permission. Therefore, for this study the process began with securing ethical approval from the University’s Ethical Committee review. Permission from the directorate of GHS in the Ashanti region of Ghana was obtained, in order to access first-time pregnant women at the ANC of
one of the local district hospitals in Kumasi. Permission letters from both institutions were obtained (see Appendices 1 and 2). In addition, access to the midwives who were directly involved in the care of interested participants was considered to be very important in this situation, as it enabled the development of a relationship that allowed flexibility and easy contact with participants.

Potential participants were recruited after midwives had made an announcement about the research project. I was also granted permission to briefly discuss my study during the ANC hours, which generated additional interest. The midwives helped to identify potential women. All eligible women were personally approached and invited to participate in the study. To determine whether a woman met the inclusion criteria, they completed a mini demographic questionnaire (sample questionnaire in Appendix 3) of less than five minutes. This included the woman’s age, educational background, marital status, address of residential home and telephone number. Interested participants were provided with participant information leaflets (see Appendix 4). The process to be followed in the research was explained, and participants were given the opportunity to ask questions.

In a phenomenological study in which participants include individuals who have experienced the phenomenon, permission was also obtained from each research participant, and informed consent forms signed. However, as indicated by Feldman et al. (2003), the access process continued throughout the research by verbally renegotiating consent before the start of each interview. Informed consent also addressed the issue of women’s voluntary participation and confidentiality.

### 3.11 Sample Size and Sampling Procedure

#### 3.11.1 Sample Size

A total sample size of 30 expectant women was initially identified and included in the study, although, for a hermeneutic phenomenological study, the total sample size of participants was acknowledged to be large. This was discussed with supervisors and was agreed upon, with the intention to allow for a dropout rate as interviews were to involve the same participants being followed up after a period of six months. The possibility of maternal or infant death was also taken into
consideration in lieu of previous records showing a high incidence of such death in Ghana. For instance, a 2010 report by the World Bank indicated 49 infant deaths per 1,000 live births and 350 maternal deaths per 100,000 births.

Using the purposeful sampling method ensured that participants met the inclusion criteria and had the intention to breastfeeding after childbirth, and were willing to share their experiences. This enhanced the richness and depth of data generated, and therefore thick description of the analysis (Cohen et al., 2000; van Manen, 1990).

3.11.2 Purposive Sampling
Purposive sampling in qualitative research is a non-probability sample method, characterised by the researcher’s effort to gain representative samples (Holloway & Miles, 2002). Patton (1990) also described the purposive sampling technique as that which lies in selecting information-rich units or participants for in-depth study. The goal of this sampling method was to select specific individuals for the study ‘because they can purposefully inform an understanding of the research question and central phenomenon’ (Creswell, 2007, p. 125). Conversely with this strategy, samples are considered not representative of the general population; however, in qualitative research this is not a weakness (Streubert & Carpenter, 2010). An advantage of this technique of sampling is that it tends to be flexible, rather than following fixed and rigid processes as in quantitative research (Huberman & Miles, 2002). In this study, utilising a purposeful sampling method was considered appropriate, particularly in keeping with phenomenology, where research participants are selected based on the fact that they have experience of the phenomenon being investigated. This strategy helped in the selection of first-time pregnant women. Therefore, sampling was intended to ensure the inclusion of women who could provide context-rich information regarding the breastfeeding phenomenon (Streubert & Carpenter, 2010; van Manen, 1990).

3.12 Data Collection
Data collection followed a longitudinal prospective approach, investigating the perspectives of women beginning from late pregnancy, the first week following the birth of their baby, and then four to six months postpartum. According to van
Manen (1990) data in researching lived experience is considered to be ‘given’ or ‘granted’ to us (p.53), which requires orienting the participant in a strong way by searching for the meaning of lived experience and the emerging phenomena. Therefore, to begin the search for meaning requires that the appropriate tool is adopted to gather data. In this study, the interviews took the form of conversation, which was considered suitable (Gadamer, 1993; Kvale & Brinkmann, 2009). This method enabled deeper exploration of the research participants’ lifeworld through reflective exploration and ‘fusion of horizon’, involving the views of individual participants and my understanding of the issues explored (Gadamer, 1993; van Manen, 1990).

Data collection took place from November 2012 to June 2013, through a series of interviews. Three series of interviews were conducted, starting from the antenatal period, the first week postnatal period and four to six months of breastfeeding. Carrying out three repeated interviews with the same participants was consistent with hermeneutic interpretive phenomenology (Benner, 1994), in order to gain a deeper understanding of the phenomenon of breastfeeding. Setting the limit of data collection at six months conforms to the WHO recommendation of exclusive breastfeeding for the first six months (WHO & UNICEF, 2003). This was also found to be consistent with the data collection approach identified in the literature (Hoddinott et al., 2013; Spencer et al., 2015). An audio recorder was used to record the data during the interviews. Before the interviews, the women read a lay summary of the purpose and procedures of the study, agreed to audiotape and signed a consent form.

Two women who seemed uncomfortable with the audio recorder, interviews were improved by using a personal mobile phone and immediately transcribed into text. Reflective notes were made immediately after returning from fieldwork, and this provided an account of what happened on the research field with participants. Cohen et al. (2000) emphasised keeping a reflexive note/diary as a useful way to enable researchers to reflect on their personal biases during data collection and interpretation of data. Keeping reflexive notes was useful in accounting for observations and gestures of participants that brought meaning to their experiences and also personal influences during visits and interaction with
participants. These were relevant to interpreting and understanding the participants’ world.

‘The Act of Dialogue’
In the fusion of horizons, Gadamer demonstrated that this occurs through the act of dialogue, as the researcher and participants engage in a conversation based on the ‘Socratic-Platonic’ art of dialectic, ‘i.e. the art of questioning and of seeking truth’ (Gadamer, 1997, p. 367). The interviewer maintains an attitude of openness to the topic, and seeks to formulate questions in such a way that the topic is ‘broken open’ to allow the essential structures of the phenomena to emerge; that is, ‘the truth that the topic reveals’ (p. 363). The purpose is not to understand individual people, but to understand that about which they speak.

Interviews were conducted at the participants’ homes. The primary source used to provide background information on the women’s narratives was an audio recorder. The average duration of the interviews was 30 to 60 minutes, with the longest taking 90 minutes. Interviews two and three, which enabled the women to recount the realities of their daily breastfeeding experience, lasted between 45 and 90 minutes. This enabled the conversation to be expressed in more depth and richness as the women reflected on their experiences. Moreover, all the women felt comfortable during this timeframe about sharing their stories.

3.12.1 Semi-Structured Interviews
The semi-structured interview is a method of research used in the social sciences. While a structured interview follows a rigorous set of questions that does not allow for diversion, a semi-structured interview is open, allowing new ideas to be brought up during the interview as a result of what the interviewee says.

3.12.2 Topic Guide
This study aimed to gain understanding of the meaning of lived experience of the phenomenon of breastfeeding by first-time breastfeeding women in Ghana. Three central research questions were considered to lead each of the series of interviews and explore more depth with the participants:
• What were the women’s perceptions and expectations of breastfeeding prior to birth?
• What were the women’s experiences of early breastfeeding?
• What were the women’s experiences of breastfeeding in the first four and six months?

The questions asked required more than just a description of experience, and sought to establish what it means to be a breastfeeding woman, which is based on Heidegger's ontological question relating to the meaning of being.

### 3.12.3 Gathering Data/Interviewing

The first data collection stage followed a series of semi-structured interviews beginning with a baseline interview at the antenatal period (from 36 weeks of gestation) following recruitment. The baseline or first interview focused on understanding the women’s perception and expectations prior to breastfeeding. I asked the women questions including the following: Tell me what you know about breastfeeding; what informed your decision to breastfeed? How did you prepare to breastfeed? What were your hopes concerning breastfeeding after birth. The overall conversations integrated probes and prompts using key phrases from the women’s own responses to maintain flow of conversation, as well as for clarity and elaborations on specific issues of interest. The duration of this first interview was between 45 and 60 minutes.

The second interview, which was a follow-up interview, took place within the first week after the individual woman had given birth. All interviews at this stage were conducted at participants’ homes. This second interview followed the women’s intentions from the first interview. The interview usually lasted 1 hour 30 minutes to 2 hours. I asked women what their first experience of breastfeeding was like. Most questions asked were follow-ups regarding their intentions outlined during the baseline interview. All the women spoke at length about their experiences using probes and prompts. Some of the women were breastfeeding at the time of the interview. Descriptions and interpretations from the previous interview were ‘checked out’, with sensitivity, with the participants at their next interview for confirmation and accurate representation of the data (Morse, 2002).
The third interviews were mainly intended to allow participants to provide a reflective account of their breastfeeding journey. This second follow-up interview took place within four to six months postpartum. As already stated, choosing the first six months conforms to the standard duration of exclusive breastfeeding (WHO & UNICEF, 2010). However, women who had introduced formula feeding were still followed. The third interviews also engaged women to provide a descriptive account of specific events or incidents in their breastfeeding journey. Gaps left in early transcription and field notes were further clarified during the interview, along with how the women’s experience changed over the pregnancy and postnatal periods.

3.13 Data Analysis
In keeping with hermeneutic phenomenology, van Manen’s (1990) inductive approach to thematic analysis guided the process. The goal of analysing phenomenological data is to ‘transform lived experience into textual expression of its essence – in such a way that the effect of the text is at once a reflexive, re-living and a reflective appropriation of something meaningful’ (van Manen, 1997, p.36). Van Manen (1990) suggested three processes to uncover the structure of a phenomenon as an essentially lived experience. These are ‘seeking meaning’, ‘uncovering thematic aspects’ and ‘isolating thematic statements’.

However, it should be noted that van Manen’s method of thematic analysis is not intended to be prescriptive. The approach to analysing the data generated was based on hermeneutic and phenomenological principles and guidelines identified in the literature. According to Cohen et al. (2000, p.72), the goal of analysing hermeneutic phenomenological data involves ‘a thick description that accurately captures and communicates the meaning of lived experience for the informants being studied’. Therefore, in this study, the process involved in the analysis of data drew upon van Manen’s approach and those of researchers in the field of phenomenological interpretive research (Ajjawi & Higgs, 2009; Cohen et al., 2000; Schwandt, 2001; Smythe, 2011; van Manen, 1990)
3.13.1 ‘Orientation to Interpretation’

The focus of interpretive analysis is to grasp meanings throughout the process of analysis (van Manen, 1990). The process of data analysis was characterised by the hermeneutic circle and dialogue as the key approach drawn from hermeneutic literature used in this research (Cohen et al., 2000; Schwandt, 2001). The concept, as described by (Ajjawi & Higgs, 2009; Cohen et al., 2000), provides a systematic and useful way of interpreting the participants’ data. As indicated earlier, the hermeneutic circle is a metaphor for understanding and interpretation, a movement between parts of the data (line-by-line reading of the text) and whole (the global meaning of text), each giving meaning to the other such that understanding is circular and iterative (Ajjawi & Higgs, 2007).

Following hermeneutic principles, analysis encompassed an ongoing interpretation of texts and the concept of breastfeeding. With this process, each repeated reading and writing cycle revealed new ideas and connections. This took into consideration my pre-research assumptions about the phenomena, while constantly examining these assumptions by comparing and contrasting them with the emergent findings. Interpretation of texts was not linear, but iterative, requiring several repeated circular movements between parts and the whole. This activity was accomplished by repeatedly cross-checking my personal (including cultural and historical background) interpretations with the original transcripts, as I sought to maintain closeness or grounding in the participants’ constructs. The strategy of maintaining truthfulness was suggested by Lincoln and Guba (2000). Dialogue with supervisors about the emerging findings served to further check the authenticity of the data.

Gadamer (2006) asserted that understanding text requires that researchers should project before them the meaning of the text as a whole as soon as initial meaning emerges in the text. He argued that a completely open mind understands nothing; however, it is important to attempt from the beginning to avoid biases, in order to focus on the text itself and allow meaning to unfold naturally.

In the context of this study, meanings projected onto the text were shaped by my own assumptions and pre-understanding. Cohen et al. (2000) refer to this as ‘narrative texts’, which is ‘meant to convey the researcher’s present understanding
and interpretation for the data’ (p.71). This is demonstrated in Appendix 9, using the example interview transcript provided. Understanding then emerged through the process of dialogue between with the text and personal assumptions (Schwandt, 2001). The act of interpretation represents a coming together to form a whole new insight and understanding to the meaning of the phenomenon (Bontekoe, 1996; Kinsella, 2006).

**3.13.2 Stages of the Data Analysis:**

Although there is no single definitive method employed to undertaking hermeneutic data, the intention is to grasp meanings throughout the process of the analysis (Cohen et al., 2000).

**Stage one: Repeating reading and writing**

This involves organising and being immersed in the original data. Texts were constructed for each participant from the interview transcripts and field notes. Texts from all three interviews were accumulate together as one, which was important in order to gain a sense of each woman's experience as a whole. Each participant’s texts were repeatedly read on several occasions to familiarise me with the data. The audio recording of the interviews was repeatedly listened to, alongside reading of my reflexive notes. This process is referred to as ‘immersion’ (van Manen, 1997). The goal of immersing oneself in the original text is to establish some initial interpretation of the data that will eventually drive its coding in subsequent phases of the analysis (Barritt et al., 1984; van Manen, 1994). This involves engaging with the meaning of the texts, with the intent of getting a sense of the whole and making preliminary interpretation of it, which then facilitates coding. The essential characteristics of each of the data were identified.

Field notes written to capture my personal experiences and construct meaning from the inquiry were used to facilitate recreation of the context, which became an important part of the process of interpreting the texts. Some of the participants’ transcripts were coded independently by supervisors, in order for them to familiarise themselves with it and enable dialogue during supervision sessions about the emergent codes and their interpretations. Dialogue between supervisors and myself served as a means of reflecting on the emerging themes and helping to
develop and expand on the ideas. Such dialogue was valuable for providing insight, considering alternative interpretations and contradictions, as well as thoroughness in examining the data (Barbour, 2001). Emerging thoughts were documented in the form of memos, linked to the relevant sections of the text.

**Stage two: Identifying participant constructs (understanding first-order constructs)**

‘First-order constructs’, according to Ajjawi and Higgs (2007, p.624), are the ideas communicated in the participants’ own words, and use of phrases that capture the exact detail of their narratives (Titchen & McIntyre, 1993). These constructs relate to the research questions of women’s lived experience of breastfeeding. First-order (or participant) constructs were identified first for all the participants, and were then used to code, with a continuous process of checking for appropriateness and completeness of the texts. All texts were coded manually in order to identify these constructs by writing on the right side margins of the texts. During this stage, the supervisors provided feedback and questioned the relevance of the constructs, identifying overlaps and/or connections between individual participants’ constructs.

My understanding of the participants’ interpretive constructs was checked at the end of each stage interview by providing a summary of the ideas raised during the conversation for confirmation and truthfulness. Previous interviews were used as probing questions in the subsequent interviews for clarification and in-depth understanding. This form of iterative member-checking provided a progressively richer and deeper understanding of the participants’ experiences of their breastfeeding journeys. This form was a key aspect of producing findings from interactions with the participants as the research progressed (Ajjawi & Higgs, 2009).

**Stage three: Interpretive summary**

‘Second-order constructs’ involve the researcher’s theoretical and personal knowledge generated from the first-order constructs (Ajjawi & Higgs, 2006, p.624). A Word document was created showing a summary of my interpretations, including all relevant extracts from the transcripts. Reflective notes were copied into that file labelled with the first-order construct. If an interpretive summary was found to be
very similar to an existing one, then all the data were copied into the existing file. Interpretation of each interview transcript was used to demonstrate the participant data as a whole, which then informed understanding of each transcript such that a deeper and richer understanding of the phenomena evolved. In the same way, a data-set for each subgroup was formulated, and this was then used to understand each woman’s data, looking for any similarities between the subgroups. At the end of this stage, all the relevant and meaningful text material was grouped under each relevant construct for each subgroup, in order to answer the main research question and sub-questions.

This stage also began the coding process, which involved repeatedly reading and writing each interview transcript alongside my reflexive notes. The audio recordings of the interviews were revisited on several occasions. Such listening enabled me to get a sense of the ‘whole’. Having familiarised myself with the data through the interview process, listening and transcribing, and repeated readings, I able to examine the interview transcripts line by line and identify some initial codes. This is referred to as ‘selective or line by line coding’ by van Manen (1990, pp.92-93). Identification of the initial codes shows aspects of the data that appears ‘interesting from the original data described by the breastfeeding women, and assessed in a meaningful way regarding the phenomenon’ (Boyatzis, 1998, p.63). I examined each account based on the overall aim of understanding women’s lived experience of breastfeeding. This facilitated a deeper engagement with the data, and understanding of what it means to be a first-time breastfeeding woman in Ghana. Unfolded understanding of the phenomenon continued to inform subsequent ones whilst I was immersed in the text.

The interpretation and coding process was guided by my pre-assumptions and understanding of the topic being investigated. Interpretations at this stage involve two processes: first, the participants making sense of the phenomenon by explaining and interpreting their own experience; second, the researcher explaining and interpreting the meaning of the participants’ accounts (Smith et al., 2009). This is referred to as double hermeneutics by Smith and Osbourn (2003, p.51).
Stage four: Developing emergent themes and sub-themes

A characteristic feature of the thematic method of data analysis is that it allows for systematic identification of patterns within the data (themes) and interpretations (Braun & Clark, 2006). I looked for connections across the emergent themes and identified ‘superordinate’ themes. Themes and sub-themes were developed from the results of stages one to three of the analysis. The second-order construct files were grouped together into a smaller number of broad themes both across and within the overall data. In this stage, themes and sub-themes were elaborated and their relationship clarified by reading and re-reading the data. This stage involved continuously moving backwards and forwards between the literature, the research texts and the initial analysis, moving from parts to the whole following a process informed by the hermeneutic circle. From this process, interpretation of the research phenomenon and the lived experience of breastfeeding evolved. This in-depth interpretation helped to identify meanings that the participants could not articulate, considering the complexity and tacit nature of the phenomenon being investigated. ‘In determining the universal or essential quality of a theme the concern was to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is’ (van Manen, 1997, p. 107).

Themes and sub-themes were presented at the University of Manchester Midwifery group meeting in October 2015, where feedback was given on the fit and credibility of themes and sub-themes. The value of presenting the research findings at the midwifery group lay in the ensuing feedback and discussions about the research topic and the help this provided in refining presentation of the research themes. It was also an opportunity for me to reflect on the emerging interpretations in the process of writing and articulating the research process and content. Finlay (2003, p. 108) stated that reflexivity in a research sense is the ‘process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings.’ In addition, consideration of the applicability of findings to other contexts was important in highlighting the perceived value of research findings for future implementation by midwives and nurses, and other researchers.
Stage five: Abstracting and integrating themes
This stage involves searching for connections across the emerging themes. In addition, literature was searched for links to the themes and sub-themes identified from the entire data set in order to support further theoretical development. Using the themes, sub-themes and their interrelationships as a basis, I reconstructed the participants’ breastfeeding journeys using their own words in order to provide depth and rich description regarding their journey and highlight key findings from the data. My supervisors provided feedback on the quality of the stories. Participants’ narratives and descriptions were repeatedly examined during this stage to ensure that the constructed stories were faithful to their breastfeeding experiences.

Stage six: Refining the themes
The final stage of data analysis involved critique of the themes, along with a final review of the literature for key developments that could impact on or increase my understanding of the phenomenon. Analysis involved looking for commonalities and differences, and renaming themes as a deeper understanding of the data developed (Smith et al., 2009). The search for constitutive patterns involved reading the whole interview texts to gain an overall perception of the stories and depict a link between the relational themes that existed in all interviews. It was also important for the final account to be plausible. Because of my interpretive stance, I do not claim here to have produced a definitive analysis. The data presented supports the claims I have made, but it is unlikely that an independent researcher would identify exactly the same themes in exactly the same way, based on their personal contexts and experiences. However, by providing this audit trail, it is possible to scrutinize development of the analysis form transcript to final presentation of the themes.

3.14 Rigour
It has been argued that the criteria used to assess the quality in interpretive research should be consistent with the philosophical and methodological assumptions on which this research is based (Koch, 1996; Koch & Harrington, 1998; Leininger, 1994). In support of this, I chose the criteria of ‘credibility, transferability, dependability and confirmability’ suggested by Lincoln and Guba
Credibility (trustworthiness): The goal of credibility establishes how far the findings of the research can be trusted, or the extent of ‘confidence in the truth’ of the reported results (Morse, 2007). Several strategies have been identified in the literature as enhancing credibility in interpretive research, including ‘prolonged engagement’, ‘negative case analysis’, ‘member checking’, ‘peer-debriefing’ and ‘referential adequacy’ (Lincoln & Guba, 1985). Leininger (1985) pointed out the importance of identifying and documenting recurrent and emerging features in the research. Meanwhile, the emphasis on recurrence suggested the need to spend enough time with participants in order to identify reappearing patterns. The techniques of credibility promoted in this research involved adequate submersion in the research setting in order to enable recurrent patterns and themes to be identified and verified.

First, the richness of the data generated was enhanced via prolonged engagement with participants using semi-structured in-depth interviews (i.e. time ranging between 45–120 minutes). This enabled exploration of the phenomenon of breastfeeding in all its aspects and context. The longitudinal approach to the design ensured adequate submersion in the research setting and familiarity with the participants. The quality of the relationships that unfolded from this type of study enriched the data collected and the results. The period spent collecting data enabled participants to relax; as suggested by Bryman (1988), in such situations the data is more likely to be honest and valid. In addition, the method of data collection was consistent with hermeneutic phenomenology, was mainly guided by the participants’ responses, and provided opportunity for the phenomena to be explored in different ways, making it possible to seek further clarification and discover any hidden aspects. Recurrent patterns and themes that emerged from the data and preliminary analysis at each stage were further developed in follow-up interviews, and interpretations verified. In this way, ‘sensitive discrepancies’ between the meanings that were pre-assumed and those understood by the participants were resolved (Kirk and Miller 1986).
With the issue of member checking, a recap of the main issues at the end of each interview was rehearsed. This gave participants opportunities to verify the interpretations for accuracy. A peer debriefing exercises handled by my supervisors, by their input in coding data and helping to refine reported interpretations of texts.

Reporting issues of reflexivity were also acknowledged in this research as important in establishing ‘truth value’ (Koch 1994; Finlay 2002). In using the hermeneutic phenomenological method, becoming aware of my own pre-assumptions as a researcher was required. This is also consistent with the need to integrate the underlying philosophy into the study method and findings (De Witt & Ploeg 2006). Reflexivity has been discussed in (3.6.2) and threaded throughout this thesis. Finally, credibility in the research was ensured by including participants’ direct quotes in the description of the findings.

**Transferability (applicability)** pertains to the ‘fittingness’ or auditability of the research (Lincoln & Guba, 1985), showing the degree of applicability or resonance of the research with other settings or contexts. Transferability determines the provision of details of the data collection and analysis processes undertaken. In addition, evidence of transferability relates to the systematic and iterative nature of (i.e., moving between specific meaning units to the sense of the whole interview texts) between qualitative data collection and analysis. This minimised the risk of misinterpretations of participants’ descriptions. One strategy used to address the issue of transferability lay in the sample selection (Lincoln & Guba, 1985). Using the technique of purposive sample, informants living the experience under consideration could be selected, leading to rich information and understanding of the phenomena.

**Dependability (auditability)** shows the consistency and the ability for the research to be repeated (Lincoln & Guba, 1985). Dependability was achieved by providing a detailed report of the systematic process of the research (Shenton 2004). For instance, a clear statement of the scope and purpose of study is provided. The study is thoroughly contextualised within the existing literature on the phenomenon of breastfeeding. The description of the method shows
consistency with the aims of the research, including a discussion of the ontological and epistemological grounding that underpins the study. Purposive selection of participants was consistent with the phenomenological method, allowing participants who had lived the experience (i.e., the phenomena) to be selected. In this way, a thick description of the experience was achieved from the data provided. In keeping with the phenomenological method and staying close to participants’ data, an inductive approach to thematic analysis allowed patterns of meaning that represent the themes to emerge. Emergent codes are discussed and demonstrated using spider diagrams in the findings of chapters 5, 6, 7 and 8. Participants were involved in member checking by providing a verbal summary of the main issues that arose during the interviews. In this way, participants were provided the opportunity to confirm or disconfirm my interpretations of the information given. In addition, both supervisors helped to establish appropriate interpretation of data. Verbatim interview quotes were used in discussing the findings.

**Confirmability (audit trail)** is the degree of neutrality or the extent to which the findings of a study are shaped by the respondents rather than the researcher’s bias, motivation or interest (Lincoln & Guba, 1985; Morse, 2006). Confirmability was accomplished by contextualising the study within the broader literature on women’s experience of breastfeeding. Thematic analysis allowed patterns of concepts to emerge across the narrative texts. Description and interpretation of findings included verbatim quotes from the participants, which demonstrate understanding within the context (Huberman & Miles 2002). Reflexive notes helped to account for any personal influences, assumptions or beliefs of the researcher and remaining open to participants’ descriptions (Miles and Huberman 2002).

**3.15 Summary**

This chapter has examined the research method and the processes that underpinned the study. The philosophical principles that guided the choice of method were examined. The chapter has highlighted the interpretive approach, phenomenology and hermeneutic phenomenology as the research method of choice, as it is critical that the process allows the lived experience of breastfeeding under study to be explored. The process of the research and the manner in which
interpretations emerged has also been discussed. Finally, the way in which I approached the issues of trustworthiness and accuracy of interpretations has been addressed. The following chapters offer the results that emerged from studying the phenomenon of breastfeeding.
Chapter Four

Introduction of Results
Chapters
Chapter 4: Introduction to the Research Findings

4.1 Introduction
The primary objective of this study is to gain an in-depth understanding of the lived experience of breastfeeding, informed by 30 first-time breastfeeding women living in Ghana. Using a qualitative hermeneutic phenomenological approach, data collection generally involved exploration of the participants’ perceptions of breastfeeding sufficiency and the adequacy of breast-milk, the nature of these perceptions and how these changed over the pregnancy and postpartum period. In addition, information was generated regarding the attitudes, beliefs, values and the role of family, which might have contributed to influencing the perceptions of the Ghanaian first-time mothers who participated in the study. Finally, the women’s self-belief with respect to practising breastfeeding exclusively was explored.

4.2 Practical challenges/decisions made
Engaging in reflective and reflexive exercises during the research process can be challenging to the researcher (Finlay, 2002). Being reflexive allowed me to become aware of any personal prejudices, and acknowledge any impact this had on the research through reflective writing in a field journal. First, being a professional nurse and my prior theoretical knowledge on the importance of breastfeeding raised some inherent conflicts in relation to some of the participants’ responses. However, the underlying Heideggerian hermeneutic principles allow researchers to bring their own preconceptions during the data generation. In order to mitigate any biases and influence in understanding the participants’ world, any ambiguities were used as follow-up questions and participants prompted to explain issues further.

Data collection took the form of semi-structured, in-depth interviews. All interviews took place in the participants’ own home. One of the challenges encountered during the first interviews pertained to the issue referred to by Chavez (2008) as ‘positionality’, which are the ‘aspects of an insider researcher’s self or identity which is aligned or shared with participants’ (p.475). This has to do with the difficulties the participants had relating to me as a professional nurse, during the initial contact.
of the first interview. This can be recognise as a general situation within Ghanaian communities, base ‘social stratification’ (Allan, 2010); for example, the differences between the ‘educated’ and the ‘uneducated’. Participants in this situation perceived my visit to their homes and my professional role as a means of helping them to learn breastfeeding practices and other health-related issues. This therefore influenced the way the first interviews proceeded. For instance, Kvale (1995) positioned hermeneutic interviews as those of conversation and interaction between researcher and participants, which involved co-creation of the meaning of the phenomenon being investigated. However, this initial interview revolved more around asking questions, to which participants gave little response. The issue was approached with sensitivity and care; in order to allay their misconceptions, the first three to five minutes were used to further explain the participant information sheet and renegotiate consent. I also adopted the strategy of prolonged engagement through the extended period of data collection, while multiple contacts with the women increased rapport and familiarity, which helped the informants to share their experiences more openly. The issue was also raised during a Skype meeting with supervisors, wherein I reported on my field work. Furthermore, the coaching skills of my supervisors helped me to clearly explain to participants my position as a student researcher, who was interested in learning from their experiences in order to inform better breastfeeding practices.

Another issue was the fact that some of the women appeared not to be familiar with the audio recorder machine used in the data collection. To some, the presence of the machine made the interview seem like a more formal activity and made them self-conscious in providing responses. In such situations, a personal mobile phone was used for recording and the text was transcribed soon after my return from the field.

There was also the question of my being an ‘insider’ within the participants’ world of experience. This was raised by one of the mothers, who asked whether I am a mother and having had the experience breastfeeding. Though my response was initially ‘no’, I gave birth to my first child during the data management and analysis stage. I had the opportunity of living my own experience of breastfeeding. Information provided to me by the participants during the data collection, helped
me to reflect on my own experience, where aspects of my experiences were similar to the experience of some participants. However, having lived my own experience of breastfeeding changed my previous perception, particularly in relation to the physical and emotional challenge and the experience of family’s support. The information gathered from the women’s stories fuelled my desire to persevere and increased my confidence to meet the challenge of breastfeeding. This helped to shape my understanding, allowing me to approach the participant data obtained during the analysis from an insider perspective.

4.3 Demographic Overview of Participants

In this study, all 30 women engaged in the interviews attended the ANC at the selected hospital. All women gave birth to singleton infants born at a gestational age of between 38 and 42 weeks, without significant childhood illness or complications after birth. The women were all Ghanaians aged between 18 and 32. Twelve are married women and live together with their partners in an apartment distant from other extended family members. Eighteen were single women, of whom 13 lived together with other extended family members, including their own mothers, older siblings and grandparents. Five were co-habiting with their partners, who were the father of their baby. In terms of education, eight women had no education, 15 reported a primary/secondary education and seven were university or college graduates. All the women were Ghanaians from different tribe/ethnic backgrounds. Of these, the majority (n=10) were from the Akan ethnicity, followed by Ewes (n=5), Nankani (n=4), Dagomba (n=6) and Nzema (n=3). The average mean age was 26.5, whilst many who were single mothers were within the age bracket of 18 to 25.

In the participants demographic characteristics, the description of families are classified under Murdock’s (1949) descriptions of family. Murdock addressed family as a social group that share a common household, resources and responsibilities. Murdock labelled the nuclear family as consisting of an adult man and woman, in a socially accepted sexual relationship, who have with children (either their own or adopted). The traditional extended family is made up of the nuclear family, including grandparents and grandchildren, siblings, cousins and next of kin. Murdock defined cohabitation as two people who are unmarried, but have lived
together on a long-term basis and are in a relationship. Primarily, the 30 participants fell within these three classifications of family. Thirteen lived together with their extended family, including grandparents, aunts, uncles and siblings. Natasha, who was married at the time of interviews, lived together with her in-laws. Nine lived together with their husbands in a rented or owned house, whilst five were cohabiting. Although the nature of study was to interpret the women’s experiences of breastfeeding, the demographic characteristics were found to significantly contribute to understanding the context of the individual participants’ experiences of breastfeeding in a unique way. Table 4 gives a summary of the demographic characteristics of the women.

4.4 Respondents Profile, Follow-up and Response rate

A total of 30 women were targeted and recruited into the study. All the women were involved in the baseline data collection (first interview) during the antenatal period. However, during the early postnatal period, two (n=2) women were unavailable for follow-up. Although specific reasons were not provided, one woman was later known to have relocated from her former home to live with relatives. The second woman was contacted by telephone on several occasions, but did not return my calls, and it became clear that she was not interested in continuing. In a UK study with a sample of 12 primiparous women, it was reported that two of the women who opted out of the study stated as reasons becoming busy with their new baby (Dykes & Williams, 1999). This was also thought to be an alternative reason why the women dropped out. The data and baseline information provided on these women were removed, since no follow-up was carried out to determine what their actual experience of breastfeeding was like.

Women were followed up through telephone contact. This was considered to be useful in order to determine the individual participants’ status and arrange for subsequent visits. Using telephone as a means to follow up participants was consistent with previous studies (Dykes & Williams, 1999; Spencer et al., 2015) in the UK. The women who consented were followed up a day or two after recruitment for the first interview. Prior to and after giving birth, the participants were contacted every fortnight. For example, knowing when a woman has giving birth and arranged a convenient time for the follow up interviews. Three women
relocated after childbirth to live with family members for support. All these women were followed up in their new home, since it was still within the vicinity of the study.

Maintaining flexibility and good rapport throughout data collection enabled a natural flow of conversation during the interview. Calman et al. (2013), in their paper ‘Developing a longitudinal qualitative design’, noted that good researcher–participant communication is important in a longitudinal research study in order to promote trust. Therefore, the ability to build a good rapport and have regular contact with participants contributed to retaining an appropriate number of women at the end of the study. However, it may be argued that keeping regular contact with the women may have had some influence upon their behaviour related to breastfeeding.

Participants who introduced supplementary feeding early (water, glucose solution, and formula milk) were still followed up at four months postpartum. However, all these women were still breastfeeding their infants at the end of data collection period and expressed intentions to continue doing so. In total, the findings represented the narratives of 28 women who engaged in all three interviews. It should be noted that, unlike other qualitative research that aims for data saturation, in hermeneutic phenomenology the individual participants’ narrative accounts are approached as unique.

Generally, all the women who participated in this study breastfed their babies at some point in time after birth, and continued to do so. However, the women varied in terms of the time they initiated breastfeeding and exclusive breastfeeding. In accordance to the WHO definition of breastfeeding in chapter one, the practise of breastfeeding by the women is represented as follows: 12 women initiated breastfeeding within the first one hour after birth of baby. Women also vary, in their practise of exclusive breastfeeding (within the first two to six months) postnatal. However, most of the women can be classified as exclusive breast feeders. Reasons that women gave for delayed early breastfeeding included surgical birth, or lack of information, instructions or support from midwives and nurses. For instance, most women spoke of ‘not knowing what to do’, and waited to
receive instructions from their midwives or nurses on ‘when to breastfeed and how to breastfeed’. Women who underwent caesarean section described feelings of unpreparedness and an inability to initiate breastfeeding. More specific details on the women’s duration of breastfeeding at the time of interview are shown in Table 4.1 to 4.3.
### Table 4.1: Overview of Respondents Breastfeeding practice

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age  (years)</th>
<th>First Breastfeed</th>
<th>Mode of birth</th>
<th>Feeding practice</th>
<th>Duration of exclusive breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amanda</td>
<td>19</td>
<td>20 minutes</td>
<td>Vaginally</td>
<td>Exclusive</td>
<td>4 months</td>
</tr>
<tr>
<td>Ruth</td>
<td>18</td>
<td>Less than 6 hours</td>
<td>Caesarean</td>
<td>One formula feed at the start, fully breastfed for 3 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Dona</td>
<td>20</td>
<td>12 hours later</td>
<td>Caesarean</td>
<td>Gave glucose solution + formula first 24 hours, then fully breastfed 5.5 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Esther</td>
<td>32</td>
<td>Less than 12 hours</td>
<td>Caesarean</td>
<td>Gave formula two days at start, then fully breastfed</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Ellen</td>
<td>18</td>
<td>Less than 6 hours</td>
<td>Caesarean</td>
<td>One formula feed at start, then exclusive for six months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Eunice</td>
<td>25</td>
<td>Less than 2 hours</td>
<td>Vaginally</td>
<td>Started formula, then exclusive for 4 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Christi</td>
<td>27</td>
<td>In 30 minutes</td>
<td>Vaginally</td>
<td>Exclusive and expressed for 5 months</td>
<td>5 months</td>
</tr>
<tr>
<td>Deborah</td>
<td>20</td>
<td>15 minutes</td>
<td>Vaginally</td>
<td>Exclusive. Gave water one’s during the second week</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Sophie</td>
<td>22</td>
<td>1 hour</td>
<td>Assisted birth</td>
<td>Exclusive for 3 months, gave water on one afternoon</td>
<td>3 months</td>
</tr>
<tr>
<td>Alison</td>
<td>18</td>
<td>30 minutes</td>
<td>Vaginally</td>
<td>Exclusive 3.5 months, then introduced cereals</td>
<td>3.5 months</td>
</tr>
</tbody>
</table>
| Pseudonym | Age (years) | First Breastfeed | Mode of birth | Detail of feeding practice | Duration of
exclusive breastfeeding |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Natasha</td>
<td>24</td>
<td>After 2 hours of birth</td>
<td>Caesarean</td>
<td>Gave (20 mls) glucose solution at the start. Fully breastfeeding for 6 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Cynthia</td>
<td>30</td>
<td>In 1 hour</td>
<td>Caesarean</td>
<td>Exclusive for 2 months, gave water</td>
<td>2 months</td>
</tr>
<tr>
<td>Olivia</td>
<td>20</td>
<td>Between 30 to 1 hour after birth</td>
<td>Vaginally</td>
<td>Predominant exclusive for 4.5 months, then introduced formula</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Emma</td>
<td>25</td>
<td>48 hours</td>
<td>Caesarean</td>
<td>Established breastfeeding on the second day. Fully breastfed for 4 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Faith</td>
<td>23</td>
<td>Less than 3 hours</td>
<td>Caesarean</td>
<td>Gave glucose solution first day, then fully breastfed for 5 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Joy</td>
<td>22</td>
<td>Less than 30 minutes</td>
<td>Vaginally</td>
<td>Exclusive breastfeeding for 5 months. Introduced cereals and breastfeed</td>
<td>5 months</td>
</tr>
<tr>
<td>Mary</td>
<td>21</td>
<td>After 3 hours of birth</td>
<td>Vaginally</td>
<td>Gave formula once in the first day. Still fully breastfeeding at 6 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Becky</td>
<td>20</td>
<td>Within 24 hours after birth</td>
<td>Caesarean</td>
<td>Established breastfeeding on the second day. Fully breastfed for 2 months then occasionally gave formula and cereals</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Ellen</td>
<td>22</td>
<td>15 minutes</td>
<td>Vaginally</td>
<td>Exclusive breastfeeding for 6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Emily</td>
<td>25</td>
<td>More than 4 after birth</td>
<td>Caesarean</td>
<td>Glucose solution + formula at first day. Fully</td>
<td>Non-exclusive</td>
</tr>
</tbody>
</table>
Table 4.3: Overview of Respondents Breastfeeding practice

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age (years)</th>
<th>First Breastfeed</th>
<th>Mode of birth</th>
<th>Detail of feeding practice</th>
<th>Duration of exclusive breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doris</td>
<td>22</td>
<td>After 2 hours of birth</td>
<td>Caesarean</td>
<td>Gave (20mls) glucose solution at the start. Fully breastfed for 6 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Eva</td>
<td>23</td>
<td>In 1 hour</td>
<td>Caesarean</td>
<td>Exclusive for 2 months, gave water</td>
<td>2 months</td>
</tr>
<tr>
<td>Holly</td>
<td>21</td>
<td>Between 30 to 1 hour after birth</td>
<td>Vaginally</td>
<td>Predominant exclusive for 4.5 months, then introduced formula</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Catherine</td>
<td>25</td>
<td>48 hours</td>
<td>Caesarean</td>
<td>Established breastfeeding on the second day. Fully breastfed for 4 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Sally</td>
<td>24</td>
<td>Less than 3 hours</td>
<td>Vaginally</td>
<td>Gave glucose solution first day, then fully breastfed for 5 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Joy</td>
<td>27</td>
<td>Less than 30 minutes</td>
<td>Vaginally</td>
<td>Exclusive breastfeeding for 5 months. Introduced cereals and breastfeed</td>
<td>5 months</td>
</tr>
<tr>
<td>Rosalyn</td>
<td>18</td>
<td>After 3 hours of birth</td>
<td>Vaginally</td>
<td>Gave formula once in the first day. Still fully breastfed at 6 months</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Katie</td>
<td>20</td>
<td>Within 24 hours after birth</td>
<td>Caesarean</td>
<td>Established breastfeeding on the second day. Fully breastfed for 2 months then occasionally gave formula and cereals</td>
<td>Non-exclusive</td>
</tr>
<tr>
<td>Angel</td>
<td>22</td>
<td>15 minutes</td>
<td>Vaginally</td>
<td>Exclusive breastfeeding for 6 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>
4.5 Presentation of Themes and Sub-themes

In this chapter, findings from the analysis of data obtained from the 30 participants are explicated. These include significant themes and sub-themes that unfolded through reflection and understanding of the data generated. Together, the themes captured an important element of the way in which the women shared stories of their experiences of breastfeeding. The various structures represented the essence of lived experiences of breastfeeding and are presented in Chapters 5, 6, 7 and 8. An overarching theme with respect to the context of the findings identified breastfeeding as emotional work. Overall, the prospective longitudinal nature of the women’s experiences of breastfeeding can be described as a journey from assumptions of breastfeeding as part of ‘nature’ and ‘women’s business’ to the experienced reality of breastfeeding; that is, from the unknown to a redefinition of what it means to breastfeed.

Chapter 4 begins with a description of the participants’ demographic data. This information includes their age, education, marital status and family structure. In addition, the women’s profiles, and follow-up and response rates during the data collection period are reported. Detailed description of the women’s profiles shows the time of breastfeeding initiation and duration of exclusive breastfeeding.

The themes and sub-themes that emerged from the thematic analysis and the hermeneutic interpretation are presented. This shows the relationship between the different themes, and each theme and sub-theme’s relation to the main objective of the study (i.e., the lived experience of breastfeeding). Within the context of this study, the results show breastfeeding as a journey that begins with the majority of women already expecting to breastfeed and breastfeeding being a taken for granted, to experiencing the reality of early and continued breastfeeding. The relevant codes of individual sub-themes are illustrated using spider diagram (figures 5, 6, 7 & 8), in the various results chapters.

An overview of the hermeneutic interpretive findings, including the themes and sub-themes and the overall phenomenon, is presented in Figure 3. The main themes are illustrated in purple; the orange colour represents the sub-themes. The
third column, in blue, represents the sub-themes that are conceptualised the overall phenomenon.

**Figure 4.1: Themes, subthemes and Overall Phenomenon**

The overall phenomenon based on the inductive analysis and phenomenological method reveals ‘social conformity’ in the Ghanaian women’s experience of breastfeeding. This experience is linked to the understanding and deeper meaning of the theme family as enabler and disabler of breastfeeding. It describes how participants project an image of themselves as successful breast feeders whilst using ‘boldface’ to cope with family and social expectation. The phenomenon is discussed in chapter nine and forms part of the discussion.
Chapter Five

Breastfeeding Assumption
Chapter 5: Breastfeeding Assumptions

5.1 Introduction

This chapter presents the findings of the study, illustrating how the participants engaged in the process of ‘coming to know’ breastfeeding. It provides insight into the lifeworld of the women and therefore provides the backdrop against which they interpreted and made sense of breastfeeding prior to initiating it. The various elements that emerged will be considered under the following themes: ‘already knowing to breastfeed’, ‘taking it for granted’ and ‘lack of preparation’. The chapter will end with a summary of the various themes.

Figure 5.1: Thematic ‘Spider diagram’ showing codes of sub-themes of the theme ‘Breastfeeding Assumption’
5.2 ‘Already Knowing to Breastfeed’

I’ve always thought that is good for the newborn baby... though I haven’t given it much thought. My sisters have been breastfeeding their children as well as most of the women in my family also breastfeed their children... so you grow up with the idea that babies are to be breastfed. Again, I believe [it] is something normal and easy, just [get] the baby to attach and automatically you begin breastfeeding... My mum breastfed all five of us, so it makes sense to also breastfeeding and besides, everybody expects you to breastfeed. (Joy, Interview 1)

‘Already knowing to breastfeed’ was associated with the women’s awareness of breastfeeding within the social and cultural context in which they live. It was noted that all the women had backgrounds with some prior exposure to breastfeeding from which they came to understand breastfeeding as a means of feeding a newborn baby. In the first interviews, all the women shared their beliefs and understanding of breastfeeding, and most had already thought about breastfeeding even before they became pregnant. Like most of the women, Sarah already knew about breastfeeding, stating that: Well, you already know about breastfeeding ... even before I knew I was pregnant [I knew about it]. (Sarah, Interview 1)

The participants engaged in a process of ‘coming to know’ breastfeeding as they socialised within their families and social networks. This process unpinned their fundamental understanding of breastfeeding. The following examples from the accounts of the women demonstrate how their sociocultural context influenced their knowledge and interpretations of breastfeeding. Like most young Ghanaian women, Amanda exemplified this by providing a description of her beliefs, and explained how socialising within her immediate family contributed to her knowledge on breastfeeding. She recounted seeing other children in her family being breastfed and subsequently embraced the idea that breastfeeding was a normal practice for every woman.
Well, I guess you just grow up with such idea that babies are supposed to be nursed at the breast, that’s what you believe. Besides, you see other women openly doing it, and they’ll tell you that breastfeeding is best for your baby... you live with that kind of idea even before you ever think of having your own baby, so you just assume that you would breastfeed your baby as well, I mean you do as you see others doing it. (Amanda, Interview 1)

From the narrative account of the participants, breastfeeding was identified as a ‘cultural given’. Cultural given(s) referred to the norms and meanings that are handed down from different generations (Walton, 2011). The Ghanaian women in this study came to an understanding of breastfeeding through traditional beliefs and interpretations that they inherited from others.

Olivia grew up in a family environment where breastfeeding was practised, and thus saw other female relatives’ breastfeed. Sophie described breastfeeding as ‘inherited’, or a heritage within her family lineage. As a teenager she lived with and supported her elder sister, who breastfed both of her children. Sophie used the term ‘tradition goes on’ to explain the value of breastfeeding as a trend within her family, where every woman is supported to breastfeed after birth. With the older women being her role model, she then expected to breastfeed after the birth of her baby. In families and communities where breastfeeding is the norm, beliefs and practices of infant feeding are believed to be handed down from generation to generation (Lööf-Johanson et al., 2011; Grassley & Eschiti, 2008). This also confirms the idea that women who are breastfed themselves choose to breastfeed (Bottorff, 1990; Marshall et al., 2007; Mozingo et al., 2000).

I grew up in an extended family home, where we all live[d] together in a family house and you get to see almost every woman who gives birth breastfeed her baby. The last time my grandmother told me how it was easy breastfeeding my mom, and I know my mom also breastfeed four of us; you tend to believe that’s the way it’s done. And at that time I lived with my elder sister, she also breastfed her two children [and] I was feeding them with expressed breastmilk every time she had to go to work, it’s kind of [a] tradition [that] goes on [laughs], it’s now my turn... although I haven’t given it so much thought but I already know that I’ll breastfeed when my baby is born. (Olivia, Interview 1)
As is evident from the accounts of the women, a familial and cultural history of breastfeeding was identified as having an impact on the women’s decision to breastfeed (Mc-Bride Henry, 2010; Street and Lewallen, 2012; Thomson et al., 2014). The women gathered information from collective sources that shaped their beliefs and perceptions prior to breastfeeding. They described having observed other female relatives breastfeed their own children. This reinforced the fact that the women would also breastfeed their babies after birth. The following excerpts provide insight into how the society in which a woman lives influences her foundational understanding of breastfeeding.

Growing up we all lived together, including my two older sisters and they [female relatives] all breastfeed their children ... and other female relatives [breastfed] as well. It makes me think the same way that I’m going to breastfeed as well, because every child born in this house is breastfed by the mother. (Sophie, Interview 1)

From the literature, it was noted that women who were breastfed themselves are more likely to also breastfeed after birth (Marshall et al., 2007). This notion plays out in Evelyn’s narrative, in which learning from her mother that she was breastfed as a child inspired her decision to breastfeed her baby after birth:

I always wanted to and the reason was because my mum breastfed me, I mean she breastfed all three of us ... so I think [it] is the right thing to do. (Evelyn, Interview 1)

Like most female children in Ghana, Abigail described how, as a child, she had seen her mother breastfeed her younger sister and had also listened to social discussions about breastfeeding, thereby increasing her awareness. She recalls imitating her mother to breastfeed her doll.

Even at a very young age I knew when my mother used to breastfeed my younger sister. I remember at 3 years, I ... watched her [my mother] breastfeed and [I sat] with her, playing with my doll and pretend to be breastfeeding as well. I couldn’t ask my mother so many questions then, but I just came to the conclusion that mothers breastfeed their newborn babies. Even though I was young then, yet it still made sense to me. I think that’s how I came to know about breastfeeding, so in the same way I would also breastfeed. (Abigail, Interview 1)
Besides the cultural impact on the women’s understanding of breastfeeding, they also expressed their knowledge about the health benefits of breastfeeding to the baby. Sources of this knowledge included public health education from social media and antenatal education. Most women frequently used the word ‘good’ to describe the nutritional, immunological and physiological benefits of breastmilk. Among several others, Eva, Linda and Natasha expressed with confidence that ‘breastfeeding is good’ for their babies. The women attached significant value to breastfeeding, and Lucy recounted her confidence in breastfeeding to confer good health on her baby. She added that by breastfeeding after birth her baby would be protected from acquiring infections that could result in illnesses requiring hospitalisation.

_I believe [breastfeeding] is good because at the clinic they [the midwives] mentioned that breastmilk doesn’t get contaminated because breastfeeding is only done by the mother and it comes from the mother to her baby ... so nobody [has] to handle any bottle. So that the child won’t get sick, I guess it’s very uncomfortable when your baby is sick and on admission at the hospital, that’s the last thing I want for my baby, and that’s the more reason why I want to breastfeed._ (Lucy, Interview 1)

The concern that using bottles might introduce infection to her baby because others might handle it motivated Amy to express that breastfeeding is best for the baby. Amy learned that breastmilk is the best form of nutrition for her baby since it comes directly from the mother to the baby compared to formula, and therefore protects the child from getting sick.

_Also the immunological aspects of it have been really important to me ... by breastfeeding him I knew that I’m giving him really good protection against bugs and infection and on top of that is the building of the relationship. The building of the relationship isn’t something I thought about until later on. I looked back at it retrospectively and I thought the breastfeeding ... has built our relationship whereas initially to me it was always the nutrition and the immunological factors that were important in breastfeeding him._ (Amy, Interview 1)
Sarah expressed knowledge of breastfeeding conferring both present and future health benefits to her infant:

*It’s a combination of the nutrition, which I believe [breastfeeding] will provide my baby with the best nutrition, and also it’s about the convenience of breastfeeding, anytime and everywhere … personally I think among all the benefits, though good, but if I’m breastfeeding is because of the convenience. I stayed with my auntie and it was easy for her to feed the baby especially when they’re out. I guess [it] is a whole job washing and cleaning bottles, even sometimes you might not get the measurement correct, others wanting to feed the baby and these children might even put the bottle in their mouth. So at the end of the day it’s best for both the mother and her baby.* (Sarah, Interview 1)

The examples from the participants’ narratives used under this sub-theme also show how they drew on public sources and the media to develop an understanding of breastfeeding. Amanda provided an apt description of how her previous knowledge of breastfeeding was informed by the daily advertisements shown on television. Through the media, she understood that breastfeeding conferred good health benefits and a potential increase in her child’s intelligence compared to those who were formula fed. Therefore, this knowledge influenced her choice to breastfeed.

*I think for me it has really [been] helpful concerning an advert they usually show on TV, where they claim that breastfeeding is good for babies in several ways compared to artificial milk … they claim that when you breastfeed, the baby won’t get diarrhoea and vomiting or any other infections. He/she is always healthy. They also claim it makes them [children] intelligent and smarter than those whose mother[s] give [them] formula.* (Amanda, Interview 1)

As the women interacted with others, a fundamental understanding of breastfeeding was developed. In Ghana, breastfeeding has come to be primarily understood as a natural source of food for infants, sometimes to the exclusion of other understandings, such as breastfeeding promoting bonding between a mother and her baby. The cultural interpretations of breastfeeding influenced the decision of the women to breastfeed. For instance, Amy articulated her grandmother’s views regarding breastmilk being a ‘gift’ for the baby.
5.3 ‘Taken for Granted’

As described earlier, the social and cultural background in which the women live influenced their perception of breastfeeding. For the majority of the women, breastfeeding was taking for granted or regarded as a natural and instinctive behaviour that was assumed to happen spontaneously. Therefore, prior to the birth of their babies, all participants expected that they would breastfeed. As part of the first interviews during the antenatal period, the women were asked about their decisions and expectations regarding breastfeeding. Most women initially responded using words such as ‘natural’, ‘routine activity’ and ‘expected to happen’. Only six women spoke of pre-planning ‘to breastfeed for as long as the baby might want to’. Overall, the women’s expectations prior to breastfeeding were ‘taken for granted’. The responses by the women to this question did not reflect thoughtful construction. For example, Faith spoke about breastfeeding as something she had ‘expected’ to do; it was a routine activity and so ‘natural’ that she ‘didn’t even think about it’. She had not considered it necessary to discuss other women’s previous breastfeeding experiences. While living with extended-family members, Sally spent time with a number of women who had breastfed their babies, and she therefore felt completely comfortable with the idea. Breastfeeding was ‘something that I thought would just happen; you just know how to do it after baby is born’ (Sally, Interview 1). Similarly, Ruth stated, ‘I always assumed that I would breastfeed I think because it’s natural ... and everybody, my auntie, everyone I know has breastfed their babies’ (Ruth, Interview 1).

In a similar way, Emma, Catherine, Christine and Lucy had not considered that there was a decision to make in terms of breastfeeding after birth: ‘you don’t really have a choice, to say you would breastfeed or not’, unless there were issues with breastfeeding that could not be overcome. Kate stated, ‘It’s just what you do’. Therefore, the account of breastfeeding and the expectations of the women reflected their ‘taking for granted’ breastfeeding as part of everyday life and accepted cultural practice. There were no conscious decision made, that might help women with something to hope for or to be committed to. ‘I just know that I will breastfeed ... I haven’t given it a thought really’
5.4 ‘Breastfeeding Veiled in Secrecy’

Besides breastfeeding being taken for granted, all the women except three spoke about preparation prior to the birth of their baby, in terms of learning how to position and attach the baby to the breast. To most women, breastfeeding was an ‘unlearned activity’, and they thus had unrealistic expectations of what to hope for. Such perceptions were mainly influenced by the social and cultural beliefs and attitudes towards breastfeeding. The assumption that breastfeeding is natural and instinctive influence the women’s attitudes toward breastfeeding. Emma, for example, disregarded breastfeeding as a learning experience as she spoke of knowing how to breastfeed after the birth of her baby (Emma, Interview 1). Most of the respondents recognised the importance of preparing to breastfeed only after the birth of their babies.

During the first interviews, Becky was asked about her preparation for breastfeeding; her response was that practical knowledge of what it is to breastfeed is not extended to women pregnant with their first child. Prior to breastfeeding, she had perceived that breastfeeding was an easy aspect of mothering; however, once she engaged in the act of breastfeeding she discovered that her assumptions had led to unrealistic expectations. *It’s so sad that nobody tells you what it will be like ... they only help you breastfeed after your baby is born.* (Becky, Interview 2)

Although they spoke of breastfeeding as an ‘unlearned activity’, most of the participants later commented about their inadequacies and inability to transform their previous knowledge into the practical experience of breastfeeding. The embodied experience of breastfeeding was a hidden experience, as described by Doreen who struggled to latch her baby to breastfeed – an issue that she could not resolve no matter how many hours and attempts she made. She spoke about breastfeeding veiled in secrecy, in reference to the associated difficulties. Therefore experiencing the physical challenge which was contrary to her expectations rendered Doreen incapable.
All I thought was to be able to breastfeed and that it would be easy to do, but I then [began] to feel it’s more difficult than I imagine. The difficulties of breastfeeding are not told to you at all. And you feel is a cheat on you. You feel like there’s something wrong with you because [breastfeeding is] not happening like you thought it would. (Doreen, Interview 2)

Sally reflected on the lack of adequate preparation prior to breastfeeding from the midwives at the ANC. She commented on the lack of information about the difficulties of breastfeeding, articulating how this negatively affected her ability to experience breastfeeding and limited her opportunities to initiate breastfeeding and overcome complications that were encountered.

At the clinic they don’t give you information to tell you what to do if it [breastfeeding] doesn’t work. If it isn’t for your mother or a friend who’s had a similar problem you’d be totally at sea really. It’s not fair. (Sally, Interview 2)

Rosalyn considered why the experience of breastfeeding was hidden from the public domain. She pondered about how women do not wish to disclose their experiences due to a ‘social perception’ that surrounds breastfeeding, and that the only acceptable people with whom one can share her experience of breastfeeding difficulties are those who have also lived the experiences of breastfeeding.

Sometimes you wonder and think … why [don’t] people don’t talk about the difficulty of breastfeeding? They don’t want others to see them as failing to breastfeed. You only discuss with those people who are in exactly the same situation as I am, like other young breastfeeding women … I think of all the women that I know that have had babies not one of them talked about the pain of breastfeeding, not one of them, or of other difficulties. I would have listened but no one wanted to share that information. Yesterday my sister-in-law came to visit and she told me it’s normal to have pains, because they all experienced the same … I asked them why they didn’t tell me before and they answered it was because they didn’t want me to feel scared. (Rosalyn, Interview 2)

This excerpt from Rosalyn’s accounts might reflect the challenge that the Ghanaian breastfeeding woman have in articulating the difficult nature of their experiences due to such things as a fear of being perceived as not coping well with breastfeeding. This is because breastfeeding is considered a social norm, which is similar to the manner in which giving birth is sometimes perceived.
5.5 Summary

In this chapter I have examined the Ghanaian women’s understanding of breastfeeding during the antenatal period. The chapter highlighted the effect that the social and cultural environment in which the women live has on their interpretations of breastfeeding (Thompson et al., 2013). This buttresses Benner’s (1994) assertion that people are capable of understanding and learning events as meaningful through the world they share with others. Through the process of socialising within one’s immediate family, an understanding of what it means to breastfeed is formed.

Coming from families and societies in which breastfeeding is the norm, breastfeeding was found to have been ‘taken for granted’, with no conscious decision made by the women. As women began to breastfeed, they experienced the reality as something veiled, where the reality of breastfeeding difficulties and the physical challenge is not revealed prior to birth. Therefore, there was lack of adequate preparation by the women, who only based their expectations on the assumption that breastfeeding, would happen naturally.

Under the theme ‘breastfeeding assumptions’, my own reflection in the field notes revealed my own presumptions, whereby as a Ghanaian and based on my experience within my family, I too understood breastfeeding as a normal and instinctive practice that is expected to happen once a woman gives birth. This perception changed when I acquired the theoretical knowledge through my nursing training.

In the next chapter, it emerged that breastfeeding was a responsibility for the Ghanaian women and therefore played a key role in their experience of motherhood.
Chapter Six

Breastfeeding as Women’s Business
Chapter 6: Breastfeeding as ‘Women’s Business’

6.1 Introduction
This chapter explores the theme of breastfeeding as ‘women’s business’. This describes the women’s views that breastfeeding is an activity that is within a woman’s domain. Breastfeeding was culturally interpreted to be a responsibility rather than a choice, which depicts the caregiving role of the mother. The essence of being a breastfeeding woman was enshrined in the belief that motherhood is a call to care. This chapter will then proceed to consider the two emergent sub-themes: ‘being called to care’ and ‘being there’. Prior to discussing the themes, insight is provided into the ontological understanding of care based on Heidegger’s explication of being.

Figure 6.1: Thematic ‘Spider diagram’ illustrating codes of sub-themes [Being called to care and Being-there] of the theme ‘Breastfeeding as Women’s Business’
6.2 Understanding the context of Care:
In his *Being and Time*, Heidegger (1962) identified one of Dasein’s distinctive modes of being in the world. Heidegger described ‘Dasein existential nature, as being ‘concern’. In the ‘concern’ mode of being, expressed the understanding that human beings have over themselves (Inwood, 1999). According to Heidegger, people engage in interaction with their world, showing concern for others. Concern of the other exists through the relationship that one has with the world and fellow human beings (Warnock, 1970). Furthermore, Heidegger claimed the nature of Dasein itself is revealed as ‘care’ (Sorge) which is fundamental to the nature of Dasein. This illustrates the understanding that the women had of themselves as existing as an entity of ‘care’, in terms of showing concern for, and taking responsibility to ensure the wellbeing of, their infants. This chapter examines the accounts of the women as they emerged during the analysis, identifying breastfeeding as a responsibility that women are called to. The two main sub-themes considered under this theme include ‘being called to care’ and ‘being always there’.

6.3 Being called to care
Being called to care describes the concern that the women who participated in this study had to take care and ensure the wellbeing of their infants. Women expressed the value attached to breastfeeding as one thing that enabled them to offer the best care to contribute to the growth and development of their baby. The women also believed that breastfeeding is naturally intended for women, being an intuitive task. The following excerpts from the narratives of the women conveyed their understanding that breastfeeding gave them the opportunity to care for their newborn baby. For example, 21-year-old Abigail acknowledged breastfeeding as a task that lies within the domain of women and therefore is a call to care for their baby after birth. ‘I believe [breastfeeding is] what women do ... [it is] about taking care of your baby after it’s born’ (Abigail, Interview 1). Ruth also stated, ‘Well,
breastfeeding is for women, you do [it] once the baby is born, we’re to breastfeed and care for our baby, that’s what I know’ (Ruth, Interview 1).

Reflecting on her experience, Amanda explained how, as a teacher, she believes teaching is her passion, which she was called to do. In the same way, she considered mothering as such. Therefore, she adopted the same attitude, believing that, as a mother, she was called to care for her son and breastfeeding made it possible and easy to fulfil this calling.

*I remember in teaching ‘they’ ask you why you wanted to be a teacher, because my mother was a teacher and for me it’s about the passion to teach, and that really helped me to think about breastfeeding the same way. I felt becoming a mother is a calling and breastfeeding makes it all easy for me to care for him [my son], without [anyone] telling me, I felt I’m made for this,… naturally the breast milk begins to flow which makes it easy to provide food for him. (Amanda, Interview 3)*

Dona also recounted that breastfeeding is naturally intended for women as an opportunity to provide care for their newborn babies:

*To me I think breastfeeding is one thing that I believe is best for your baby. It gives me the opportunity to care for him [my son], which I feel happy about … yes, because I believe I’m doing a good thing for him. (Dona, Interview 3)*

For most women, the activity of breastfeeding was acknowledged as a responsibility. In recognising breastfeeding as one’s responsibility, the women explained it to mean fulfilling their basic role as mothers. This was contrasted with the role of males in traditional Ghanaian community, and the fact that they are unable to provide care using their body. The women exemplified an attitude of being solely responsible for providing nourishment to their baby through the breast. For example, prior to breastfeeding Esther mentioned ‘I guess is my responsibility and nobody can do it for you’ (Esther, Interview 1). Besides stating that breastfeeding was good for her baby, Sally recognised that breastfeeding made her sole responsible for her newborn baby, among others who could equally take care of her baby.
Well, I know breastfeeding is good for my baby, and you feel lucky to be the only one who can breastfeed, apart from that everybody can care for her, but it’s you she’s getting all the good stuff from ... I know it because they told you all about its [breastfeeding’s] benefits that my daughter stands to gain. So I don’t worry, because I know I’m giving her the best. (Sally, Interview 3)

All the women were also cognisant of the significance of breastfeeding to their new maternal role. Coupled with the perception that breastfeeding is natural, they acted based on ‘women’s intuition’ and, from this perspective, many of the women spoke even before delivery about being capable of such an activity. For example, 19-year-old Rosalyn believed that breastfeeding was instinctive for women, which meant she could exercise control over feeding her baby after birth. I believe I’m up to it [breastfeeding], it’s just about attaching your baby to breast ... I’ll know how to do it. (Rosalyn, Interview 1)

Thinking about the natural motherly role, Eva spoke of her confidence and conviction that she could breastfeed. I have always thought of breastfeeding as normal for women, I believe every woman can breastfeed, so I know I can do it too. (Eva, Interview 1)

Notwithstanding the ability to exercise control over breastfeeding and to fulfil their call to care as good mothers, challenges emerged for some of the women. It was later reported that while breastfeeding is natural it is not necessarily easy, as they had previously perceived. Throughout the interview, Emma repeatedly returned to her inability to resolve her feelings of inadequacy as a mother based on her struggle to breastfeed. She recounted her worry about being unable to satisfy her baby’s nutritional needs. However, Emma demonstrated how her definition of being called to care and being a successful mother changed with every positive step she achieved. Thus, she questioned her body’s capabilities as a breastfeeding woman:

I struggled a lot and you’re absorbed in yourself and it feels so hard to do. I know it didn’t last very long but the first two weeks were definitely a long time in my life, because I wasn’t expecting it to be that hard, but I still counted my success when we were able to make progress. (Emma, Interview 3).
For the majority of women in this study, breastfeeding as ‘women’s business’ was accepted in terms of the activity of breastfeeding being primarily within women’s domain. This explains the views expressed that those who engaged in breastfeeding, including those who offered support, were older generations of women who had previously breastfed. This assumption, however, resonates with a study by Aborigo et al. (2012) that explored exclusive breastfeeding and family influences in rural settings of Ghana. As part of his results, Aborigo et al. (2013) reported the thoughts of the men he interviewed, who indicated that breastfeeding and support should be provided by the older women in one’s family. Conversely, some of the women in my study acknowledged the active involvement of their husband/partner in a significant number of ways. This is demonstrated under the sub-theme ‘family as enablers and dis-enablers’.

6.4 ‘Being Present’

In their day-to-day existence, the women experience their ‘lived space’ as always occupied by their infants. Most women felt that breastfeeding their infants meant that they needed to be around the baby all the time. The women spoke of how their daily lives were filled with the consciousness of their baby. The women interpreted this kind of lived experience as one of feeling bound or tied down because of the baby. The women felt that their presence was needed in order to render nourishment, comfort, and get to know their baby, derive satisfaction and help the baby to sleep. The narratives below provide examples of how the majority of women narrated the need to always be there for their baby. Again, meeting the basic needs of their babies was observed as a great achievement for the women, with most of them deriving satisfaction from this. Evelyn expressed how it was difficult going anywhere without her baby; she explained how she always needed to be there to be satisfied her baby’s needs:

*It’s difficult going anywhere without him [my son], even spending a little time at the market. I’m worried that he’ll cry and cry ... leaving him with his dad doesn’t ... make any difference, as the baby needs me ... yesterday I thought I could sneak out when he was sleeping, but I was told he woke up immediately I stepped out and cried and cried, his dad [had] to call me back just in the middle of shopping, and that was distressing for me ... because you thought you could just buy one or two things and come back quickly ...*
immediately he saw me he smiled and I breastfed him. I can’t go anywhere, or ... I go with him. (Evelyn, Interview 3)

Getting to know her baby was reported to be a gradual process. However, some reported that becoming familiar with the different feeding patterns was something that they learned in the process of breastfeeding, as was developing a relationship with the baby over time. The women learned to recognise when the baby was feeding for comfort as opposed to sleep. Some of the women who were able to breastfeed exclusively spoke about the intimate relationship and the sense of belongingness they enjoyed with their baby.

I’m always there, so that when my son wants a feed he gets it. Sometimes at night he might want an extra one before he goes to bed, it comforts him as well. Two nights ago he woke up crying for no reason, and I just know that he wanted a comfort feed, kind of [a] top up to go back to sleep again. It wasn’t a feed, more a comfort thing for him. There’s no way of calming him like a comfort feed, just feed and feed but not really feeding. (Ruth, Interview 3)

Similarly, Amanda told a story of her experience in relation to breastfeeding. Breast milk became her baby’s source of consolation when she was unsettled. Amanda discussed how the breast provided a safe haven and satisfaction for her daughter and had observed that breastfeeding seemed to ‘soothe her’. The pain that made her daughter irritable was removed through breastfeeding. Amanda spoke of how, as a mother, she wanted to offer her daughter what is best and meet her basic needs.

It [breastfeeding] makes so much difference, it makes things easier because she easily calms down ... when we went for her immunization, I was so scared for her, the pains, but she was almost completely satisfied after breastfeeding. It really satisfies her and makes it easy to put her at ease and she’s much happier after feeding and contended after breastfeeding. It’s all she need[s] when she's in pain ... Sometimes if something sort of upset[s] her, she's not drinking at all. She’ll just soothe herself with the breast, rather than any other thing, she’ll even refuse her dad's cuddling, it’s about being close and kind of playing, just enjoying herself, going off and on. At almost six months she still wants to enjoy breastfeeding, usually first thing in the morning and the last thing before she goes to sleep. (Amanda, Interview 3)
The women acknowledged the benefits they personally derived from a sense of being needed. This was often described in terms of the advantage it gave them over their male counterpart relating to the care of their baby. Breastfeeding provides comfort and facilitates the health of both mother and child, allowing the mother and baby dyad to be engaged and explore new experiences (Marshall et al., 2007). Upon continued reflection, Lucy realised a kind of emotional satisfaction that she personally derived from breastfeeding her daughter.

*It’s always a nice feeling to know that you’re the most important person in her life at that moment ... I can feel my daughter wanting to be close. To be able to comfort like that is satisfying, really satisfying and it’s really a good feeling for me. We laugh, we play, you know, and both of [us] are happy. It’s amazing.* (Lucy, Interview 3)

Rosalyn also expressed the psychological and emotional well-being derived from breastfeeding. After resuming her teaching work at three months, she knew spending time breastfeeding her son was the only thing that would take away her fatigue and emotional stress.

*I returned to work at three months and it was very difficult for me leaving him at home, and for him as well ... it’s just that you’ve been with him all [that time] and he’s used to you. Spending eight hours every day except on weekends could have destroyed our relationship, but that magic was still there, because every time I showed up at the door, [he’d] jump, smiling and could really make me out, sometimes he greets me with a cry, as a sign of missing me. I’ll sit down immediately and breastfeed him for about an hour or more, and we both get revived ... I also enjoy the night feeding since I started work, it feels great, kind of making up with the time I was away. I don’t feel pressured at all, having any other commitment, everything seems calm and you actually feel relaxed and enjoy it.* (Rosalyn, Interview 3)

Joy felt happy to own something that made her the only source of food for her daughter and, most importantly, helped her daughter to get settled. Reflecting on her daily experiences, Joy spoke about the fact that being her baby’s food meant that she always needed to be there to satisfy her daughter’s needs.

*I feel very proud about it, it was challenging, but coming through to the other side is a real success for me. I am her food and you know she so much depends on [me it] makes me feel tied down. Sometimes having my bath when her dad has gone to work was difficult. We sit here, she’ll feed,
sleep and wake up, feed again, change her Pampers, and the cycle goes like that. She likes feeding all the time, sleep[s] very little and breastfeeds again. It’s difficult to even complete the housework I [aim] to do in a day. (Joy, Interview 3)

Moreover, some of the women described feelings associated with the fact that they were the only source of food for their baby. These women spoke about their sense of being needed by their baby. In particular, the women valued being able to satisfy their infants. The satisfaction of infants comes in various forms, in terms of food, health, provision of comfort and the baby’s need for sleep. Other women also recounted their experience with their baby as deriving pleasure from breastfeeding, satisfaction and warmth. When reflecting on breastfeeding her baby, Esther shared her story of getting to know her daughter through breastfeeding. She described her daughter as one who drinks for three reasons: for food, comfort and sleep.

It wasn’t like the first time when we got started, but I guess you really learn, both of you really learn every day and you get to know when she [needs] sleep or she’s hungry or she’s just playing with your breast. I think it’s all part of it … now I know she sucks for three things, either she’s hungry, or she needs sleep or she just wants to play. And most times it’s about wanting to be held and play. (Esther, Interview 3)

The women in this study enjoyed being there and constantly breastfeeding as long as breastfeeding was experienced as easy and pain-free. Rosalyn described a perfect time she enjoyed breastfeeding as during the night and having her baby lying beside her.

It isn’t like when you get started, it’s really a lovely feeling when you can breastfeed for hours [on] end without having pains, at that moment it feels lovely. You know he’s growing healthily and doing OK using your own body, which is a big thing and you feel good about it. If he’s unsettled for one reason or another, I just [latch] him on and he stops crying, completely calm and enjoying it … Whether he’s hungry or not, he just gets the comfort, which makes me happy. (Angel, Interview 3)

6.5 Summary
This chapter highlighted that women attached specific value to breastfeeding, in that it helps them to take care of their infants. As the women who participated in this study learned to understand the ways in which they are able to communicate
with the needs of their babies, breastfeeding was identified as a great source of comfort that completely meets those needs. The comfort and satisfaction obtained through breastfeeding was a result of the women fulfilling their call to care and showing concern for their infant’s wellbeing. The women were able to engage with their essence of ‘being’ as they physically shared their body with the baby through breastfeeding. The privilege of taking care of their baby through breastfeeding re-enforced the women’s sense of being needed by their baby, as the only one who can provide the ultimate satisfaction of their baby and add to their wellbeing. Chapter 7 examines the women’s experience of birth and the early postnatal period, as well as how this influenced their initiation of breastfeeding.
Chapter Seven

Postnatal Breastfeeding Experience
Chapter 7: Postnatal Breastfeeding Experience

7.1 Introduction
This chapter describes the early breastfeeding experiences of the mothers. It focuses on providing insight into the participants’ experience of establishing breastfeeding, the support they received, and the immediate postnatal experience. Frequently identified in the narratives by the participants was an understanding of their postnatal body that had not been imagined prior to birth. The three main subthemes identified under this chapter include ‘Early encounters’ and first breastfeeding; the women’s emotional expression of being ‘not in control’ of something expected to be natural and within women’s domain; and finally, the participants’ understanding of their ‘postnatal body’ in relation to breastfeeding body in a more technical way.
Figure 7.1: Thematic ‘Spider diagram’ showing codes of sub-themes of the theme ‘The Postnatal Breastfeeding Experience’.

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<tr>
<th>‘The Postnatal Breastfeeding Experience Sub-themes’</th>
<th>Colours of Sub-theme codes</th>
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<tr>
<td>Early Encounters</td>
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<td>‘Not in Control’</td>
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<td>The Breastfeeding Body-</td>
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<td>Unready-to-hand</td>
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7.2 ‘Early Encounters’

This theme demonstrates the women’s description of their first encounters with their baby and their experience of their first breastfeed. These experiences were unique to the individual mothers, and were vividly recounted during the second interview following the birth of their babies. Some of the women spoke about the fact that their baby latched on to the breast immediately, which seemed natural and instinctive, with the baby already knowing what to do. These were emotional times, described by the participants using words such as ‘amazing’, ‘wonderful’, ‘natural’, ‘instinctive’, ‘satisfying’, ‘happy’ and a special moment for the mother and baby. In the below narrative, Millicent expressed how amazing and satisfying it was to breastfeed her baby for the first time. Her baby latched on straight away and already seemed to know what to do.

_It was really amazing, straightaway she seems to know what to do, I mean, she just attached to it [my breast] and began to suck. She actually sucked for a few minutes, but I think it was great, I felt very satisfied and she slept afterwards for a while and I breastfed again._ (Millicent, Interview 2)

With the first breastfeed immediately following the natural birth of her baby, Lucy described the experience of putting her baby to breast as special and happy. Although she encountered a bit of struggle, she still believes it was instinctive and natural, describing her baby’s easy attachment to the breast and ability to suckle. For Lucy, the initial breastfeeding was fulfilling.

_Yes, it was just amazing, because it took us just a few minutes of struggle, which I think was normal for a first-time mother like me. I had a natural birth and, within 30 minutes when I gave it a try he attached straight on and he was feeding on the left side. And since, [it] has been pretty easy for both of us, he attaches on straight away and I remember, just looking at him and that was really fulfilling … he sort of fed for quite some time and then fell asleep._ (Lucy, Interview 2)

However, not all the women experienced breastfeeding to be natural. Out of the 28 women who engaged in the second interview, 20 described their first breastfeed as ‘not entirely pleasant’ or as ‘something they had not expected to be difficult’. Sometimes, it was the struggle of synchronising two bodies together. For instance, the majority reported the difficulties in ensuring they found the correct position and
had a good latch of the baby to the breast. Among these women, Millicent explained that, ‘Nobody told me that it could be so difficult to do ... I was just there, I didn’t know how to get started ... it was [more] difficult than I thought’ (Millicent, Interview 2). Dona also spoke about the frustration of getting her baby latched on the breast when she was left alone with her baby.

\[I was tired, anxious and talked to myself that this is not going to work, because it’s so hard. I was struggling to put him to the breast. I [kept] trying ... no body was there [to help me] breastfeed.\] (Dona, Interview 2)

Esther commented on how the realities of breastfeeding greatly contradicted her expectation of breastfeeding being natural and automatic after the baby is born. She spoke about breastfeeding being uncomfortable.

\[My first breastfeed after she was born wasn’t entirely pleasant because I had a very long labour before she was born, I was very tired and I didn’t really know what to do and I just remember the midwife taking the baby and holding my breast in one hand and the baby in the other hand and just putting them together, and I didn’t really know what was going on, and it did hurt a little, and she goes like, ‘Oh its fine, it’s because she’s got a small mouth’... I didn’t enjoy that very first breastfeed and subsequently it became a bit easier, but that wasn’t what I thought. I was told it’s natural and something that happen[s] automatic [ally].\] (Esther, Interview 2)

Like Mary, some women commented on the lack of confidence they felt because the early breastfeeding was hard and was also at odds with their previous expectations of natural and instinctive breastfeeding. Mary stated that:

\[You’re not aware of how hard it could be getting started ... sometimes I feel it’s really a cheat and sets me thinking that the reality is not told, even by those who have experience[d] it. You just assume that every woman can do it and you can’t, and at the end of the day you become so anxious about it.\] (Mary, Interview 2)

The idea that breastfeeding is difficult, especially for first-time mothers, is consistent with previous empirical studies that have reported on the critical moment of early breastfeeding for women attempting breastfeeding for the first time (George, 2005; Hauck & Irurita, 2002; Williamson et al., 2012). However, though these studies have reported on the difficulties that women experienced during the early establishment of breastfeeding. For example the understanding of
factors, such as the women experience of birth may have a direct impact on initiating breastfeeding. In this study, it emerged that the women were concerned about the mode of birth, especially those who underwent CS. The women recounted this as one of the challenges limiting their readiness to initiate breastfeeding and their ability to enjoy a close attachment with their baby following birth. Most commonly, women expressed their experiences by stating that ‘I wasn’t in control’. Therefore, the next section discusses the stories of the women in terms of not being in control in relation to their experience of breastfeeding. The experience of birth and breastfeeding was commonly reported as contradicting the women’s perceptions prior to initiation.

7.3 ‘Not in Control’: Emotional experience

This section describes the understanding of the emotional and psychological aspects associated to the women’s experience of breastfeeding. Although the study did not set out to include questions related to the experience of birth, the participants commonly made reference to their birth experience and how it negatively influenced early initiation of breastfeeding. For instance, the group of women who had a natural birth and those who underwent CS described their vulnerability and loss of self-control in establishing breastfeeding. The question ‘Tell me what your initial breastfeeding experience was like’ always led to a description of the process of the birth of their baby and its impact on feeding their baby. This emerged in particular as a hindrance to the women’s attempts at breastfeeding.

During the second interview, the emotions of some women ran high as they thought about not being in control of breastfeeding. For example, Mary received an instruction from her midwife after her CS to avoid rapid movement from the bed, in order to avoid symptoms such as severe neck pain and headache. Mary was overwhelmed, describing the lack of instructions from the midwives on when to start breastfeeding.

_ I was told not to get out of bed after the CS; I wondered how I would breastfeed. We were there for hours and nobody told me when I could possibly breastfeed ... I didn’t know I could do it. I felt pressured and was anxious when she started crying inconsolably .... My mother hadn’t visited then. She [my baby] was taken care of by a concerned relative of another_
woman on the ward. She was giving formula milk ... I did felt sad, because I couldn’t do anything for her. (Mary, Interview 2)

The experience of pain was identified as a factor in preventing good positioning and proper attachment by the baby. As was identified in the accounts of the women, it was difficult for them to synchronise their body and that of the baby to establish a good attachment. For most women this was attributed to a fear of pain at the incision site. However, this typically demonstrated a lack of midwife support for the women during the early postnatal period, in terms of their providing reassurance and helping the women to assume the most comfortable position as they began breastfeeding.

They [the midwives] didn’t show me how to ... position him well, I was scared it might cause me so much pain ... I was so careful, but that also made it difficult for him to get attached to my breast ... and you know, he’s so small and tender. (Becky, Interview 2)

Maternal ill-health was another factor that some women spoke about after the birth of their baby. These women highlighted the physical and emotional separation from their baby that stemmed from this. It was also reported as a reason to delay the initiation of breastfeeding, rather than encouraging early introduction of formula milk and administration of glucose solution to the baby. When asked to talk about their first breastfeeding experience, Dona, Anna and Eva recounted their experience of separation from their infants, ranging from three to six days following birth. The excerpt below clearly demonstrates Dona’s experience of the post-caesarean birth experience. She spoke about falling ill within the first six days following birth. Although her baby was being taken care of by Dona’s mother and husband, she still expressed the emotional trauma of separation from her daughter and a sense of failing her daughter and herself and not being in control. She could not breastfeed and her baby continued to receive formula milk until she was able to breastfeed.

Everything was just like a nightmare to me, because I never thought I [would] be able to breastfeed her after birth ... I thought everything would happen and I could feed her but it happened that I was very sick after the CS and couldn’t breastfeed her, I couldn’t even hold her. She was taken care
[of] by my mother. We bought formula milk and the nurses prepared it every time she needed to feed. (Dona, Interview 2)

Eva also felt she was not in control over herself after the CS; she described what felt like the pain of contractions when she first latched her baby to breastfeed:

*I could have tried to breastfeed, but it [the surgical incision] was so painful after they sent me to the maternity ward ... I think that was when the anaesthesia [had worn] off, and I couldn't do anything. The funny thing was that as she was crying for food, I was also groaning in pain almost having tears in my eyes ... I wasn't even thinking of breastfeeding at that moment.* (Eva, Interview 2)

Becky had emergency CS after a prolonged labour. She was, however, overwhelmed by her rapid transition and felt inadequately prepared to manage breastfeeding her baby. In particular, she was concerned about the delay of her breastmilk coming in and the lack of support to establish breastfeeding. She also struggled with feelings of not being in control over breastfeeding.

*I had [an] emergency CS after a long labour at the hospital ... I [felt] pressured and unhappy about the whole idea of the operation, and then, also, not able to breastfeed the first day ... It was a general anaesthesia, but then it took a long time before I recovered. Whilst at the ICU, my baby was taken to the intensive care unit. And that was a big separation for me. Soon as I woke up I requested to see my baby, but the nurse’s advice [was] that I fully recover first ... so I couldn't see him the first day ... I only breastfed on the third day. I mean it's sad and [I] got so overwhelmed about the whole situation, especially when you feel you're not of yourself or in control. I never thought of it [breastfeeding] this way or I thought all the time that is natural.* (Becky, Interview 2)

The process of initiating breastfeeding can be very challenging for the first-time mother, and particularly for some of these women this was complicated by the lack of professional advice provided. They described receiving conflicting advice and felt the instructions from the midwives regarding initiation of breastfeeding to be inadequate. Almost all the women explained that they were not told what to expect before undergoing a surgical birth, and nor were clear instructions given by the nurses after birth. Being novice breast feeders, the women expressed their feelings of vulnerability and uncertainty, whilst they expected to receive care and clear, systematic instructions in their establishment of breastfeeding. For instance, Mary
reported ‘I was waiting for them [midwives] to tell me what to do’. The women’s informational needs before and after the birth most commonly emerged from their narrative account. It was identified at times that they did not know what to do after the birth, in terms of establishing breastfeeding (Spencer et al., 2012). McFadden et al. (2009), in a study that explored the establishment of breastfeeding from the experiences of 10 UK women post-CS identified ‘maternal vulnerability’ as a result of ‘separation of the mother baby dyad’, ‘isolation’ and ‘unrealistic expectations’ (McFadden et al., 2009). The post-CS women in this study were also found to have suffered emotionally and psychologically from separation from their infants, which also delayed their initiation of breastfeeding.

In addition, the women described their experience in the maternity ward in relation to overcrowding and busy midwives who ‘rush you’, along with a lack of support to breastfeed. Following the caesarean birth of her baby, Faith expressed her need for midwives’ assistance to determine the correct position and attachment of her baby to the breast. She later expressed her disappointment in realising that though breastfeeding was natural, it was not as easy as she had imagined prior to birth. She spoke about the lack of realistic expectations.

They [the midwives] were too busy ... I mean don’t get somebody to attend to you or call for help; they attended to other women in labour ... at that moment I only needed somebody to tell me to do it this way or that. Later the healthcare assistant who attended to me couldn’t help much. He [my son] was hungry and inconsolable. I think all he needed was food, and I’ve not got my breastmilk at that time ... I was so worried and angry, because nobody told me that it would take some time before I could breastfeed. I thought everything would just happen soon after he was born and that he’ll have my milk, so I need not buy any formula when going to the hospital to give birth. I had all the hopes that it would just happen after birth. (Faith, Interview 2)

Angel also explained that she felt rushed by her midwife caring for her, without ‘taking time and touching base’. She further described the difficulties in attempting to synchronise her body and support the baby to breastfeed.

She [the midwife] wasn’t showing me, after she’d ask me to sit on the bed, she just put her [my daughter] on my arms, then direct my breast to her mouth. She left immediately my daughter could hold on to it [my breast] ...
she only breastfed for a while and came off. Everything was in a rush; though [the midwife] told me to keep trying, I couldn’t on my own. It was still difficult trying to do it without somebody to hold the neck and the head. It was hard trying to bring the two bodies together. I guess it’s because it’s my first time. (Angel, Interview 2)

‘Taking time and touching base’ relates to the women’s encounters with the midwives at the postnatal ward, which was portrayed based on an absence of giving enough time to help the woman learn to establish breastfeeding with their newborn babies. Contrary to the experience of the women in this study, Schmied et al. (2011), in a metasynthesis of qualitative studies, pointed out that taking time and touching base demonstrates an effective approach to support that helps women to feel relaxed, promotes their comfort and overcomes feelings of being rushed. However, Dykes (2005), in an ethnographic study observed midwives’ interactions with breastfeeding women at a postnatal ward and identified reasons including midwives’ work patterns and their experience of ‘temporal pressure’ resulting in their inability establish relationality with women’ (p. 241).

In addition to the early experience at the maternity ward, the women sought ways of interpreting the nature of breastfeeding as it relates to bodily experiences. The next section therefore demonstrates the nature of such experiences, including examples from their narratives.

7.4 The ‘Breastfeeding Body’

The interpretations provided by the women revealed that prior to birth they had a good understanding of their feminine body as a source of food for the newborn baby. Thus, they understood the lactation function of the body. Debbie spoke about how she knew her body to be functional, and able to produce milk for her baby after birth as ‘nature intended’:

_I know my breast is there so that I can have milk for my baby after birth ... I guess that’s what nature intended for it. I feel okay about it ... and that my body could produce milk for my baby._ (Debbie, Interview 1)

In Chapter 6, it was identified that one of the ways in which the women came to know about the caring capacity was through their acknowledgment of their breasts
as functional. However, after birth, most women spoke about their experiences in terms, for instance, of the body appearing more ‘real’ than they had ever experienced before. This was associated with the changes they experienced as they in the process of breastfeeding, involving the production of milk and a body that needed to be manipulated in order to be effective. Natasha had a caesarean birth, and later conveyed her experience of her body producing milk for her daughter, which included discussions about frequent engorgement of the breast, massaging it and taking antibiotics. Her story focused on the treatments that were unsuccessful:

*Once my milk started coming in, I had frequent engorgement, which later I was told I was overproducing ... my milk was coming [in plentifully]. And it made it difficult for my baby to hold on to it with his little mouth. My mother was massaging with shea butter, which was unbearable. Other people also advised using herbs and all sorts of things. But finally my doctor prescribed antibiotics that worked for a while. But when is like two hours or so without feeding, both get engorged ... and painful.* (Natasha, Interview, 3)

Lucy discussed the first four weeks of her experience with breastfeeding. She revealed how she struggled to comprehend that her body was producing more milk than her baby needed for a feed. She spoke about the overwhelming pain as her breasts become engorged with milk. She put her baby on the breast and the subsequent feeding was something that helped to get relief for her body, rather than to her:

*It was probably within the first four weeks just after the week she [my daughter] was born then I was actually ... producing more milk than she could take, and I was getting pains that move[d] towards my shoulders ... It was one of the things I couldn’t, I didn’t know, like it's all happening to your body and you could feel it.* (Lucy, Interview 2)

All the women who participated in this study were engaged in the process of breastfeeding. They saw their breasts as ‘objects’. In order to determine the mode of an object, and how human beings experience it in their daily lives, Heidegger used the term ‘entities’ (Heidegger, 1962). Drawing on this philosophical idea will help to understand the women’s interpretations of their postnatal body. In their reflective accounts, it was reported that the women needed to manipulate and learn to effectively manage their ‘object-breast’ in order to properly function. Heidegger identified three concepts in terms of how objects exist: ‘present-at-hand’, ‘ready-
to-hand’, and unready-to-hand. The below discussion will focus on the understanding of the ‘object-breast’ as unready-to-hand and ready-to-hand, as reflected in the women’s interpretations of their experiences.

7.4.1 ‘Unready-to-hand’
The ‘unready-to-hand’ mode demonstrates an object that is problematic and sometimes ceases to work in a functional sense, allowing the transparent nature of the object that previously existed in the ‘ready-to-hand’ mode to be suspended. According to Heidegger (1962), the object then becomes the focus, not the intended outcome. In the unready-to-hand mode, it is noted that one always seeks means or strategies through which to cope with the uncertainty and learn how to use it effectively. In this study, the concept of the breast being ‘unready-to-hand’ was illustrated a number of times during the conversation with the participants. Before initiating breastfeeding, all the women saw their breasts as having a function; however, this perception changed during the early process of establishing breastfeeding. Many described how their breasts were ‘unready-to-hand’ in their new mothering responsibility of breastfeeding. The participants discussed how they had to become technically competent at ‘using’ their functional breasts, and therefore focused on learning to effectively engage the breasts at breastfeeding, rather than the outcome of breastfeeding. The women’s perception of their breasts in the mode of ‘unready-to-hand’ especially dominated the conversation as the women described struggling to effectively manipulate their breasts; that is, learning the technical skills, which commonly occurred within the first three months after birth. Additionally, the women recognised their breasts as unready-to-hand when their breastmilk was delayed coming in.

Sally struggled to correctly latch the baby to breast, and later described her nipples as ‘unready to hand’. She came to understand that breastfeeding is a skill that she and her baby had to learn. Through her mother, she learned the techniques to correctly latch her baby. She received information about nipple care and frequently massaging the breasts to ensure an adequate supply of breastmilk. She gained knowledge on how to breastfeed (learning the correct position and latch of the baby to the breasts). Sally had to intentionally practise techniques that enabled her baby to suckle and obtain more breastmilk:
I was faced with the issue of having a flat nipples and they weren’t coming out as much as they should have which made it difficult to breastfeed after my baby was born and I thought of my baby attaching to on but he couldn’t really. Midwives advised me to always massage and try to stick them out when he’s not feeding. Actually it was quite a lot of effort to learn the techniques of putting him right and [getting] the baby ... to suck ... we were trying to work things out which took the whole of the first eight weeks before my nipples came to a good shape. It doesn’t come naturally at all as I thought before. You actually learn and the baby has to learn too. My mother has to consistently show me all sorts of different techniques, and then it’s lots of hard work, you’ve got to practise and practise a lot. It’s only now, after two months ... that I feel confident that my baby and I are doing it right, that he’s getting enough, that he feels happy and I feel happy about it as he feeds well all the time. (Sally, Interview 2)

Doris also struggled to get her daughter latched onto her breast, trying many different techniques suggested by her midwife. She discussed how her left breast was faulty (pains breastfeeding from sore nipples) and therefore both she and her daughter struggled with breasts that were ‘unready-to-hand’, but two weeks after the birth they managed to make breastfeeding work:

I [couldn’t get] my breasts producing milk for three days following the CS ... I thought it would happen and my breastmilk would start coming after the baby was born. It’s like your body is not ready, [my breasts felt] so hard and painful. We were trying all sorts of things like, massage ... I tried expressing, even others also advise[d] that I eat plenty of roasted nuts, and mashed ‘kenkey’ (cornmeal dish). We were giving him water and artificial milk to keep her satisfied. My mother and I tried doing everything, then after all these, that morning it just started coming, she attached well to it and then continued and [has been] doing fine since ... I mean it’s got better now. (Doris, Interview 3)

In the first week of her son’s life, Becky was completely focused on learning how to breastfeed, rather than the outcome of breastfeeding. She felt engrossed by acquiring the new techniques so that, in the process of feeding her son, she realised her breasts were ‘unready-to-hand’. However, Becky went on to describe how, once she had effectively learned the act of breastfeeding, she stopped being so careful about whether she was getting it right and focused on those concepts that lay beyond the need to provide her son with essential nutrition:
It took probably the first week really, learning the skills of getting him attached well to the breast. My whole time was about knowing the mechanics of it. I always sort of have the thoughts of whether he’s properly attach to the breast, or holding him well, [are] his lips covering most of the dark area of the breast, you know, all those things because it’s all new to me. ... In the beginning, I was just thinking whether I’m doing it right, and my mind was fixed on all those sorts of things. So you don’t think outside of that, but once you’re able to master it then you can begin to see other things. (Becky, Interview 3)

Sometimes the women become emotional about the unready-to-hand mode of their breast and therefore experienced breastfeeding as emotional. Faith spoke about her emotional experience of breastfeeding, when she struggled to feed because of a prolonged experience of painful breastfeeding. She described her mood as resentful and dreading to breastfeed. However, she overcame this experience after taking antibiotics and painkillers:

It’s so hard [participant was tearful], I just hate it being painful. I thought it was not supposed to be hurting ... sometimes it gets so bad and you feel incapacitated, I will groan in pain and clench my feet together. It doesn’t make life happy for me. At a point I was resentful, towards myself and even my husband, the last thing I want to do was to feed [my baby]. Though I didn’t want to stop ... yes, it got better after a while, when I started taking some antibiotics and painkillers. (Faith, Interview 3)

These narratives described how the participants interpreted the body as being unready-to-hand. This has a significant influence on the way in which we can understand how women’s lactating bodies (i.e., breasts) function as an object. Exploring the women's narratives through the fundamental concepts outlined by Heidegger (1962) provides an understanding of how they interpreted these objects and, therefore, interpreted their breasts and breastfeeding. As the women were able to master the techniques and understand the mechanics, they developed control over the feeding and therefore experienced their breasts as ready-to-hand.

7.4.2 ‘Ready-to-hand’

Ready-to-hand illustrates how people proximally encounter entities or objects (Heidegger 1962, p.121), and is discovered when one takes hold of an object and uses it. Through constant engagement with the object, it becomes transparent and familiar. The focus at this stage is on the outcome of what is being done rather
than the object. The following narratives emerged from the stories shared by the women, some of whom spoke of a sense of wonder that their bodies were able to nourish an infant. Those women who had learned to be competent at breastfeeding exemplified the concept of ‘ready to hand’. At this stage, the women focused on their breasts representing the nurturing and wellbeing of their infants.

Linda reported how her mother assisted her during the early weeks, putting the baby to her breast, then overcoming the struggle of positioning until she gradually learned to gain control over breastfeeding. Linda spoke about being able to breastfeed with ease and enjoying feeding her baby, without being fully aware of the body, her breast, as producing milk for her baby. Her breasts were then considered ‘ready to hand’:

*It reminded me when my mother put him on my breast, everything was happening and it was a very emotional time, especially struggling to put him to the breast ... gradually you learn the skills and then I could do it even when my mother needed to leave ... we were doing great and [it] was easy, you don’t feel anything, like the milk coming in or something ... all you know [is] that he’s getting and enjoying it as well.* (Linda, Interview 3)

Lucy could not comprehend that her body could produce milk that would nourish her baby. Five months after giving birth, she could visibly see the positive effect that she was able to achieve by being a source of food for her baby.

*It was amazing to comprehend that I could even produce milk that was going to feed my baby ... because my body wasn’t ready for about the first seven days, but just putting her on the breast as they advise ... it started coming when she latched on ... and here she is, doing well, being active and you know you’ve done the right thing.* (Lucy, Interview 3)

As part of her experience of her breasts as ready-to-hand, Katie explained the fact that a woman’s body will naturally produce milk after giving birth. She experienced her breasts as a ‘ready-to-hand’ part of her body, and enjoyed being physically close to her baby, as she spent much time providing this nourishment:

*I believe it’s something that the body of a woman naturally does in the same way as giving birth, everything about breastfeeding and your milk coming in, makes it so natural ... in the early days it’s really the only thing that...*
brings you to contact with your baby, others might want to cuddle him and able to put him to sleep. But having him on the breast is really the time you alone can do, and we [mother and baby dyad] become close, you’re looking at him, and he’s getting nourishment from you. (Katie, Interview 3)

Emily also spoke of how it was just convenient for her to go anywhere with her daughter without worrying about carrying bottles. She commented on how simple breastfeeding was, because the breast was ‘ready-to-hand’, which meant she could breastfeed everywhere at any time:

It’s so much easier to go out with her, when you can just breastfeed and away you go. I think that I’m happy about breastfeeding [because] I don’t need to worry about sterilising bottles and carrying formula with me. (Emily, Interview 3)

7.5 Summary
In the literature, the actual breastfeeding experience for first-time mothers has often been reported as contradicting the perception of breastfeeding prior to initiation (Hauck & Irurita, 2010; Hoddinott et al., 2012; Mozingo et al., 2000). This chapter highlighted on the birth and the early postnatal experience and nature of breastfeeding as engrossing. It was a transitional process from a previous pregnant body to the women’s experience of the birth and ability to exercise control over breastfeeding. Consistent with findings in the literature, it was clear from the accounts of the participants that the first-time mother’s experience of putting their baby to the breast is challenging (Andrew & Harvey, 2011; Williamson et al., 2013). It was identified from this study that the experience of birth has a negative impact in the early stages of breastfeeding, especially with the limited support from midwives at the postnatal ward. Although the women felt responsible, they were not in control of themselves to manage their newborn babies and initiate breastfeeding. Consequently, this was observed to have a psychological and emotional impact associated with the mother’s separation from their baby when the former became unwell (McFadden et al., 2009). However, as outlined in the next chapter, the women experienced support from others in two contrasting styles as they journeyed through their new experience.
Chapter Eight

Family as Enabler & Disabler
Chapter 8: Family as Enabler and Disabler

8.1 Introduction
This chapter describes the support that the participants received with respect to breastfeeding. It was identified from the analysis that the women highly valued the support and advice they received from family members. This support was experienced at some points as enabling or encouraging successful breastfeeding. Thus, it was seen as a positive approach to facilitating learning the techniques of breastfeeding, providing encouragement and validating the breastfeeding practise. This form of support was interpreted by the women as enhancing their confidence, and contrasted to the disabling barriers that participants encountered from family and society as they continued breastfeeding. Women were expected to become successful breast feeders by conforming to the expected social and cultural norms. The participants interpreted this as having a negative influence on their continued breastfeeding. Consequently, the approach of family as disabling was described as ineffective and discouraging, and countering the enabling support.

To obtain an in-depth understanding of the effect of these contrasting approaches as experienced by the women in this study, it is important to understand who ‘the others’ are and their position in the support of breastfeeding. The next section will therefore provide a brief description to explain who ‘the others’ are in this context.

8.1.1 Description of ‘the Others’
In this context, ‘the others’ is used as a collective term. It includes all other persons within the extended family and the social network of the women who provided care and support to the breastfeeding woman and her baby. In the accounts of the women, references were made to family members as the primary source of support. Commonly mentioned were those within the extended family, with whom the woman had a close relationship with and relied on for support. This included grandmothers (both maternal, and mother-in-law), older siblings and aunties. Some women also mentioned the baby’s father as the main source of support. For others, support was identified to involve a whole community, including
friends and neighbours that they could freely relate to. From the analysis, it emerged that older women played an important role, using their expertise obtained from previous breastfeeding experiences. For instance, the participants in this study were supported in areas of establishing breastfeeding, learning to breastfeed, recognising the baby’s cues and the motherhood experience. The remainder of the discussion in this chapter will focus on the various elements and factors that emerged as enablers and disablers that influenced the breastfeeding experiences.

Figure 8: Thematic ‘Spider diagram’ showing codes representing the sub-themes of the theme ‘Family as Enabler and Disabler’
8.2 ‘The Others’ as Enablers

Enablers of breastfeeding were described by the women in terms of a provision of care by their family members that enabled them and created a facilitative environment for learning to breastfeed. Enabling support was associated with the trust and confidence that the woman had in the caregiving, especially support that came from the women’s own mothers. Four key elements were identified, which were perceived by the women to enhance positive breastfeeding support for the mother-and-baby dyad. These included the women’s recognition of the presence of others, offering practical help, sharing their experience and providing validation.

The Others’ presence

From the analysis, it was identified that the mere presence of others was important to the women, especially following the birth of their baby. Whilst some described the hospital environment and the presence of the midwives as intimidating, rushed and lacking empathy, all the women spoke about the presence of family members as facilitating a sense of connection and calmness. Following the birth of her baby, Doreen talked about a ruthless encounter with a midwife at the maternity ward, but later felt a sense of calmness and sharing the joy of her newborn baby with her mother, the husband and the younger brother.

*My mother was the one taking care of my baby and I at the hospital … she came to see us as soon as he was born … and she showed me how to do it [breastfeed]. She positioned him on my hands and then wrapped my hands around him, and supported his neck as well, it was difficult holding my breast making him to latch … so she helped me … yes my husband was also there, he was happy to see the way the baby was able to feed … I felt really calm to see my family and my mother, helping [me] to breastfeed.* (Doreen, Interview 2)
At home, Debbie also recounted the value of her mother’s presence as she breastfed. She described her mother as someone who shows empathy and therefore encouraged her to ‘keep trying’.

Because it’s [breastfeeding] my first time, so she’s [my mother] always here with me … sometimes she seems to understand and will tell me to keep trying … every time she’s around I feel okay and it [breastfeeding] seems to work better for us [between myself and the baby], than when she’s not here. I mean, she [my daughter] will attach to the breast very well and feed so well than when my mom is not there. I don’t know the reason why it happens that way; maybe I’m scared that I might be doing it wrong … we struggle. (Debbie, Interview 2)

The accounts of Doreen and Debbie described the presence of others as facilitating improved performance and the confidence to breastfeed. The others showed empathy and provided encouragement that created an enabling environment for both the women and their babies. In the below example, Olivia mentioned how she valued and enjoyed her husband’s presence, and that he sat with her as she woke up in the night to breastfeed their newborn baby:

When I’m breastfeeding him at night, my husband will wake up and sit with me till I finish feeding him, and that is really important to me … you feel that you’re not doing it alone … he care[s] so much about the baby, which is good, because you just feel relax[ed] and take away every anxiety. (Alice, Interview 2)

Offering practical care and advice

When I first had a problem, I didn’t think to go to the clinic. I mean she wasn’t eating. I just called a friend who I know had similar issues and asked her what I was supposed to do … So, just calling someone I know has been in a similar situation was OK for me and was helpful. (Linda, Interview 3)

Moreover, it was noted that the others were not passive, but rather actively provided practical support in an encouraging way. The others used their expertise from previous breastfeeding experiences to offer support and care for the women and their newborn babies. The following narratives reported by the women highlight the various aspects in which the women and their babies received support that enabled them to successfully breastfeed.
Although the first-time breastfeeding and motherhood experience was challenging at the beginning, almost all the women in this study shared their experiences of support offered by their family members and social groups. Sally found breastfeeding to be more technical than she had imagined prior to initiating it. However, with support from her mother, she learned how to sit when breastfeeding, positioning the baby on her arms and ensuring correct attachment of the baby to breast.

*It’s amazing to now think that breastfeeding isn’t as simple as I had thought before. My mother asked me to sit on a low chair every time I’m breastfeeding, ensure that my back touches the wall and is straight, then she’ll put him [my baby] on my [lap], show me how to wrap my hand around him and help me fix him well on the breast ... I think that way you even feel more comfortable.* (Sally, Interview 2)

In the early weeks following the birth of her baby, Christine talked about the relationship she had with the mother-in-law, who always took time to sit with her, supporting Christine and the baby as Christine breastfed.

The others’ provision of practical support was not only limited to assisting the woman and the baby to breastfeed. For instance, Emma spoke about her mother’s care in other areas that encouraged breastfeeding. Emma’s mother believed that ‘a mother’s breastmilk is what she eats’. Therefore, Emma’s mother prepared food and ensured that whilst Emma breastfed, she was being well nourished by eating the right food, which also meant that Emma’s son would get enough breastmilk from the mother to promote growth and development.

*Every afternoon or sometimes in the evening, my mother will ... give me a [large] bowl of ... soup and ask me to eat plenty of groundnuts, I will have it ... at least twice a day. She [my mother] believes [that] by so doing I’ll get enough breastmilk for the baby.* (Emma, Interview 3)

Debbie also demonstrated her mother’s concerns regarding Debbie’s nourishment by frequently providing food for her, especially what most women referred to as the ‘maternal diet’. Debbie spoke about her mother’s constant recommendation of the
maternal diet, which Debbie’s mother believed would solve the issue of inadequate breastmilk.

My mother [is] concerned that he [my son] might not be getting enough of my breastmilk, because he cries even after feeding … and seems not to get enough sleep … so my mother always make[s] me soup and porridge so that my milk will come in plentifully. (Debbie, Interview 3)

The women in this study made frequent references to the ‘special maternal diet’. The beliefs in this study surrounding the maternal diet also fit those of a UK-based study, where women equated the quality and quantity of their breastmilk with the composition of their diet intake (Dykes & Williams, 1999). In the Ghanaian context, particularly in some ethnic communities the maternal diet for breastfeeding women is a rite performed by older women (e.g. grandmothers) in the family (Aborigo et al., 2012). This is believed to serve a number of purposes: first, herbs help the woman to recover from the stress of birth; second, the diet is believed to nourish the woman and increase milk production. In the narratives, the women mentioned several food items that make up the special diet, which include roasted groundnuts, porridge made of millet or corn, herb soup, which is referred to in the common local language (Twi) as Abemuduro and acts as medicine for the woman. Similar to the accounts of Alice, Rosalyn and Linda, most women reported common recommendations proposed by others, especially when there was a perceived insufficient milk supply. The women were often advised to eat adequate food containing these food ingredients.

8.3 Others as Disablers

As the women continued their journey of breastfeeding, it was clear that their daily experiences rested upon the interpretations of others’ advice. The others often acted in ways that were described as discouraging, rendering most women incapable of fully expressing or making decisions regarding their infant’s feeding.

Deborah persevered with breastfeeding and thought about continuing exclusively for the first six months, as this was considered best for her baby. However, she was made aware by others that at three months old her daughter was not thriving well on breastfeeding alone. She explained how others’ comments made her
‘understand’ that after three months babies need more than breastmilk to grow well. When Deborah’s daughter was compared with the ideal image of a three-month-old baby by others, she was seen to be performing poorly. Therefore, Deborah was advised to introduce 150mls a day of formula milk at four months. During this time, her confidence was reduced and she feared that she was not being a good mother.

I didn’t want the idea of people putting fear in you and thinking that you’re not doing your best. I was breastfeeding her every time and yet people thought that she wasn’t gaining that much weight. Maybe that’s her nature, because they [health professionals] claim we should breastfeed for the first six months and that’s what I wanted to do. But the last time my mother-in-law came to visit us, she told me that [my daughter] [felt] light [in weight], so I should give her formula. May aunty also said the same, which at the end of the day makes you feel that you’re not taking good care of your child. So I started [giving] formula about 150mls every day to top up. (Deborah, Interview 3)

At the time of the interview, Rhoda was married and living with her husband and her own mother under the same roof. She talked about how her daily experience was dictated by others, whom she described as secondary caregivers. This was based on others’ interpretation that anyone can nurture a baby, although it is only the mothers who can breastfeed. Rhoda felt that she was not in control, because her mother seemed to dictate the care of her baby; this resulted in her becoming insecure.

My mother takes care of [my son] most of the time, because [he] is her first grandchild and she wants to be [in] control all the time, which makes me feel less of a mother to him, because you don’t get the chance to be close all the time and breastfeed, which I sometimes believe is the reason why my breastmilk was not coming in [plentifully]. The other time when he was vaccinated at the clinic, and I thought he was in pain so spending time with him and breastfeeding was the best thing he needed and to calm him down, although he was really enjoying [it] and was doing OK, my mum later wanted to have him so she kept saying ‘oh I think you’ve breastfed him enough, you [Rhoda] need to go and eat as well, he’s doing fine’. I know [my mother] was concerned about me, but I was also concerned about my baby and [didn’t] care about me. She even influenced my husband to also say that [it] is okay, you’ve breastfed him enough. All that pressure on you and it makes you feel so emotional, like … so I stopped and was very [upset] that they [had] to do this to me. It makes you feel like you’re not in control of taking care of your own child. (Rhoda, Interview 3)
In the narratives, other women also reaffirmed that those who failed to submit to the dictatorship of others suffered consequences. In this case, family members might withdraw their support. This evidence was found to be consistent with other research conducted in Ghana (Aborigo et al., 2012; Iddrisu 2013; Tawiah-Agyemang et al., 2008) in which new mothers were identified as vulnerable to the control and expertise of others.

The strong messages offered by others contributed to some women not being able to make decisions that would promote the wellbeing of their baby. The ideals articulated by Lucy showed that what might be a good decision for a woman and her child can become a source of guilt, and possibly a sense of failure, if a woman adheres to others’ judgment. However, Lucy was determined to practise exclusive breastfeeding for the benefits it would offer her child; therefore, she decided to go against any form of traditional beliefs and practices suggested by her mother and mother-in-law. Instead, she chose to do the unexpected by refuting their contradictory advice despite the potential consequences.

*I was adamant and didn’t give my mother [a] chance to do whatever she wanted to do. Because I decided I was doing exclusive breastfeeding without giving water for the first six months, which was healthy and prevents [my son] from having diarrhoea. I wasn’t going to let anybody persuade me from doing what I think was right for my child. It all started soon after he was born, when we had returned from the hospital and mother’s idea every time was her advice that we should give water, alongside and all these traditional beliefs and practices. But I was very firm not to allow her, and always watching out, especially when she baths him, I sit by her side and sometimes ... prefer to breastfeed in the middle bathing before she continues... just to be sure she [my mother] doesn’t give him water. Although I kept explaining to her that I’m doing [it] exclusive[ly], she would say something like, he’s thirsty, his mouth is dry and all sort of things to get my attention to give water. And my husband also supported my decision to breastfeed exclusively. And after the fourth week, I realise[d] my mother was very uncomfortable with my whole idea of exclusive breastfeeding, saying that, she gave me water when I was a baby, and I survived, so there’s nothing wrong giving my child water. After spending about three weeks she returned back to her house because she felt left out in his care. I was even happy she did, I could [make the] decision on my own [and] my husband has [been] helpful. (Lucy, Interview 3)*
Joy had given in to the idea that the only thing capable of making her a good mother was her ability to breastfeed. Thus, she became lost in others’ interpretation that anyone can nurture a baby, but only a mother can breastfeed. As she struggled to establish breastfeeding, she began to question her ability to be a good mother. This resulted in her becoming insecure and questioning her capability.

*I wanted to be able to breastfeed, because to me, [it is] one thing that makes you feel more like a mother, and a good mother that others cannot do. It’s really upsetting when you struggle to feed her and others make you feel that you’re not making so much milk that is why she want[ed] to be feeding every time. I remember people were advising that I eat a lot of groundnuts, take herbs or massage my breasts with Shea butter, others also thought otherwise, which at the end of the day makes you more confuse[d].* (Joy, Interview 3)

In the following story, Christi talked about how she was invited by her mother-in-law introduce weaning food that will help her baby to settle. But she chose to avoid the pressure to conform. Instead, Christi navigated her own path that enabled her to see through the advise presented by others and remain true to the public health discourses surrounding the benefits of breastfeeding her infant. She was still feeding her six-month-old child during the interview at six months.

*It wasn’t that easy at the start, after he [my baby] was born he latched on straightaway and I thought that was good, that moment I felt we can do this [breastfeed]. Even in the early three to 10 days when we came home, everything was going fine. My husband was the only support … I didn’t want to be intimidated by others, who try to put pressure on you really. It was [another] reason why I chose to stay with my husband after birth. You’re not a mother enough if your baby is not looking the way they had expected. I thought I’m going to have a really good go at this, without allowing my mother to subject me to [this] kind of pressure, I can’t do it.* (Christi, Interview 2)

To Eva, the interpretation of breastfeeding belongs to others. She relinquished her decision to wean her son to the mother, leading her to believe that she did not own the decision. This however freed her from bearing the responsibility and the blame of having failed. However, she still had confidence in others’ interpretation that all good mothers breastfeed, yielding to feelings of guilt that she resolved only when she accepted that she had not actually made the decision to wean her son.
I think you have this expectation that you can do it and that it’s relatively going to be easy. People say it’s painful but you can get through it, if you … persevere it will be fine. I was disappointed just that it wasn’t going to work for me. And I started thinking that it was all me, and that I should be able to do it. People kept saying just keep going and it will go ok, it will go away, but we should be stopped heaps earlier. We shouldn’t have got to such a state where I couldn’t stand up, I couldn’t eat – I couldn’t do anything. I was useless to everyone including my daughter. You get all this stuff shoved at you all the time about how breastfeeding is best and you almost feel like you’re not a good parent if you can’t. (Rhoda, Interview 3)

Due to the vulnerability experienced by the first-time mothers during the transition to motherhood, they appeared to be at the mercy of others; as a result, the others used their ‘expertise’ to influence the women’s interpretations of what it meant to breastfeeding. Therefore, several of them sought to conform to others’ expectations.

### 8.4 Relinquishing Control

The sub-theme of relinquishing control highlights the influence and expertise of the others in the motherhood experience. Interpretations provided by the participants revealed others as those who have their own interpretations of childcare and breastfeeding activities, which they feel determine acceptable breastfeeding behaviour. This also demonstrated a lack of independence and control over the baby for the new mothers. Therefore, the women were constantly subjected to fulfilling the expected cultural and social breastfeeding behaviour.

Three characteristic features were identified by the women. The first describes the perceived inexperience of the new mothers by others. Secondly, others acted in their capacity as advocates of traditional values and practices whilst ensuring that the new mothers conformed to those practices, and thirdly vulnerability of the new mothers. The women experienced positive outcomes (i.e. support) after submission. It was also found that the women experienced positive outcomes after submission in terms of getting the necessary care, support and acceptance. However, whilst they put on a brave face to portray an image of coping, in reality they actually weren’t, creating a source of emotion work.

I absolutely hate it, but there is nothing I can do. You’re not independent to do what you want. They still tell you what to do even after five months … want to give water and other infant food. (Doreen, Interview 3)
It’s not that simple, I have to [follow] her [my mother’s] advice of [giving] water, because she’s the one helping me and taking care of the child. (Linda, Interview 3)

For example, most women spoke about how it was important to give up control to others. From the narrative accounts of the women, it was identified that they did not own any aspects of interpretations regarding the outcome of their breastfeeding, for instance failure or success. For some of these women, the daily experience of breastfeeding was dictated by others.

It’s my first time, and I don’t know anything yet, sometimes it can be difficult. They [others] tell you what to do, how well you and the baby [are] doing... (Sally, interview 2)

As the women continued to breastfeed, they found ways to manage their own feelings in order to be seen as coping well with their experience. They described the daily encounters with others as one ‘doing no better or worse’ than the-other (Inwood, 1999). During the early postnatal period, it was important for the women to give up their control in order to demonstrate a dependence on others’ expertise. After the birth of her baby, Sally thought she needed the care and support of others to enable her to breastfeed. Therefore, she demonstrated her complete reliance on others care, whilst following their advice and suggestions for herself and the baby:

My mother told me, ... four of my sisters breastfed their male children for [a] longer time, whilst the female babies [were] breastfed for three months and [were] introduce[d] to mixed feeding. I knew from the moment I gave birth to my baby girl that I would breastfeed the same way, I plan to breastfeed for three months ... but it changed, mine was different. After the three months I tried giving my daughter cereal but she wouldn’t take it ... she wanted to keep breastfeeding, I tried different ways ... like different infant food, and sometimes my mum will take care of her whilst I stay away, thinking if she’s hungry she would eat but even when she was hungry she refused, so it gave me no option but to continue with breastfeeding. (Sarah, Interview 3)

Amy told a story of how, in her commitment to breastfeed her baby, she desired to model others. She related how she gauged her success at breastfeeding in relation to how her auntie breastfed her own daughter, and how the knowledge that she
had breastfed for a certain length of time meant that she could wean and not feel like she had failed the other and her child. By modelling her experience on that of others, Amy expressed her unfulfilled:

The whole thing didn’t go the way I thought would ... and I remember after the first month we were to visit her family and I was thinking and saying to my husband that I didn’t want his parent to see me bottle-feeding [my son]. I couldn’t think of anything worse in the world than thinking about the perception that her family would have concerning me, probably I am not a good mother or something or I couldn’t provide what is best for their grandson, it made me scared to face them. Well, at the end of the day it’s a silly pressure that you put on yourself but to me it seems like that would be the worst thing [participant had tears in her eyes]. At the same time I wonder if it was really worth it. I know that it is in terms of the nutritional and the health value and all of that kind of thing, but the stress that [I] put myself through, [it was] so hard to let him latch and the pain, I don’t know whether it was worth it really. (Amy, Interview 3)

Other women also viewed others as experts in the motherhood experience, and therefore sought their approval and received instructions relating to breastfeeding problems. Faith explained that,

I was brought from the recovery to the theatre and was told not to get out of bed until the next morning; otherwise waking from bed will cause me to have some complications. So in the night when my baby started crying I needed them to tell me what to do, or somebody helping me to latch him on my breast for me, but none of the nurses was there to even request for their help. (Faith interview 2)

Some women who wanted to escape from others’ pressure struggled in silence or relied on other the experiences of mothers who were also breastfeeding or had breastfed. Amy described how the pressure to be the best breastfeeding mother caused her to shy away from situations in which she may have been open to criticism from her mother-in-law. For instance, in a study by Seidu (2013), new mothers were found to face criticism not only from family members, but also people within the community, leaving the women feeling vulnerable. Cynthia’s baby suffered from a severe reflux, which occasionally led the baby to vomit after feeding and to not gain much weight. When Cynthia’s baby was scrutinised by others, it was suggested that her baby had not gained ideal weight. However, Cynthia preferred to seek professional advice and was told that her baby’s weight
was normal and that she was doing well on the breast milk. Most women expressed vulnerability and doubted their capabilities when they were perceived as not reflecting a good image of motherhood, or of being subject to doubt in their capabilities.

My baby was spitting up in the early weeks when we were discharged home, though it stopped, but later I think it affected her weight; she wasn't gaining much weight like her peers ... My mum wanted me to feed her more by [giving] her other SMA, I refuse[d] and she didn't know what to do ... but I felt a bit of a failure and when we visited the ANC to check the weight ... she fell below the line. At that moment I was exposed to the criticism of the nurses. So then it was back to what I was thinking really, it is about me, something wasn't right with me my milk wasn't good enough. (Cynthia Interview 3)

Cynthia went on to express her feeling of powerlessness with respect to becoming the mother she wanted to be to her baby. She felt overwhelmed and under scrutiny from others who evaluated her ability to cope with her daily experience. She also reported feeling inadequate. Cynthia's experience fits in with other research studies that have identified the social impact on breastfeeding and mothering experience (Kronborg et al., 2014; Thomson et al., 2014). In order to avoid being scrutinised Cynthia withdrew from the presence of others, preferring to develop mastery of her experiences on her own.

Lucy, like some of the other mothers, handed over interpretation of her mothering and breastfeeding experience to others. Lucy's narrative demonstrates a common idea shared in the responses of other women in this study in terms of a need to conform to cultural ideals and expectations.

I thought I could ... exclusively breastfeed for six months, as health professionals claim, but at a point her weight gain was a bit sluggish but once I received assurance from my midwife that she's doing well that was okay for me. My mother-in-law was always commenting about her weight, suggesting to my husband that we supplement ... but my husband bluntly told her that we’re not doing it ... we’ve decided to do exclusive breastfeeding ... and knowing that we were not ready to introduce any food until six months, she left to her village. It [was] as if we were rejecting her support. (Lucy, Interview 3)
Angela, on the other hand, discussed how the pressure to model herself after a good breastfeeding mother was so great that although she knew that adhering to the image was destructive, she was influenced by the need to conform. She believed that by not breastfeeding she had failed as a mother, and wished she could have had the opportunity to breastfeed without difficulty, and not have to endure the associated feelings of guilt. Angela longed to escape others’ interpretations; however, she responded to pressure to conform to the image of the ‘perfect mother’ symbolised by others, despite the pain and the negative emotional impact that her breastfeeding experience held for her.

I didn’t want to bottle-feed but I knew I would eventually have to do so. I couldn’t cope with the way I was becoming hurt and I was depressed; it was just horrible. But because of this stigma about breastfeeding, everyone makes out that if you bottle-feed you’re a bad mother that’s why I struggled on for so long. We didn’t bond until the fourth month when I started bottle-feeding him. It was the resentment of him hurting my body. (Angela Interview 3)

8.5 Summary
This chapter identified that the women’s source of support and process of breastfeeding occurred within the context of their family and immediate society. Interestingly, only two women mentioned friends and peers as enablers, but were not dominate theme within this work. Those that were of most positive influence were the partners, while the maternal mother had the most negative influence.

The women responded in a variety of ways to the support provided by others, especially their authoritative power. The first-time mothers expressed their need for care, especially practical support to enable them to breastfeed. For most women, breastfeeding was a struggle in silence. This chapter laid out an interpretation of how others influenced women’s day-to-day experience of breastfeeding. Others, through their long years of experience, rendered interpretations that judged how well the woman and her baby were doing in terms breastfeeding. There was also a perception of the infant’s weight being a direct measurement of the adequacy and sufficient production of the woman’s breast milk. Whilst the women’s maternal mothers were usually described as disablers, some women stated that the support
offered by their own husbands had a positive impact on their commitment towards breastfeeding.

As part of the reflection process during the analysis, I had my own presumption that partners would have been less helpful, but the women acknowledged how helpful their partners were in providing enabling support.
Chapter Nine

The Phenomenon of Study
Chapter 9: The Phenomenon of Study

9.1 Social Conformity

The lived experience of breastfeeding from the sample of Ghanaian women in this study is identified as multifactorial. Based on the inductive approach of thematic analysis and hermeneutic interpretations, the interpretive findings suggest that successful breastfeeding is dependent on a complex interplay of social, cultural and physical challenges and emotional factors, which were influenced by the women’s ability to self-adapt. The women portrayed an image of themselves as successful breastfeeders in an effort to manage social norms and family expectations. The phenomenon conceptualised suggests that the breastfeeding journey is suffused with ‘emotion work’, a concept drawn from Hochschild’s emotional labour and emotion work. Evidence of emotion work is deduced within the context of the family as an enabler and disabler through the support of breastfeeding.

The concept of emotion work draws on Hunter’s (2005/2006) explication of emotional labour or emotion work suggested by Hochschild (1983). Emotional work refers to how individuals manage their emotions as a result of social expectations and conformity (Wharton, 2009). In other studies, emotional labour describes an individual’s effort to display appropriate behaviour in an attempt to comply with organisational rules or social norms (Chu, 2002). In this context, sources of emotional work are based on the findings from the theme ‘family as enabler and disabler’ and the fact that some women relinquish control in order to conform to social and family expectations. Some women reported this as constantly acceding to the will and power imposed on them by others through their supportive role. The nature of social influence on the new breastfeeding mothers undermined their confidence and led to a loss of their authentic self, while putting on a brave fact to portray themselves as coping. They developed confidence and strength from others’ shared experiences and advice. Most notably, their husbands were a key enabler for successful breastfeeding and maternal confidence.

A detailed discussion of the phenomenon is discussed in the following chapter.
Chapter Ten
Discussion
**Chapter 10: Discussion**

**10.1 Introduction**
The aim of this study, as articulated in Chapter 1, has been to explore the lived experiences of first-time breastfeeding mothers in Ghana. It focused on six set objectives that have been achieved through in-depth interviews carried out during the antenatal and postnatal periods. It explored the attitudes, beliefs and values contributing to breastfeeding; the women's perceptions relating to sufficiency and adequacy of their breast milk; the nature of these perceptions and how they changed over the pregnancy and postnatal period; the influence of cultural issues, the role of the family contributing to the mothers’ perceptions of their breast milk and finally their self-belief relating to their ability to exclusively breastfeed. The concepts that emerged in relation to the research aims and objectives include the dominant influence of society’s interpretation of breastfeeding, and the embodied nature of breastfeeding and motherhood in ways that were previously hidden from the women, and would have remained so without the experience of breastfeeding. These new experiences provided the mothers with a wealth of knowledge about what it means to become a mother and experience breastfeeding, and the societal interpretation of breastfeeding.

**10.2 A Recap of the Main Objectives and Methodology of the Study**
This study employed a hermeneutic phenomenological research methodology, based on the philosophical work of Heidegger (1962). Heidegger's interpretive ideas guided me to approach my research based on my own preconceived perceptions of breastfeeding, including my motivations for carrying out the research, yet with a stance of openness. It also provided a foundation for research on the hermeneutic circle, which is integral to making meaning from the participants' narratives. Most importantly, I acknowledged my own personal experience as a first-time mother that underwent breastfeeding, which enhanced my understanding of the women’s experiences.

A review of the relevant qualitative empirical literature in Chapter 2 also provided in-depth insights into women’s experiences of breastfeeding across the different
socioeconomic classes. Although the literature review touched on the various social, physical and psychological aspects that challenge successful breastfeeding, the few studies identified from Ghana and other low-resource countries frequently ignored the ‘meaning of breastfeeding’ to women. Addressing this issue required use of a methodology that enabled a return to a well-researched phenomenon to re-examine the meaning of breastfeeding for women in Ghana. Using hermeneutic research allowed me to do this.

In the following paragraphs, a discussion of the main issues arising from the findings is conducted. The discussion is framed under two main headings, ‘The untold story’ and ‘Emotional management’. It is interwoven with the existing theories and relevant literature, drawn from similar settings and studies. The methodological influence (i.e., strengths and limitations) on the research processes are outlined, including the researcher’s reflexivity.

10.3 The Untold Story
An untold story usually emphasises how some events or occurrences in everyday life go un-narrated, unrevealed or unspoken. Yet the truth about these unrelated or unreported stories is that they may have some intricate underlying factor(s) that become a challenge for people to openly express. Telling a story can help an individual to reflect on situations that have been taken for granted, thereby leading to thoughtful action (van Manen, 1990). With reference to such reports, the media will usually highlight the unreported aspects of disasters, conflicts and vulnerable groups. For example, Gardener and Bushra (2004) wrote about the untold aspects of Somalian women’s experience of war. Similarly, Razavi (2015), in a single case study investigation, reported the plight of the homeless in Britain.

In my study, the untold story does not relate to a major traumatic event or series of events that would be considered irregular. Rather, it relates to the experiences of Ghanaian breastfeeding women, where it is identified that the embodied knowledge of what it means to breastfeed is not extended to women who are pregnant with their first child. For instance, neither the positive nor negative aspects relating to the embodied experience are often discussed in a way that prepares women prior to breastfeeding. The embodied experience of breastfeeding is therefore recognised
as a hidden experience of which the women later gain knowledge through their personal experiences. This was frequently demonstrated in the narratives, where prior to breastfeeding women perceived that breastfeeding should be an easy aspect of their mothering role, however, once they engaged in the act of breastfeeding they discovered that their assumptions had led to unrealistic expectations. This discussion seeks to highlight the concept of unrealistic expectations and the impact this had on the women’s perceptions and daily experience of breastfeeding. To better illuminate this concept, the discussion will be considered in relation to the following aspects:

- Social Context of Breastfeeding
- Social dynamics and impact on exclusive breastfeeding
- Breastfeeding Difficulties
- Re-knowing breastfeeding

Evidence from the findings indicates that the knowledge surrounding breastfeeding prior to the women giving birth is based on culture givens. ‘Givens’ referred to rules and meanings as signposts (Walton, 2011). Alternatively, they are cultural beliefs, values and assumptions that give meaning to events in life. However, this culture of givens limits women’s knowledge of what it means to be a woman breastfeeding for the first time. Detailed discussion of this is presented based on the findings.

10.3.1 Social Context of Breastfeeding
Within Ghanaian society, breastfeeding is identified as the integral part of a woman’s experience of mothering, and knowledge of it is for most women embraced through a process of socialising within their immediate family and social groups. Breastfeeding symbolises the traditional responsibilities of a mother’s love and care. Observing female relatives breastfeeding reinforces the expectation that children are taken care of by means of the mother breastfeeding. In one example, Eva, a single mother who lived in an extended-family house, described how growing up in a family where she observed other women breastfeeding was an indication that she would also breastfeed: ‘...you see every mother breastfeed her baby ... so growing up you just pick up the idea that you will also breastfeed once you have your baby and that is what it means to be a mother’. Among the
Ghanaian first-time mothers, the maternal role and breastfeeding were culturally defined as belonging to the feminine gender. Therefore, women came to know breastfeeding as part of their mothering responsibilities.

Breastfeeding is a value-laden activity that, in my study, resonates with the work of Lööf-Johanson et al. (2013), who demonstrated that breastfeeding has specific value in the lives of women. In addition, this assumption agrees with most studies considered in the literature review (Bottorff, 1990; Hoddinott et al., 2011; Leff et al., 1994; Lööf-Johanson et al., 2013; Marshall et al., 2007; Schmied & Barclay, 1999; Williamson et al., 2013). Similarly, Schmied and Barclay (1999) recognised the central role that breastfeeding played in the subjective maternal experience of participants in their study.

In reference to my own narrative review (Afoakwah et al., 2013), I noted that breastfeeding also signifies a ‘symbol of motherhood’. Breastfeeding in the review is indicated as both a biological and sociocultural activity. In the literature, the sociocultural construction of breastfeeding as natural is something that goes unquestioned and unchallenged (Marshall et al., 2007; Mozingo et al., 2000; Schmied and Barclay, 1999; Wall, 2001). This viewpoint supports the notion that breastfeeding is part of a woman’s basic role and therefore an inseparable part of her nature. In Ghana, this viewpoint is firmly held. In other cultures, however, women view breastfeeding as infringement of their body rights, and particularly breastfeeding in public is often seen as a perversion (Avery et al., 2000; Murphy, 1999). Furthermore, the feminist literature (Schmied & Lupton, 2001) would argue that motherhood is not primarily based on the biological and natural process of a woman, but cultural practice.

Most of the women were supposedly drawn into motherhood by their inner instincts, which at the same time guaranteed their ability to breastfeed and care for their child. However, the literature suggests (Dykes & Williams 1999; Williamson et al., 2013; Spencer et al., 2014) that being a mother and having a desire to nourish one’s baby does not automatically lead to successful breastfeeding. The women in my study believed that they would successfully breastfeed and that it would be effortless and automatic, which depends on the natural instincts of both the mother
such assumptions heightened their disappointment and frustrations when their expectations were not met. This has been reported in the literature as the ‘taken-for-granted’ (Bottorff 1990; Dykes and Williams 1999; Hall and Hauck 2007; Marshall et al., 2007; Schmied and Barclay 1999).

Breastfeeding is identified to be a biological aspect of motherhood (Blum, 2000; Schmied & Lupton, 2001). For instance, Holmes (2006) stated that all societies have their own unique mythologies surrounding motherhood; however, some common grounds in the norms and expectations surrounding mothers and motherhood are shared between cultures. Motherhood is simply defined as a state of being or experience of a mother (Mercer, 2004). Moreover, Mercer (2004) revealed that though motherhood is described as the ultimate achievement and fulfilment of life, others have argued that it is rather a form of female oppression.

For instance, within Western culture the description of motherhood has been contested by feminist ideologies (O’Reilly, 2004; Rich, 1976). O’Reilly, a feminist theorist, argued that ‘...motherhood is primarily not a natural or biological function; rather, it is specifically and fundamentally a cultural practice that is continuously redesigned in response to changing economic and societal factors. As a cultural construction, its meaning varies with time and place; there is no essential or universal experience of motherhood’ (2004, p.5). In addition, Glenn et al. (1994) maintained the idea of motherhood as an activity shaped by cultural perspectives.

Women’s perceptions of the synergy between breastfeeding and the maternal role greatly influenced the mothers’ intentions and approach to breastfeeding in my study. Such beliefs provide an understanding of the significance and value that women attach to breastfeeding. In the chapter, of the theme ‘women’s business’, women acknowledge breastfeeding as a sole responsible. In the dictionary (Oxford dictionary, retrieved October, 2015 ), the term ‘business’ has several synonyms, which pertain to one’s occupation, profession, job, field or calling, within which a person is expected to demonstrate expertise. This notion therefore contains a great deal of influence and importance in the life of women. For the women who participated in this study, breastfeeding was not only a means of feeding the baby, but one of developing the personal ego of the individual mothers to offer the best
they could for their children. Mothers are expected to naturally exhibit some dexterity and proficiency in carrying out their duties or responsibilities. Women sense of effort to offer their new-born babies the best concur with the participants in the study of Bottorff (1990), who believed that breastfeeding their baby, was a gift. Consequently, failing to show ‘expertise’ by getting things under control (e.g., the correct attachment and position of the baby), in what can be termed as their primary duty, means failing in maternal responsibilities.

10.3.2 Social dynamics: Impact on EBF
Social variability is described in this context as independent variables observed to have a major influence on the way that the Ghanaian women came to know and experience breastfeeding. This variability’s are inferred from the demographic data and the women’s profiles, which include the family structure, marriage status and educational level. Although in the literature none of the studies have identified these social variables as contributing either positively or negatively to how women experience of breastfeeding, the impact of family members (e.g., grandmothers) on the practice of breastfeeding has been commonly noted (Andrew & Harvey, 2011; Awumbila, 2003; Demirtas et al., 2011; Grassley & Eschiti, 2008; Marshall et al., 2007). In a study that explored the social dynamics and infant feeding practices in northern Ghana, Awumbila (2003) demonstrated the effect of ‘household dynamics’ on infant feeding. Similarly, Demirtas et al. (2011) observed the influence of older family members on 24 participants from Turkey using in-depth interviews.

The two main forms of family identified among the Ghanaian women taking part in this study were the nuclear and extended family structure (Murdock, 1949). Murdock (1949) and Parsons (1959), both of whom are functionalists, identified the family structure as an institution that serves a number of functions. For instance, one of the primary roles is to maintain order and stability in society and significance for individual family members (Parsons, 1959). Whilst the nuclear family indicates two generations of family members living under the same roof, the extended family structure consists of three or more generations living in the same household (Murdock, 1949). In my study, it was observed from the analysis that most women who were not married at the time of data collection lived together in an extended-family situation. This consisted of grandparents, aunts, uncles and other siblings.
Awumbila (2003) noted that this structure of family operates under a hierarchy. For instance, the first-time mothers in my study mentioned the supportive role from others (e.g., older female relatives) and the expertise of people who have breastfed previously. This was often reported in the early stages after birth when the women attempted to find a foothold in their new experience. The supporting role has also been pointed out by Parsons (1959) as a significant aspect of the extended-family structure. Although it was reported that members in the top hierarchy (e.g., grandparents) possessed authority, their role was described as controlling, rather than empowering. For instance, most women in my study cherished support that enabled them to make decisions relating to their infant feeding choices, rather than feeling pressured to comply with others’ expectations.

The majority of women who lived with three or more generations reported a negative influence and confusion through the conflicting advice people offered in relation to managing breastfeeding. This often led to a loss of commitment and enablement to practise exclusive breastfeeding. This resonates with a recent study conducted in the UK where the attempt to conform to social pressure shifted women’s focus with respect to achieving breastfeeding expectations (Spencer et al., 2015). However, relinquishing control due to pressure was less among married women living under the same roof with their partners. Mothers in this category experienced mutual and emotional support from the father of their baby. Although studies in the literature did not clearly demonstrate marriage as having an influence on the women’s lived experience of breastfeeding, it has been acknowledged that partners/fathers play a supportive role in helping their wives to breastfeed (Datta & Wellings, 2012; Rempel & Rempel, 2011). Together, this gives a picture of motherhood that is not confined to the idea of being a biological process, but rather also a cultural practice, shaped by social rules and expectations from the extended-family situation.

On the other hand, marriage is seen as a means of liberation, in a sense that minimises being under subjected by the others (Seidu, 2013). This is well observed in my study, where the few mothers who were married and lived together with their husbands expressed commitment in their resolve to breastfeed exclusively. Most significantly, the women described the authentic and facilitative support received
from their partners. In this context, marriage may be considered as a refuge, a place where the women are protected from the strong influence of ‘others’ that lurk outside of the home. For instance, those mothers attested to their husband’s physical and emotional support.

In my study, besides the topic of breastfeeding being shrouded in silence, the first-time mothers dealt with other constraints as they strived to breastfeed. In this context, the traditional meaning of motherhood seems to conform to the social structure and household dynamics. The traditional Ghanaian concept of motherhood is observed to be a feminine role. This, however, defines the feminine role of women as homemakers, and child-bearers who are responsible for the care and wellbeing of children (Parsons, 1959; Tettey, 2002). In my study, women were empowered by wanting to do the best for their baby, but constrained by the lack of information, conflicting advice and values imposed by others. In other instances, breastfeeding was viewed as within a woman’s domain. Women perceived their breasts as functional, especially prior to giving birth. For example, in the first interview Linda claimed that breastfeeding is what her breast was intended for (Linda, Interview 1). This makes breastfeeding accepted as an open activity in Ghana, contrary to Western society where men often oppose breastfeeding, considering the female breast as a sexual object (Andrew & Harvey, 2011; Hauck & Irurita, 2009). Some women described their experience of breastfeeding in public as that which authenticates being a good mother. Although this is seen as acceptable norm, most women talked about discreet feeding when their baby needs to breastfeed in the public.

Another aspect that greatly influenced the way the individual woman approached breastfeeding and managed their daily experience with a breastfed baby was their level of educational. As gathered from the data analysis, mothers without education or who were educated up to primary-school level only formed the majority of the sample. On the contrary, women with tertiary educational backgrounds appeared to be more receptive to information-seeking and showed persistence in breastfeeding. For instance, Christi had a master’s degree and lectured at a private university; she believed that the Internet would provide her with current information to manage her frequent battle with breast engorgement. In the same way, Julie believed
education was important because it affords women self-confidence. Thus, it seems that women who are knowledgeable are better able to make informed decisions, which may enhance breastfeeding success. On the contrary, other researchers have argued that breastfeeding knowledge alone does not necessarily transform into a woman’s ability to successfully breastfeed (Sheehan et al., 2012). This suggests that health professionals’ support that is tailored to meet the individual needs of breastfeeding mothers is paramount.

10.3.3 Breastfeeding Difficulties
The traditional concept that depicts a woman’s caregiving capacities as their intended role within the society allows a negligible amount of explicit attention to be paid to the embodied unique experience of breastfeeding. Based on the women’s narratives, the use of language and information was found to provide a realistic picture of actual breastfeeding practice in the Ghanaian communities as veiled in secrecy. Neither the positive nor the negative aspects of what it means to be a woman who breastfeeds are accessible to women who are giving birth for the first time. Women commonly reported that an accurate image of breastfeeding was unavailable within their family, social networks and antenatal education. For instance, during pregnancy most women expressed understanding breastfeeding as natural and therefore effortless. Conversely, once they had begun to engage in breastfeeding after birth, they discovered that their prior assumptions had led to their having unrealistic expectations that resulted in feelings of uncertainty. Eva, like most of the women, reported having previous knowledge that breastfeeding is easy and a routine activity within the domain of women, and therefore imagined that nothing could possibly go wrong. Later, Eva’s perception changed whilst she struggled with getting her baby to latch well. Upon reflection, Eva felt she was inadequately prepared, pointing out a gap between her expectations and the actual breastfeeding experience. The experience of sore nipples, pain and fatigue also came as a shock to the women. In the literature, Schmied and Barclay (1999) found the embodied experience of some of the women in their study to be disruptive and unpleasant. Similarly, Williamson et al. (2012), in their UK-based study, talked about the lived embodied experience of the women in their study to be a struggle, rather than the prior expectation that breastfeeding would be relatively straightforward by virtue of its being natural.
This study identified a silence that exists around the realities of what it means to breastfeed — including the potential problems that one could encounter during breastfeeding. However, breastfeeding among the women in this study was not without difficulties, which were unexpected before the birth their babies. For example, it is observed that the women ensuring a good position and latch with their babies, delayed breastmilk coming in, learning their baby’s cues and understanding the lactation function of their body were some of early difficulties the women had not expected. This was also difficult for the women who underwent a surgical birth, and therefore needed time to recover. Following childbirth, only five out of the 28 women engaged in the second and third interviews reported breastfeeding as straightforward. The majority expressed shock, because the reality of breastfeeding is not as easy, and nor did it happen automatically, as they had perceived.

The women commented on the fact that there is no realistic picture of the experience of breastfeeding, as an integral part of mothering, given to first-time mothers prior to childbirth. For instance, the interview during pregnancy portrayed breastfeeding as natural and therefore effortless. Conversely, once a woman had engaged in breastfeeding after the birth, she discovered that her prior assumption had led to her having unrealistic expectations, and therefore seeking support. Most women, like Eva, reported a previous knowledge that breastfeeding is easy and within women’s domain and therefore imagined that nothing could possibly go wrong. However, this changed when the women began to search for a foothold in their newly found experience. For example, Eva later felt inadequately prepared whilst she struggled to get her baby to latch well. The experience of sore nipples, pain and fatigue also came as a shock to the women.

Eva questioned why the experience of breastfeeding is hidden from the public domain. She spoke about how women do not wish to disclose their experiences of difficulties, but the only acceptable place to voice one’s experience with breastfeeding difficulties is with those who have already lived the experiences of birth and breastfeeding. In a similar way, the literature reported the overwhelming experience that women encounter as the reality seems to conflict with the natural
nature of breastfeeding. This, however, suggests a lack of adequate preparation by healthcare professionals and family members who have already lived the experience. More essentially, there is a lack of embodied knowledge amongst first-time mothers.

It was also identified that the women struggled with feelings of uncertainty. In particular, they were unable to decipher whether what they were experiencing is the norm or whether they were failing. An example was recounted by Donna, who felt intimidated by her frequent experience of painful breastfeeding and bleeding cracks on her nipples. During the interview, she questioned whether her situation was peculiar or whether it is normal to experience pain. Her raising this issue for the first time during the interview illustrates her reluctance to be seen by others as a ‘misfit’. Most of the mothers reported similar experiences, but shielded them to avoid a label of failure. The women questioned the normalness of breastfeeding, suggesting that one would not expect something that is ‘natural’ to be so painful. The subjective feeling of pain, engorged breasts and loss of control of the body appeared contradictory to the nurturing role of the mother ensuring the baby is well supported and nourished. The breastfeeding experiences of the mothers in my study concur with women’s experiences in other parts of the world. In a study conducted in the US (Mozingo et al., 2000), for example, the perception of mothers’ failure to successfully breastfeed was related to the lack of realistic images of breastfeeding.

Furthermore, it was identified in my study that the embodied knowledge of what it is to be a mother is not extended to women who are pregnant with their first child or as preparation for women during the reproductive age. This lack of information about the potential difficulties of breastfeeding overwhims women and limits their opportunities to overcome complications they may encounter. In a US-based study, George (2005) demonstrated a model showing the lack of adequate preparation for first-time mothers during the antenatal period and its negative consequences in terms of unclear role expectations change in priorities, overwhelming responsibility and knowledge deficit. In my study, the women reflected on their early postnatal experiences as having unclear expectations and feelings of uncertainty, especially as they get started to breastfeed. However, the novice women sought to balance
this by relinquishing control to others who for support. A mismatch in the expectation of breastfeeding and struggling to breastfeed often leads to women feeling inadequate and hence losing confidence (Hauck, Dykes & Williams, 1999; Williamson et al., 2012). Similarly, Dykes and Williams identified this negative impact among women in their study as ‘falling by the roadside’ and early cessation of breastfeeding. Williamson et al. (2012) also identified the negative consequence on women’s self-identity.

10.3.4 Re-knowing Breastfeeding

In my study, it became evident that the perceptions of the participants prior to birth were based on taken-for-granted assumptions; with the motivation that breastfeeding is natural. All the women interviewed during the antenatal period expressed an attitude of natural breastfeeding as something unlearned; an instinctive practice. Since the society in which a woman lives has a great influence on her knowledge, attitudes and beliefs, it is important for the public to be educated to a standard that will enable women to be empowered. In this context, the education of older women, perhaps through social groups, may result in less judgemental support for them. Midwives and other health professionals’ involvement through evidence-based support is paramount in helping women to ‘re-learn’ to breastfeed. This concurs with Cater (1995, p.67), who proposed that breastfeeding is ‘something that women must be re-taught through scientifically based professional intervention’. In my study, the mothers related their ability to appreciate breastfeeding through their own individual experience, highlighting that the embodied practice of breastfeeding is not only based on natural and instinctive practice, but also a learning process (Bottorff 1990; Dykes and Williams 1999; Kronborg et al., 2014; Marshall et al., 2007).

This social talk surrounding natural breastfeeding lends itself to the view that women can successfully breastfeed, and in particular that mothering requires little support. In the face of these challenges, it is suggested that the provision of unique support that meets the needs of first-time mothers, as well as empowering them to breastfeed successfully, is paramount (George, 2005; Lavender et al., 2005; Kronborg et al., 2014). By hiding the reality that breastfeeding is often difficult, the silence that shrouds breastfeeding fuels the propagation and reinforcement of
unrealistic ideals of mothering. It is important, therefore, to examine women's embodied experience of breastfeeding, regardless of its duration. Additionally, it is observed that because of this situation the women resulted in using emotion work to display the appropriate behaviour.

A closer examination of the unique lived breastfeeding experience of the women in this study also identified their emotional situation through the support offered by others.
10.4 Emotion Work of Breastfeeding

It is evident from the findings of my study that the attempt to cope with what is perceived as expected breastfeeding behaviour by the women was suffused with emotional feelings. A useful way to examine the participants’ ability in managing this expected behaviour imposed by others is conceptualised within Hochschild’s (1983) ‘emotion work’. In the literature, the term ‘emotion work’ (also known as emotional management) is the control of a person’s emotions or feelings in order to display the appropriate behaviour (Chu, 2002).

In addition, Turner and Stets (2006) described emotions as a means to ‘strategically change the expression of a felt emotion to try to influence behaviour’ (p. 25). Appelrouth and Edles (2008) argued that emotion(s) are not primarily a biological or psychological response to mechanisms (Lazarus, 1991), but rather are actively produced and managed by individuals during interactions with others (Appelrouth & Edles, 2008). They added that emotions are ‘something created’ or that we ‘do’ in the form of emotion work (Appelrouth & Edles, 2008), and this implies efforts to ‘manage the intensity or type of feelings one is experiencing’ (Thoits, 2004, p.360). It can be noted that in most empirical studies on breastfeeding, the emotional experiences of women are attributed to the overwhelming feelings of the difficulties of breastfeeding, and the stress in trying to fit breastfeeding into their normal lives. In this context, emotion work can be defined as the effort displayed by the breastfeeding woman in an attempt to manage and cope with families and social expectations within the context of continued breastfeeding (Oliker, 1989). The purpose of emotion work is therefore to evoke or suppress a person’s true feelings into a socially approved behaviour (Hochschild, 1983). Within this context, I argued that emotion management is shaped by cultural and social norms of the community in which the women live.

10.4.1 The Concept of Emotion Work

Emotional work is simply the way people manage emotions or feelings to conform to the appropriate social or organisational norms. Directly related to the concept of emotional work is emotional labour, and both terms are attributed to Hochschild (1973). Whilst both terms portray emotional management, emotion work pertains to a private act, with the intent to maintain relationships and avoid sanctions (Cook
Emotional labour is emotion work based upon organisationally defined rules and guidelines (Wharton, 2009 p.147). Examples of emotion work are portrayed in the way people show affection, apologise after an argument and address problems in an intimate way in order to maintain good interpersonal relationship that result in friendly atmosphere (Thoits, 2004). In this study, the term ‘emotion work’ is preferred because the women’s efforts to control their emotional feelings occurred within their private lives rather than being institutionally specified. For example, the participants used emotional work to create pretence and demonstrate an attitude of compliance.

Whilst application of this concept to the women’s experience of breastfeeding is a novel idea, emotional labour and emotion work has inspired an immense amount of research, for example in areas of nursing and midwifery profession (Hunter, 2004/2005; Msiska & Smith, 2014). A study by Hunter (2004) in the UK explored the views of students and junior midwives in their practice and interactions with senior colleagues. Hunter identified that these group of midwives require emotional work in order to coordinate their feelings that allow them to accommodate hospital-based norms imposed by the senior midwives (Hunter, 2004). The junior midwives therefore ensured conformity by negotiating and maintaining relationships with their senior colleagues (Hunter, 2004). In a similar fashion, the analysis in my study shows that women sought to: ‘maintain their boundaries’ by recognising others’ expertise. They also demonstrated an ‘illusion of compliance’ by conforming to socially acceptable norms of breastfeeding behaviour. Finally, participants also sought to find an easy way to ease the pressure imposed by others, as they identified with peers for advise. These three areas will be discussed below.

10.4.2 ’Maintaining Boundaries’

It is evident from this study that women’s breastfeeding experience occurs within the extended family and society in which they live. In Chapter 8, the theme ‘family as enablers and disablers’ demonstrates two contrasting approaches to breastfeeding support, as perceived by the participants as they reflected on their lived experiences. This is identified to have a direct influence on how the women experienced the journey of breastfeeding. Within the sociocultural context, it can be observed that families in Ghana function under a hierarchical structure, where the
flow of communication and function of individual family members is determined (Awumbila, 2003). For instance, decisions regarding infant feeding and breastfeeding activities are determined by the older female relatives (Aborigo et al., 2012; Awumbila, 2003). A description of others highlighted the way these others interpret the women’s breastfeeding experiences and framework for acceptable breastfeeding behaviour. Therefore, maintaining boundaries that exist within the family was important for the women as they sought to gain others’ approval and support. These boundaries required the women to constantly engage in an attempt to conform to the family’s expectations and social norms. Interactions with others are presumed to require significant amounts of emotional work, and this work is the effort needed to maintain and negotiate relationships. The women’s use of emotion work to maintain family relationships fits a study by Hunter (2005), who identified how junior midwives sought to negotiate relationships with senior colleagues in the hospital environment.

For the women, managing the way they felt under the direct influence of others was suffused with emotional feelings. Maintaining boundaries was commonly referred to by the women irrespective of the stage of breastfeeding. For instance, most women spoke about ‘relinquishing control’, which demonstrated a submissive attitude and reliance on the others’ expertise as the primary source of support. The others maintained this position through social norms, supported by their claim of greater expertise in breastfeeding providing them with the capacity to mentor the young mothers. The others also imposed sanctions by withdrawing their support.

Being novice breast feeders, the women were submerged under the influence of others. As evident in the accounts of the women, they could rarely challenge the others’ authority, and therefore prioritised fulfilling the expected requirements over their commitment to practise exclusive breastfeeding. For instance, the traditional practice of introducing water to the baby before six months was determined through others’ decision making. In the interviews during the antenatal period, Anna demonstrated a clear understanding relating to the healthcare professional’s discourse of exclusive breastfeeding, which stated ‘giving breastmilk without water in the first six months’. Yet it was the others’ who possess interpretations in terms of care of the baby, and therefore could not challenge her mother’s decision to
introduce water to the baby on the fourth day after birth. She stated that ‘I couldn’t have stopped her [my mother] ... she knows better than I do... I’m not in the position to challenge her ... They [the others] provide support and helped me to breastfeed, so I believe in their advice too’ (Anna). Similarly, Katie added that, ‘it’s about making sure they’re happy with you, you don’t want them to be upset with you ... and they think you’re disrespectful’ (Katie). In maintaining appropriate boundaries, some of the participants were unable to challenge the behaviour of others although all the women were aware of the benefits of exclusive breastfeeding. It can be inferred from the above stories that the Ghanaian first-time mothers sought to maintain the appropriate boundaries and therefore submitted to others’ influence. Accordingly, Wharton (2009), in her discussion of ‘the sociology of emotional labour’, noted that a major source of emotional management is through the impact of institutional or social structure, which imposes constraints on individuals’ efforts to ‘actively [express] their feelings through the acknowledgement of prescriptive rules or social norms’ (p. 148).

From the analysis, it is interesting to note that whilst the existing traditional and social norms enabled the women to recognise their role in society in terms of being responsible for the care of their infants and the house, the discretionary power belonged to the older women, such that decisions concerning breastfeeding and childcare needed to be approved and authorised by the older women in the family. In addition, the everyday possibilities of the women being independent were taken over by others. The findings in my study support those of previous studies in Ghana that have highlighted the influence of older female family members on young mothers’ breastfeeding experiences (Aborigo et al., 2012; Tawiah-Agyemang et al., 2008). These divergent interpretations surrounding breastfeeding activities in Ghana may increasingly undermine young mothers’ confidence in their experience of breastfeeding and childcare (Hochschild, 1983). The women are constrained in their decisions regarding breastfeeding and taking care of their baby.

From the analysis, it was clear that amidst the acknowledgement of social interactions, some women maintained an ‘authentic self’ by taking responsibility for the care of their infants (Heidegger, 1962; Inwood, 1997). Moreover, women who gave over their responsibility to others tended to dissociate themselves from the
outcome of their infant’s care, especially blaming others for any negative consequences. However, in giving over responsibility to others, it may be argued that a woman has not yet come to her authentic (true) self (Heidegger, 1962), and therefore may still lack confidence and commitment to achieve goals regarding exclusive breastfeeding. These later groups of women acted through an illusion of compliance. The next section considers emotion work and how women ensured conformity to social norms in their experience of breastfeeding.

10.4.3 ‘Illusion of Compliance’
From the findings of my study, it is clear that the women maintained a public pretence in order to conform to the appropriate breastfeeding behaviour and social norms. This was in contrast to how the women sometimes felt about their experience, putting on a ‘brave face’ to show how well they might be coping. Most women ensured compliance by projecting an outward appearance that suggested they were in control and coping well in their new role, even though they may not have felt this in reality.

Wharton (2009) used Hochschild’s term ‘feeling rules’ to describe the kind of emotional feelings expected by an individual. Feeling rules aligned to certain social norms are designed to create an appearance of compliance. For instance, feeling rules, also known as social norms, ‘tells about how a person should feel, when to feel, where to feel, how long to feel, and how strong our emotions can be (Hochschild 1979, pp. 551–575). In the case of the women in this study, projecting a public pretence was associated with the attempt to attain the public image of being a good mother and having an ideal baby. An idealised image of the good mother was reported by the women as someone who breastfeeds comfortably, whilst it was unacceptable to overtly express breastfeeding pains.

The management of one’s emotion was intended to achieve a specific goal. Hochschild (1979) used the term ‘deep acting’ to express the alignment of one’s actions to conform to their inner feelings. In deep acting it is suggested that an individual either suppresses or evokes emotional feelings (Stets & Turner, 2006). Emotion work can be seen in an attempt to evoke certain feelings within a given situation, or rather an attempt to suppress the experience of undesired effects.
(Stets & Turner, 2006). For instance, some of the women reported that breastfeeding in the presence of friends and family members required that they either evoke or suppress their inner feelings by showing ‘calmness’ and a ‘cheerful facial expression’. This might not necessarily have been what they actually felt, but as an attempt to influence the other’s perception that they were coping well and therefore qualified as a good mother. For example, Sally, one of the participants, related her experience of how she sought to conform to the image of a good mother in the presence of her mother-in-law, which required her to suppress her experience of pain. The effort to modify her inner feelings to show a positive outward expression required emotion work.

Revealing how an individual manages emotional feelings, Hochschild (1983) identified three strategies of emotion work that are commonly expressed in an effort to either evoke or suppress emotions: cognitive, bodily and expressive. The cognitive method of emotion work refers to ‘the attempt to change images, ideas, or thoughts in the service of changing the feelings associated with them’. Bodily work ‘entails efforts to alter the physical effects of an emotion’, for instance refraining from crying in a painful situation. The expressive technique of emotion work ‘involves attempts to alter the public display of an emotional state in order to realise a specific feeling’ (Hochschild 1979, p. 562; Appelrouth & Edles 2003, p.96). In my study, the ‘bodily’ and ‘expressive’ aspects of emotion work apply to the ways the women aligned their emotions appropriately to conform to social norms and others’ expectations.

The women described their attempts to portray an appearance of calmness, effortlessness, enjoyableness and control, hiding the difficulties and struggles they may have been experiencing with breastfeeding. This pressure to conform led to them maintaining expressive feelings regarding breastfeeding, particularly with other mothers. In one example, Linda used the technique of expressive emotion work to portray herself as a mother capable of breastfeeding her baby by remaining calm and putting on a cheerful facial expression: ‘when they ask I’m always quick to say everything’s fine. I daren’t say she’s [my daughter] not getting breastmilk, otherwise they would say, ‘It’s because you don’t want to breastfeed’ (Linda). Similarly, Lucy told others that she was comfortable and confident breastfeeding. In
a study by Hunter (2005) participants referred to an ‘illusion of compliance’ as a way of ‘playing the game’, demonstrating their awareness of creating an illusion to conform to expectations. Consistently, like Linda, most of the women described an awareness of designing strategies to cope with situations in their social environment. Several of the women who struggled with breastfeeding did so in silence. Hochschild referred to this experience as ‘self-deception’ (i.e., when an individual is not expressing the real emotional state being experienced). The emotion work was necessary for most participants in such situations of conforming to social norms. However, Anna, along with a few other women, recounted how it was not always possible to impress others, but rather challenged the ‘good mother’ and ‘ideal baby’ rhetoric. For instance, Anna challenged her mother’s prescription of the ideal baby when it was perceived that her daughter had not gained the expected weight. This resulted in her mother’s withdrawal of support. This situation was related to conflicting ideologies of traditional practices and healthcare professional discourses of exclusive breastfeeding. These women found sharing experiences with their peers and receiving support from their own husbands as a good source of enabling support, thereby affirming their experience of breastfeeding in what is described in the next section as ‘discursive resistance’.

10.4.4 ‘Facilitative Support’
The findings in this study suggest that support was a continuous process, starting from the establishment of breastfeeding and continuing throughout the journey of the mother and her baby. The women only recognised the enabling role of others during the early postnatal period. It was apparent from the analysis that the women valued support that created an encouraging environment for both the mother and her baby. This approach can be described as effective and building the woman’s confidence and trust. The provision of support in this study fit in with other studies in being identified as facilitative, effective, positive and helpful (Dykes, 2005; Schmied et al., 2011; Sheehan et al., 2009).

The women reported the affirmative influences of paternal support and shared experiences from peers. The support obtained from the baby’s father is an aspect identified in my study as enabling breastfeeding by the women. A few of the women distinctly commended the care extended by their partners/husbands as
providing emotional, psychological, as well as a practical support. For instance, Lucy reflected on her husband’s support during the third interview. She was positive about the support given by her husband regarding her decision to practise exclusive breastfeeding, which encouraged her to persevere. Lucy also intimated that she could relate to her husband in a way that made them a ‘team’ that worked together to promote the wellbeing of their baby, and above all were able to share in her discomforts. Consistently, Datta and Wellings (2012), in a study conducted in the south-east of England, interviewed both mothers and fathers and revealed the father’s role in breastfeeding as: ‘support in making decision; practical support, including emotional encouragement’ (Datta & Wellings, 2012, p.7). In their conclusion, they acknowledged the positive impact of this aspect of breastfeeding support in increasing the initiation and duration of breastfeeding (Datta & Wellings, 2012). Based on my findings, it can be argued that encouraging the father’s support may lead to a sense of shared responsibility for the women; for instance, during the periods in which the women had to engage the babies whilst still performing household activities. The women were also able to meet their emotional needs through sharing their difficulties, which may have enabled them to maintain viable maternal confidence.

In Ghana, the concept of the father’s role in breastfeeding support is an emerging one brought to light through the in-depth experiences of the women in this study. It is therefore suggested that encouraging and involving fathers in decision making and breastfeeding education is important to promote positive breastfeeding behaviour. Fathers are reported to have a positive attitude and therefore lend encouragement to breastfeeding (Brown & Davies, 2014; Sheriff et al., 2013). This new perspective within the Ghanaian context means that fathers should be encouraged to take an active role in supporting breastfeeding.

Furthermore, it is apparent from the analysis that the women had a strong sense of collective identity with their peers (i.e., breastfeeding women) with reference to a shared perspective. It is evident that this sense of belongingness was important for the novice breastfeeding women in constructing and seeking viable advice as a way of managing breastfeeding difficulties.
In most studies, it is highlighted that women value support that is extended in a sensitive and effective way (Dykes, 2005; Hauck et al., 2002; Schmied et al., 2011). In a metasynthesis of qualitative studies, Schmied et al. (2011) described the facilitative aspect of support to involve the provision of ‘realistic information, encouragement of breastfeeding, offering practical help and being proactive’ (p.54). This review, however, focused on the influence of professional and peer support, whilst my study reveals the importance of support from family members.

A study by Grassley and Eschiti (2004) identified the importance summary of support from grandmothers to act as breastfeeding advocates, a deeper appreciation for breastfeeding and loving encouragement, acknowledging challenges, confronting myths and acquiring current breastfeeding knowledge (pp. 329–334).

In summary, the discussion in this paper focused on emotion work drawing upon Hochschild (1983), and explained how the breastfeeding women in this study managed their breastfeeding, as emerged from the findings. This provides a new way of understanding the breastfeeding experiences of first-time mothers. It also gives insight into the emotional management within the family and social context and the impact this has on the young breastfeeding women. In addition, it portrays a unique dimension for considering women’s subjective experiences of breastfeeding. This has particular implications for midwifery practices, where a holistic approach in the consideration of care to support breastfeeding women is needed. In my study, it was discovered that the challenges of the actual breastfeeding experience may evoke negative feelings, which might lead to attrition and discontinuation of breastfeeding. By placing significance on the breastfeeding women’s emotions, midwives may be able to convey the significance of emotion in their relationships with the women.

Heideggerian hermeneutic philosophy has assisted in providing a more insightful explication of the experiences of breastfeeding by making sense of the lifeworld of the Ghanaian women who participated in the study. By using Heidegger’s philosophy in the interpretation of data, a deeper experience and more meaningful knowledge about the emotional world of the women was revealed. Although the
study did not set out to investigate the emotional experiences of the breastfeeding women, in a hermeneutic phenomenological study interpretation are important to the process of understanding the phenomenon being investigated (Laverty, 2003). In comparison to the physical aspects of breastfeeding, the emotional experience of the women and the professional healthcare support required in Ghana has received little attention to date.

10.5 Reflection on the Research Journey
In keeping with Heidegger’s hermeneutic phenomenological research, I maintained a reflexive position throughout the research process that allowed me to bring in my pre-assumptions and personal experiences of the phenomenon in a transparent manner. This is important in order to manage my own conceptions at every stage of the research and writing of this thesis. My position as a professional nurse, having a theoretical knowledge of breastfeeding and the cultural awareness, shaped my understanding of the data. My pre-existing beliefs and knowledge were proactively managed during the series of interviews and data analysis in order to understand afresh the phenomenon being explored. I became less aware of my preconceptions as participants shared their stories about the realities of their breastfeeding experiences. I believe these views arose as a result of a lack of familiarity with the nature of breastfeeding and the complex situations that confront women as they breastfeed. Having engaged in the interactive interviews I became enlightened, with a better understanding of the essence of breastfeeding.

Moreover, part of my journey following collection of the data was based on my personal experience of being a first-time mother and a novice breast feeder. During this period I became increasingly aware of my own experience and the reality of breastfeeding through the stories provided by the women who had participated in this study. In particular, I was more grounded in the analysis and interpretation of data, where both horizons of understanding met (as did the participants’ experience and my personal experiences). This, in turn, moved the process of meaning making it deeper and clearer. This is consistent with the hermeneutic circle of interpretation, where my own assumptions and personal experience are acknowledged as legitimate influences in the interpretation of knowledge, based on the acknowledgement that there is more than one way to understand a
phenomenon and attain knowledge (Finlay 2003). This deepened my understanding, particularly enabling me to situate myself within the interpretation and meaning whilst becoming more entrenched in the extent of my own subjective experience of breastfeeding. It also enabled me to move the inductive process of the analysis and interpretation of data along, where I was not limited to considering only parts of the data, but looked within my own experience to arrive at a deeper and richer interpretation of the findings.

Finally, the consciousness of being self-reflective was acknowledged in the process to understand the nature of breastfeeding as a human experience in the many and varied ways in which it is lived within the Ghanaian community. Therefore, being aware of my own stance was seen as a way of ‘being’, a way of researching that made my explorations pragmatic and enlightening.

**10.6 Unique Contribution of the Study to Knowledge**

In this thesis, the phenomenon of breastfeeding was identified as multifactorial, yielding several important findings. Key findings in this study contributing to new knowledge are demonstrated below.

This is the first study to discuss the concept of ‘emotion work’ in relation to women’s lived experience of breastfeeding. Through the Heideggerian hermeneutic approach and inductive thematic analysis, first-time mothers’ orientation to the task of breastfeeding were illustrated through the use of emotion work to negotiate relationships and adopt measures to cope. The women used emotional management to impress others and their wider social network. As a result, the women adopted a cognitive strategy (illusion of compliance) to redefine and provide their own interpretations of breastfeeding. For instance, the cultural image of breastfeeding as natural was later reinterpreted to mean a learned behaviour or activity. Increasing awareness of emotional work in nursing and midwifery practice is needed to deal with emotionally challenging factors and meet the individual needs of women in a social context. An enhanced and supportive therapeutic environment for breastfeeding mothers at all levels is considered important.
This study has highlighted on the nature of support experienced by the Ghanaian women, where breastfeeding is generally considered the norm. The dynamics of breastfeeding support within social environment of a woman is highlighted under the others as ‘enabler’ and ‘disabler’ of breastfeeding. Within the context of support for the breastfeeding woman, the grandmothers and older female relatives were often identified as disablers. This reveals the aspect of control by others’ through their expertise and experiences. First-time mothers adopted what was identified as an ‘illusion of compliance’ in order to conform and avoid any form of sanctions. In addition, the study provided valuable insight into the involvement of fathers in supporting breastfeeding. Fathers were identified as enablers of breastfeeding, who shared in the responsibility by providing encouragement that enhanced the women’s commitment and led to successful exclusive breastfeeding. Being enablers was recognised by the facilitative style of support provided by the baby’s father.

The study also builds on understanding of the social impact on breastfeeding. Thus, the women made efforts to impress others and members of their social network. Despite their difficulties in breastfeeding, the women attempted to meet the expectations of others and attain the status of a ‘good mother’ with an ‘ideal baby’.

This study makes a significant contribution to the existing literature. It provides insight into how women can experience breastfeeding as emotion work. This pertains to the management of breastfeeding behaviour in situations where the well-being of close family members and others’ expectations are prioritised, and shifts the focus from the baby and the mother. It also subverts the confidence of mothers, rather than projecting encouragement to exclusively breastfeed. The study illustrates how women conduct themselves to influence moral sanctions over their infant-feeding behaviours. Fear of being judged or criticised by others seems to inhibit first-time mothers from being sincere about infant feeding practices. This seems to relate to the cultural practices communicated by close family members and the mothers’ social network.
10.7 Strengths and Limitations of the Study
This study presents interpretations of the lived experience of 30 first-time breastfeeding women in Ghana. A number of strengths and limitations are evident, as highlighted below.

10.7.1 Strengths
A very significant strength of this study is related to my understanding of the historical and cultural background as a researcher and Ghanaian. This reinforced the strength of the study through my ability to conduct interviews in the local language (Twi), in which all the participants were fluent, and that therefore promoted effective communication and flow of conversation to examine issues more deeply. My being Ghanaian also enabled the participants to easily identify with me and voluntarily share their experiences in-depth. In addition, it was important that the women recognised my appreciation and respect for the Ghanaian culture. These aspects strengthened the interpretation that allowed relevant themes to emerge. Adopting Heideggerian hermeneutic phenomenology enabled interpretations to be made, thereby increasing understanding of the phenomenon of breastfeeding within the Ghanaian context. This methodological approach offered a useful way, underpinning the collection, analysis and interpretations of the data.

Using longitudinal approach to the research design, not only enhanced richer and in-depth generation of data from the participants, it offered insight into the transitional process of the women’s subjective experience of breastfeeding. Additionally, engaging participants in a series of interviews (antenatal period, first week after birth and four to six months postnatal) allowed data to be generated as the participants lived through their experiences, meaning that recall was good. In addition, my prolonged engagement with the participants enhanced my relationship with them so that they were willing to tell me their story, which may not have happened if the data had been gathered at a single point in time.

Carrying out a narrative review of the literature provided a broader view of the breastfeeding experience of women from different socio-economic backgrounds. This was considered enlightening with respect to conducting data collection and allowed me to situate the Ghanaian experience within the global literature.
Finally, a potential strength pertaining to my journey as a researcher was related to my own opportunity to live the breastfeeding experience. Being a first-time mother, the reality of my own experience of giving birth, initiating and continuing breastfeeding offered an excellent way to deepen my understanding of the whole event of breastfeeding. My personal experience also contributed to the interpretations and meaning-making of the data.

10.7.2 Limitations

Some limitations to the study were identified and are clarified as follows.

Firstly, in terms of the demographics of the participants, the study only focused on women in urban cities, excluding those living in rural settings. This is regarded as a limitation, excluding the perceptions and experiences of breastfeeding women living in the rural setting. Secondly, all participants were recruited from the ANC. This was thought to provide an added advantage of their awareness of breastfeeding (e.g., the decision to breastfeed), compared to if they had been recruited from the wider community.

While some researchers might have considered recruiting both primigravida and multigravida women in order to obtain varied views, I decided to recruit only primigravida women (i.e., women with no previous experience of breastfeeding). This is also in keeping with phenomenological principles, in terms of choosing participants on the basis that they had experience of the topic under investigation and could accurately inform it by telling a story.

In keeping with phenomenology, my study presented findings on the breast-feeding phenomenon as experienced by only 30 women from one city. Because I did not set out to generalise, this means that I cannot assume that the results are transferable to other parts of Ghana. However, the findings identified in this study resonate with those of other studies carried out in other regions in Ghana.

Furthermore, in keeping with phenomenology, exploration of the phenomenon generated information from the women’s subjective narratives. In order to remain true to their experiences and allow the women to own the findings of the study, I
took what they said at face value, and did not make attempts to seek further validation. This is in keeping with the approach of the hermeneutic phenomenology.

Two women were lost to follow-up during the second antenatal period. However, in relation to the principles of phenomenology, an individual’s experiences form a unique contribution to understanding of the overall phenomenon. Information from the two women might have provided additional insights to the overall findings.

10.8 Summary
The chapter has synthesised the main headings of the discussion ‘untold story’ and ‘emotion work’ within the phenomenon, social conformity. The whole of the study demonstrated an existence within a given culture and social environment, which influenced attitudes, beliefs and knowledge of an event in life. The culturally mediated understanding of natural breastfeeding and motherhood influenced the first-time mothers’ approach to breastfeeding. Breastfeeding was observed as integral to the women’s experience of becoming a mother. However, when the expectation did not match the reality, the women began to comment on their difficulties and naivety in getting breastfeeding started, and the lack of information and midwifery support. The challenges associated with breastfeeding and the influence of social support led to the women using a strategy of cognitive emotion work to cope with breastfeeding. Additionally, the women adopted an illusion of compliance to conform to others’ supervision and expertise in order to maintain harmony in their relationships. The study has provided insights into Ghanaian first-time mothers’ journeys of actual breastfeeding experiences, which might otherwise have remained uncovered. These findings reveal the uniqueness of the study and add to the knowledge base in this area.

In keeping with the phenomenological method that underpins this study, I have maintained a reflexive approach, which is integral to ensuring the transparency and quality of research. Finally, the discussion chapter acknowledged the potential strengths and limitations of this study in order to ensure validity. The following chapter offers a concluding account of the findings that emerged from this study into women’s experience of breastfeeding, including the implications and future research directions to further increase knowledge on breastfeeding.
Chapter Eleven

Conclusion and Recommendations
Chapter 11: Conclusion and Recommendations

11.1 Introduction
This thesis aimed to provide in-depth understanding of the lived experience from the perspective of 30 first-time breastfeeding women in Ghana. This chapter concludes the study by highlighting areas of priority for practice, policy and research relevant to promoting successful breastfeeding in Ghana.

11.2 Conclusion of Study
Exploration of the lived experience of breastfeeding from the women’s perspectives identified themes and sub-themes that offered insight into the phenomenon of breastfeeding as essentially a human experience. This insight, however, moved the understanding of breastfeeding beyond the presuppositions and traditional ideology of breastfeeding being just an instinctive practice; rather, it revealed the complexity of the real experience as influenced by social and cultural factors. The evidence from this study may lead to thoughtful actions regarding what might previously have been taken for granted regarding breastfeeding in Ghana.

Evidence from the study reveals that the experience of breastfeeding is multifaceted. This portrays the reality of breastfeeding by those living the experience, who identified the event as a learned activity for both mother and baby, contrary to the prior conception of it being natural and easy. Importantly, the family and social context within which breastfeeding occurred had a direct influence on the women’s perceptions and the interpretations they brought to their experience of breastfeeding. However, these ideologies by the women resulted from a lack of preparation and unrealistic expectations during the antenatal period.

From the findings of my study and those of other studies (e.g., Lööf-Johanson et al., 2013; Schmied & Lupton, 2001), it is evident that breastfeeding has unique value, and is central to a woman’s experience of motherhood. It is considered a vital aspect of baby care, and to promote the health and proper development of the baby.
Furthermore, the fundamental structures of the breastfeeding experience described by the women reveal the challenge of getting breastfeeding off to a good start following delivery. The women expressed their frustration at the practical struggle to establish breastfeeding. This highlighted the lack of support from midwives and other healthcare professionals during the early postnatal period. Based on these findings, the following recommendations are suggested for practice, policy and future research.

11.3 Recommendations for Practice
Antenatal education and preparation of first-time expectant women:
- A more proactive approach to antenatal care that offers reliable information and practical demonstrations of breastfeeding based on the current scientific evidence is needed. Midwives should take the central role in guiding women to make informed decisions on breastfeeding, including anticipating challenges that could be encountered during breastfeeding and devising the best support system before birth.
- Effective in-hospital support for women after birth by midwives is recommended. It is imperative that trained midwives and governmental organisations that advocates for breastfeeding, tailor breastfeeding education within the broader context of maternal subjectivity.
- Breastfeeding and support for women occurs within the social context. It is therefore recommended that midwives encourage a family-centred antenatal approach in which they work in partnership with pregnant women and their close relative(s) through the provision of scientific and evidence-based information on support systems for breastfeeding mothers.
- Fathers should be specially engaged in breastfeeding education as a means to enhance an enabling environment that allows women to cope well with breastfeeding and care of the new-born baby.

11.4 Recommendations for Policy Makers
The observations made in this study call for modifications to interventional policies at the community level and the level of healthcare services in Ghana. The suggested recommendations include:
• Regular update training for all midwives on new and evidence-based practices regarding breastfeeding to build their capacity for the culturally sensitive needs of the woman and her family.

• Implement ‘breastfeeding classes’ as an intervention to enhance effective provision of support during the antenatal period. For effective preparation prior to birth, education on breastfeeding and practical support systems should be separated from routine antenatal activity. This will give healthcare providers dedicated time to provide practical support, and a more friendly atmosphere for women and their relatives to learn simple and practical techniques such as positioning and latching the baby to the breast.

• Training and promoting peer support is recommended to encourage a positive sense of belonging among first-time breastfeeding women in Ghana.

• National policy should encourage more school leavers to enrol in midwifery training so as to provide more hands to reduce the workload in antenatal and maternity wards. Some of these midwives can be trained as special breastfeeding counsellors and advocates.

• Policies are needed that encourage more females to pursue formal education that serves to empower them to overcome traditional beliefs that expose their infants to harmful breastfeeding practices.

11.5 Recommendations for Future Research

Based on the results and discussion, a further research is needed in the following areas:

• Exploration of the perception of fathers’ involvement in the support of breastfeeding. This would aim to assess fathers’ views relating to their role in supporting breastfeeding, which may assist in formulating policies to enhance the provision of effective support by fathers in Ghana.

• In-depth exploration that assesses the effectiveness and impact of midwife–mother interactions during maternity care services (i.e., both antenatal and postnatal). This will help to improve strategies that enable midwives to provide tailored care, and also create an enabling environment that allows women and their babies to establish breastfeeding.

• Examination of the views of aged women and their support is a major area for consideration. The outcome of these studies will help in formulating
strategies that aim to enhance their knowledge and improve care for breastfeeding women.

11.6 In closing
The study was underpinned by the hermeneutic phenomenological method, and focused on exploring the lived experiences of first-time breastfeeding women in Ghana. Results from the participants’ data show that the experience of breastfeeding is multifaceted. With it many features, the Ghanaian women in this study experience breastfeeding, within the social environment in which they live. Support and learning to breastfeed are therefore negotiated by the newly mother, who also strive to conform to social norms and others’ prescriptive ways of breastfeeding behaviour.

The concept of emotion work within the context of the breastfeeding experiences, suggests a new dimension of looking at breastfeeding holistically. This suggests a critical consideration of the emotional aspect of breastfeeding among other factors, in promoting, protecting and supporting breastfeeding in Ghana. The findings in this regard are insightful, and have the potential to enhance and expand in-depth understanding of the meaning of breastfeeding to first-time breastfeeding women living in Ghana, while at the same time providing insights into how healthcare professionals might effectively support these mothers to achieve successful breastfeeding.
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Appendices
Appendix 1: ‘Appraising the quality of qualitative Studies’

<table>
<thead>
<tr>
<th>Stages</th>
<th>Essential</th>
<th>Specific prompts</th>
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</thead>
<tbody>
<tr>
<td><strong>Scope &amp; purpose</strong></td>
<td>Clear statement of, and rationale for, research question/aims/purposes</td>
<td>• Clarity of focus demonstrated</td>
</tr>
<tr>
<td></td>
<td>Study thoroughly contextualised by existing literature</td>
<td>• Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing</td>
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<td></td>
<td></td>
<td>• Link between research and existing knowledge demonstrated</td>
</tr>
<tr>
<td><strong>Design</strong></td>
<td>Method/design apparent, and consistent with research intent</td>
<td>• Evidence of systematic approach to literature review, location of literature to contextualise the findings, or both</td>
</tr>
<tr>
<td></td>
<td>Data collection strategy apparent and appropriate</td>
<td>• Rationale given for use of qualitative design</td>
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<td>• Discussion of epistemological/ontological grounding</td>
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<td>• Rationale explored for specific qualitative method (e.g. ethnography, grounded theory, phenomenology)</td>
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<td></td>
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<td>• Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims</td>
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<tr>
<td></td>
<td></td>
<td>• Setting appropriate</td>
</tr>
<tr>
<td><strong>Sampling strategy</strong></td>
<td>Sample and sampling method appropriate</td>
<td>• Were data collection methods appropriate for type of data required and for specific qualitative method?</td>
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<tr>
<td></td>
<td></td>
<td>• Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail?</td>
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<td></td>
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<td>• Was triangulation of data sources used if appropriate?</td>
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<tr>
<td><strong>Analysis</strong></td>
<td>Analytic approach appropriate</td>
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<td></td>
<td>• Thickness of description likely to be achieved from sampling</td>
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<td></td>
<td>• Any disparity between planned and actual sample explained</td>
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<td></td>
<td>• Approach made explicit (e.g. Thematic distillation, constant comparative method, grounded theory)</td>
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<td></td>
<td>• Was it appropriate for the qualitative method chosen?</td>
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<td></td>
<td>• Was data managed by software package or by hand and why?</td>
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<td></td>
<td>• Discussion of how coding systems/conceptual frameworks evolved</td>
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<td></td>
<td>• How was context of data retained during analysis</td>
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<td></td>
<td>• Evidence that the subjective meanings of participants were portrayed</td>
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<td></td>
<td>• Evidence of more than one researcher involved in stages if appropriate to epistemological/theoretical stance</td>
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<td></td>
<td>• Did research participants have any involvement in analysis (e.g. member checking)</td>
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<td></td>
<td>• Evidence provided that data reached saturation or discussion/rationale if it did not</td>
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<tr>
<td></td>
<td>• Evidence that deviant data was sought, or discussion/rationale if it was not</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Interpretation</strong></th>
<th>Context described and taken account of in interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Description of social/physical and interpersonal contexts of data collection</td>
</tr>
<tr>
<td></td>
<td>• Evidence that researcher spent time ‘dwelling with the data’, interrogating it for competing/alternative explanations of phenomena</td>
</tr>
<tr>
<td>Clear audit trial given</td>
<td>Sufficient discussion of research processes such that others can follow ‘decision trail’</td>
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<td>------------------------</td>
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<tr>
<td>Data used to support interpretation</td>
<td>Extensive use of field notes entries/verbatim interview quotes in discussion of findings</td>
</tr>
<tr>
<td>Clear exposition of how interpretation led to conclusions</td>
<td></td>
</tr>
</tbody>
</table>

**Reflexivity**

<table>
<thead>
<tr>
<th>Refractor reflexivity demonstrated</th>
<th>Discussion of relationship between researcher and participants during fieldwork</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Demonstration of researcher’s influence on stages of research process</td>
</tr>
<tr>
<td></td>
<td>Evidence of self-awareness/insight</td>
</tr>
<tr>
<td></td>
<td>Documentation of effects of the research on researcher</td>
</tr>
<tr>
<td></td>
<td>Evidence of how problems/complications met were dealt with</td>
</tr>
</tbody>
</table>

**Ethical dimensions**

<table>
<thead>
<tr>
<th>Demonstration of sensitivity to ethical concerns</th>
<th>Ethical committee approval granted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants</td>
</tr>
<tr>
<td></td>
<td>Evidence of fair dealing with all research participants</td>
</tr>
<tr>
<td></td>
<td>Recording of dilemmas met and how resolved in relation to ethical issues</td>
</tr>
<tr>
<td></td>
<td>Documentation of how autonomy, consent, confidentiality, anonymity were managed</td>
</tr>
</tbody>
</table>

**Relevance and transferability**

<table>
<thead>
<tr>
<th>Relevance and transferability evident</th>
<th>Sufficient evidence for typicality specificity to be assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies</td>
</tr>
</tbody>
</table>
- Discussion of how explanatory propositions/emergent theory may fit other contexts
- Limitations/weaknesses of study clearly outlined
- Clearly resonates with other knowledge and experience
- Results/conclusions obviously supported by evidence
  Interpretation plausible and ‘makes sense’
- Provides new insights and increases understanding
- Significance for current policy and practice outlined
- Assessment of value/empowerment for participants
- Outlines further directions for investigation
- Comment on whether aims/purposes of research were achieved

(Walsh & Downe, 2006, pp.108-119)
### Appendix 2

#### Table 2.1: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; Purpose</th>
<th>Design &amp; method(s)</th>
<th>Sampling Strategy/ Participants</th>
<th>Findings</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aborigo et al. (2012), Ghana</td>
<td>• To explore infant feeding practices in a resource-poor setting</td>
<td>• Exploratory design Data collection strategies used: • Interviews • focus group discussion</td>
<td>• Not clear about the sampling strategy used • Sample size 250 participants.</td>
<td>The findings suggested: • Breastfeeding knowledge • Influence of traditional practices associated with breastfeeding and infant nutrition</td>
<td>• Brief review of literature • Sampling Strategy clear • Good description of sampling • Multiple qualitative data collection tools used and multiple sources of data • Collaborative analysis between three researchers, this means decision trail is clear • However no mention of researchers reflexivity • Quality rating B</td>
</tr>
</tbody>
</table>
### Table 2.2: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; Purpose</th>
<th>Design &amp; method(s)</th>
<th>Sampling Strategy/Participants</th>
<th>Findings</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agunbiade &amp; Ogunleye, (2012) Nigeria</td>
<td>• To investigates Bf* practices and experiences of nursing mothers and The roles of grandmothers, and Work-related constraints affecting nurses in providing quality support for breastfeeding</td>
<td>• Mixed method Qualitative Strategies: • In-depth interviews • Focused Group Discussion</td>
<td>• Purposive Sampling • Sample size • 11 breastfeeding women • 10 nurses and • 10 grandmothers</td>
<td>Study identified: • Breastfeeding practices • Breastfeeding experiences • Constraints and breastfeeding challenges</td>
<td>Quality rating B</td>
</tr>
</tbody>
</table>
### Table 2.3: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; Purpose</th>
<th>Design &amp; method(s)</th>
<th>Sampling Strategy/Participants</th>
<th>Findings</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Andrew & Harvey (2011), UK  | To investigate, and differentiate between, the factors affecting mothers’ initial infant feeding decisions and the factors involved in their continued infant feeding choices in the first few months                                                                 | In-depth Interviews with 12 of primi- and multiparous women Age of infants 7-18 months                                                                                                                                 | Randomly selected participants through letter invitation                                                                                           | Aspect of breastfeeding focused on women’s infant feeding choices and considered: 1. Information, knowledge and decision making 2. Physical capability 3. Family and social influences 4. Lifestyle, independence and self-identity                                                                 | - Clear link of statement of purpose.  
- Constant comparison approach in the analysis of data constant  
- Attention paid to disconfirming data  
- participants verification of data to ensure truthfulness  
-Authors identify the limitation relating to the issue of generalisation due to the small sample size  
- Author mentioned the limitation of selecting only new mothers  
Overall quality is rated as A                                                                                                                                 |

222
Table 2.4: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope/Purpose</th>
<th>Design, methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
- Concurrent data collection and analysis using Grounded theory method. However no evidence of saturation, triangulation and disconfirmation of data  
- No researchers reflexivity demonstrated  
- Not sufficient data provided in the discussion of how explanatory propositions fit other contexts.  
Quality rating B |

223
Table 2.5: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; Purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bottorff (1990) Canada</td>
<td>To examine the underlying meaning of the reality of persisting with breastfeeding</td>
<td>Phenomenological approach Interviews</td>
<td>Not mentioned Three participants</td>
<td>Findings suggested: 1. Decision to Breastfeed 2. When it is not easy 3. Giving 4. Being committed - The ties of commitment - The talk of others - The talk of self 5. Choosing a time to stop</td>
<td>- Clarity of focus linked with relevant theoretical literature cited - No mention of sampling strategy, rationale and description of participants - Specific design appropriate and rationale given, but no description of rationale and processes of data collection - No explicit approach to the data analysis - Sufficient with use of verbatim interview quotes in discussion of findings Quality rating C</td>
</tr>
</tbody>
</table>
Table 2.6: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope/ Purpose</th>
<th>Design, methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
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</thead>
</table>
| Demirtas et al. (2012), Turkey | To describe Turkish women’s experiences of traditional breastfeeding practices | Descriptive, qualitative design. Used in-depth interviews | Purposive Sampling of 24 Turkish mothers of 4 to 24 month old babies | Results of study suggests: 1. Influence of the older family members 2. Influence of social learning 3. Influence of religion | - Clarity of research aims - Content analysis that revealed the traditional beliefs and it influence on women breastfeeding practice  
- Collaborative analysis of two researchers to demonstrate reliability of study.  
- Triangulation not mentioned or apparently not part of study.  
- Participants verification of data  
- No evidence of researchers reflexivity  
Overall quality rating = B |


<table>
<thead>
<tr>
<th>Study</th>
<th>Scope/ Purpose</th>
<th>Design, methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Dykes (2005); UK | To explore the nature of interactions between midwives and breast-feeding women within postnatal wards | Critical ethnography Participant observation and focused interviews. | No sampling strategy cited. 61 postnatal women and 39 midwives at the postnatal ward of selected hospital. | Global theme of findings: ‘taking time and touching base’, and four themes emerged: 1. Communicating temporal pressure 2. routines and procedures 3. Disconnected encounters 4. Managing breastfeeding and rationing information | - Explicit focus of study - Both directly relevant and theoretical literature cited  
- Author described analysis process as “cyclical” (involving a process of iterative, concurrent data collection and analysis)  
- Evidence of saturation achieved  
- Evidence of trustworthiness demonstrated by; concurrent data and analysis process, participant validation and peer review  
Quality rating A |
<table>
<thead>
<tr>
<th>Study</th>
<th>Scope/Purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Dykes & Williams (1999); UK | To provide insight into the lived experience of breast feeding, in primiparous women. | Phenomenological longitudinal study, used in-depth interviews to gather data at 6, 12 and 18 weeks after women childbirth | A convenience Sampling method of a total of 10 primiparous Caucasian women                  | Study focused on women perception of their breastfeeding. Authors identified four main themes: - The quest to quantify and visualise breastmilk; - Maternal dietary concerns: “My milk is what I eat” - Falling by the wayside - Giving out and the need for support nurturing and replenishment | - Data analysis emergent, iterative, using van Manen’s method.  
- Method identified to be appropriate to the research aim. Made explicit the ontological and epistemological, position of the study  
- Collaborative analysis between the authors  
- Mentioned peer supervision and debriefing exercise as part of decision trial  
Quality rating A |
Table 2.9: Summary Characteristics of Reviewed papers - Arranged in the Alphabetic Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope/Purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| George (2005) | To examine the experiences of first-time mothers following discharge from the hospital after vaginal delivery | Qualitative, Grounded theory Semi structured interviews and Field notes | Sampling strategy not mentioned 10 primiparous, aged 18 to 44 years | Identified the theory of “Lack of preparedness” that included the following themes: 1. A change in priorities, 2. Overwhelming responsibility, 3. Unclear role expectations, and 4. Knowledge deficit. | -Clear description of purpose that links fairly with literature  
- Use a process of constant comparison analysis  
- Participants validation and saturation reached.  
- Triangulation of data (by additional sampling)  
- Validation of theory by comparing to raw data and participants verification.  
- Ongoing data analysis  
Quality rating A |
Table 2.10: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope/Purpose</th>
<th>Design, methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hauck and Irurita (2003)</td>
<td>To analyse the maternal process of managing the later stages of established breastfeeding and ultimately weaning the child from the breast</td>
<td>Grounded theory. Individual and Group interviews; Field Notes and Postal questionnaire</td>
<td>Theoretical Sampling of n=33 Caucasian women; 17 first time mothers and 16 multiparous n=9 partners n=12 child health nurses</td>
<td>Findings suggests: 1. Expectations influenced by beliefs and knowledge 2. Consequences of incompatible expectations</td>
<td>- Explicit statement of purpose and showing a clear of samples and appropriate data collection method - Triangulation data from women’s partners and health professionals - Multiple data sources that strengthened the credibility of study - evidence of saturation of data by ongoing data analysis and discovery of categories - Researchers reflexivity not demonstrated Quality rating B</td>
</tr>
</tbody>
</table>
Table 2.11: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design, methods</th>
<th>Sampling Strategy/ Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Hoddinott et al. (2013), UK  | To investigate the infant feeding experiences of women and their significant others. | Qualitative serial interview study from pregnancy until 6 months after birth to establish what would make a difference | Purposive sampling of 36 women and a total of 37 significant others. | The overarching theme describe breastfeeding as a clash between overt or covert infant feeding idealism and the reality experienced | - Evidence of clarity demonstrated with clear links of literature cited  
- The authors demonstrate saturation of data reached and evidence of disconfirming data  
- Collaborative analysis between a research team of four  
- Participants verification used to show trustworthiness  
- Researchers reflexivity not mentioned  
- The authors demonstrated sufficient data within the larger theoretical knowledge  
Overall quality rated A |
Table 2.12: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/ methods</th>
<th>Sampling Strategy/ Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Kelleher (2006)     | To examine women’s experiences of pain and discomfort associated with breastfeeding| Qualitative design. Semi-structured in-depth interviews| No sampling strategy mentioned n = 52 women | Findings identified that: 1. Women surprised by the extent, intensity and duration of discomfort and pain 2. Pain and discomfort associated with breastfeeding ranged from mild and temporary to more severe and at times unbearable 3. The physical impact of breastfeeding impaired mother and baby relationship and made women hesitant to continue. | - Explicit focus of study aims, contextualized within relevant literature.  
- Data collection strategy apparent and appropriate  
- Analytic approach not stated, however scantily demonstration of coding mentioned.  
- Evidence of processes for achieving rigorous not described  
- No mention of participant or external verification of findings  
quality rated B |
<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design, methods</th>
<th>Sampling Strategy/ Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Kronborg et al. (2014); Denmark | To explore mothers early breastfeeding experiences    | Open-ended questionnaire          | A total of 108 primipara women | First time mothers experiences of breastfeeding identified three overlapping phases:  
• On shaky ground  
• Searching for a foothold  
• At ease with choice feeding | - Clarity of focus of study that explores first-time breastfeeding women experience of the first month following birth.  
- Analysis undertaken by research team  
- the social and physical aspects of study discussed  
- Authors demonstrated relevance of study by: (1) discussing how explanation fits in other context (2) acknowledging study limitation (i.e. a recall bias due to retrospective nature of study).  
- Thorough description of analysis process and context outlined.                                                                                                                                                     | Overall quality rated B                                                                                                                                                                                                                                                                 |
### Table 2.14: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/ methods</th>
<th>Sampling Strategy/ Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leff et al. (1994) USA</td>
<td>To explore and identify important components of maternal descriptions of successful breastfeeding</td>
<td>Phenomenology Interviews</td>
<td>A total of 26 Caucasian breastfeeding women.</td>
<td>Findings identified maternal perception of successful breastfeeding dependent on: • Infant health • Infant satisfaction • Maternal enjoyment • Desired maternal role attainment • Lifestyle compatibility</td>
<td>- A clear statement of purpose is identified and good links with the literature. - Appropriate method - However, not clear what the sampling strategy is - The authors state that they reached data saturation by concurrent data collection and analysis. Thick description likely to be achieved - Analysis undertaken collaboratively by all three authors - The final synthesis was also discussed with independent health professional outside the research team to demonstrate trustworthiness - The process is fully explained Overall quality is rated A</td>
</tr>
</tbody>
</table>
Table 2.15: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Leurer & Misskey (2015)      | To explore infant feeding practices during the first 6 months and the perspectives of mothers to inform breastfeeding support programs | A survey study using open-ended comment questions that captures narrative responses | A total of 191 women. Aged 26 to 35 years evenly distributed primi and multiparae               | Aspects of the breastfeeding experience indicate: 1. Positive experience 2. Mixed emotions 3. Negative experience                                                                                               | - A clear aim is identified  
- Findings are presented clearly with direct quotes to justify findings  
- The setting and characteristics of participants are adequately described to enable judgement of transferability; however there is a high disparity since participants are women socio-economic background, higher incomes and education.  
- Implications for policy and practice and further research provided  
Overall quality rating A                                                                                                          |
Table 2.16: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Lewallen & Street (2010) USA | To explore issues related to initiating and sustaining breastfeeding in African American women | Qualitative design Focus group interviews, guided by Leininger’s theory of culture care diversity and universality | 15 women who are breastfeeding at the time of interview, Age from 18 to 38 years | Findings include: 1. Perceived lack of information about the benefits and management of breastfeeding 2. Difficulties breastfeeding in public 3. Lack of support system for continued breastfeeding | - Clarity of statement of aims linked with relevant literature.  
- Appropriateness of method discussed and justified  
- No sampling strategy mentioned  
- Discussion of findings linked with the larger literature review.  
- Insufficient description of analysis process: no mention of the approach to the analysis  
- Overall the study addressed the aims, outlined the limitations of non-representation of sample  
Quality rating B |
Table 2.17: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design/methods</th>
<th>Sampling/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raisler (2000), USA</td>
<td>To explore the experiences of low-income nursing mothers within and beyond the healthcare system</td>
<td>Focus group discussion</td>
<td>Convenience sampling of 42 women (23 first time and 19 multiparas), participating in WIC program and assisted by peer breastfeeding counselor. Aged 16 -39</td>
<td>Study demonstrated two aspects of women breastfeeding experiences: 1. Health System Factors: • Prenatal Care • The Hospital Experience • Postpartum Encounter with the Health System • Influence of the WIC Program - Effect of the Breastfeeding Peer Counselor 2. Breastfeeding Beyond the Healthcare System: - The Physical Bond of Breastfeeding - Modesty and Physical Exposure. - Returning to Work or School</td>
<td>- Link between research and existing literature demonstrated, but very little literature cited - Sufficient data describing context of study in the results section: i.e. women experience of breastfeeding care both at the hospital and home. - used verbatim quote to support interpretations of results. - No demonstration of researchers reflexivity Quality Rating B</td>
</tr>
</tbody>
</table>
Table 2.18: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design, methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
- Followed van Manen thematic method of analysis  
- Demonstrate trustworthiness by the following means: piloting study; peer review; member checking; bracketing; and a longitudinal approach of data collection.  
- Evidence of detailed discussion of research process that can be replicated and show relevance study.  
- Researchers reflexivity mentioned  
- Identified researcher’s position as a lactation consultant to be a potential limitation  
Quality Rating A |
Table 2.19: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design, methods</th>
<th>Sampling / Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ryan et al, (2011); UK</td>
<td>Study explored the phenomenon of the interembodied experience of breastfeeding</td>
<td>Semi-structured, 'narrative constructing' interview. Used video-recording</td>
<td>Participants were 46 women either breastfeeding or had breastfed within the past 2 years at the time of interview. Participants were referred by health practitioners and support group.</td>
<td>Findings suggests three dimensions in the phenomenon of the interembodied experience of breastfeeding: 1. Calling 2. Permission 3. Fulfillment</td>
<td>- Extensive theoretical literature cited that clearly links with the research aims - Existential phenomenological analysis based on constant comparison between data and developing analysis. However not clear if saturation was reached. - Clear statement of participants verification - Analysis undertaken by research team Quality Rating A</td>
</tr>
</tbody>
</table>
Table 2.20: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/ methods</th>
<th>Sampling / Participants</th>
<th>Findings</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith et al.</td>
<td>To examine how adolescent mothers’ lives and experiences shape their breastfeeding practice over time</td>
<td>‘Prospective qualitative design’ Semi-structured interviews</td>
<td>No mention of sampling strategy. No explicit description of research participants. A total of 5 teenage mothers: 4 breastfeed for nine days and one exclusive for five months</td>
<td>Study identified the following findings: 1. Breastfeeding intentions and practice  - Mixed breastfeeding messages and support - Poor breastfeeding knowledge and skills - Uncontrollable and unpleasant physical experience with breastfeeding - Inadequate health care response 2. Hopes and expectations - Navigating multiple roles - Youth and dependency</td>
<td>- Explicit focus of study  - Independent transcriptionist used. - Collaborative coding and discussion of conceptualized framework by two of the authors, to show credibility of study. - Author identified the strengths, based on the prospective nature of study. - Triangulation not apparently part of the method. quality of study B</td>
</tr>
</tbody>
</table>
Table 2.21: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
</table>
| Spencer et al. (2014); UK | To understand the experiences of breastfeeding. | Interpretive phenomenological approach by Heidegger (1962), used in-depth interviews | No mention of specific sampling method used, but detailed discussion of recruitment process. A total of 22 primiparous and multiparous; identified by health visitors and all gave birth at the local hospital. Age range 16-37 years. | 1. Emotional rollercoaster of infant feeding  
- maternal guilt,  
- unpreparedness for breastfeeding, and  
- unrealistic expectations  
2. Professionals: expertise, communication and impact:  
- perceived power of ‘experts’,  
- breastfeeding communication and - support for breastfeeding | - Very little literature cited  
- Analysis base on interpretive phenomenological principles and rationale given.  
- Evidence of decision trail (i.e. use of audio recordings; verbatim transcription; recorded reflective field notes of each interview; interpretations cross-check with original transcripts and collaboration between research team of 3)  
Quality of study B |
Table 2.22: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/ methods</th>
<th>Sampling Strategy/ Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spencer et al. (2015); UK</td>
<td>• To explore the experience of breastfeeding women.</td>
<td>Qualitative design</td>
<td>• Not clear about the sampling method used, however detailed information of recruitment process made explicit rich</td>
<td>Key theme identified: “Illusion of compliance:”</td>
<td>• Clear link of literature review and theoretical framework</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Interpretive phenomenological method by Heidegger (1962),</td>
<td>• n=22 of both primiparous and multiparous. Age range 16-37 years.</td>
<td>• Compliance to healthcare professionals and society</td>
<td>• Method of data collection and analysis identified to be appropriate.</td>
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<tr>
<td></td>
<td></td>
<td>• in-depth interviews</td>
<td></td>
<td>• Passively acquiescing</td>
<td>• Evidence of rigor enhanced through discussion of all research team members.</td>
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<tr>
<td></td>
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<td>• Compliance to family and friends</td>
<td>• Credibility achieved through; audio-recorder, field notes, participant’s quotes, validation of findings by second and third authors and a decision trail for verification of findings.</td>
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<td></td>
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<td>• Active decision-making</td>
<td>Quality rating = A</td>
</tr>
</tbody>
</table>
Table 2.23: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Findings/Results</th>
<th>Quality Appraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schmied &amp; Barclay, 1999; Australia</td>
<td>To explore the experience of breastfeeding in a group of 25 Australian women</td>
<td>Semi structured interviews that began in late pregnancy and continued until 6 months</td>
<td>No mention of sampling strategy</td>
<td>1. Breastfeeding as Connected, Harmonious and Intimate Embodiment</td>
<td>- Clarity of study aims demonstrated and contextualised by existing literature</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>2. Breastfeeding as Disruptive, Distorted and Disconnected Experience</td>
<td>- Discourse analysis of data, rationale given and evidence of how coding evolved,</td>
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<td>large amounts of data provided</td>
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<td></td>
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<td>- Clear context of data described; that identified breastfeeding as central to</td>
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<td></td>
<td>the experience of motherhood</td>
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<td></td>
<td>- No mention of ways that ensured trustworthiness of study or accounting for</td>
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<td></td>
<td>disconfirming data</td>
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<td></td>
<td>quality rated B</td>
</tr>
</tbody>
</table>
Table 2.24: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/ methods</th>
<th>Sampling Strategy/ Participants</th>
<th>Critical Appraisal</th>
<th>Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tarrant et al, (2002); Hong Kong, China</td>
<td>To identify contextual factors that influenced first time mothers breastfeeding practices in the immediate postpartum period</td>
<td>Exploratory qualitative design - Unstructured in-depth interviews</td>
<td>No explicit statement of sampling method - 19 primiparous women with median age 29.84. Recruited at one month postpartum period from two public hospitals.</td>
<td>Relevant discussion of the contextual influence of breastfeeding within two aspects: sociocultural context and environmental support of breastfeeding - Inductive coding and thematic content analysis; used NVIVO to manage data. - Analysis undertaken by research team and two independent researchers who reviewed transcripts. - Data saturation and disconfirming data not evident</td>
<td>B</td>
</tr>
</tbody>
</table>
### Table 2.25: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/ methods</th>
<th>Sampling Strategy/ Participants</th>
<th>Critical Appraisal</th>
<th>Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tawiah-Agyemang et al., (2008) Ghana</td>
<td>1. To explore why women in Ghana initiate breastfeeding early or late; who gives advice about initiation; and what food/fluids are given to babies when initiation is late. 2. To understand how any future breastfeeding policies could be implemented, data were also collected on the current breastfeeding policy environment in Ghana. Very little literature cited.</td>
<td>‘Qualitative design’ Method (Semi-structured interviews and focus group discussion) appropriate to the intent of study.</td>
<td>Purposive selection of 52 recent mothers - Nurses &amp; Midwives (n=7) - policymakers (n=6) Women selected by Gatekeepers (community leaders) from villages in four districts</td>
<td>- Not sufficient description of the research processes including how analysis evolved. -Study was part of a large ongoing trial, however, no mention of ethical consideration -Analysis undertaken by two independent researchers - Entries of field notes and verbatim interviews used to support interpretation of data - No accounts on researchers reflexivity</td>
<td>B</td>
</tr>
<tr>
<td>Study</td>
<td>Scope &amp; purpose</td>
<td>Design/ methods</td>
<td>Sampling Strategy/ Participants</td>
<td>Critical Appraisal</td>
<td>Quality Rating</td>
</tr>
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</tr>
<tr>
<td>Twamley et al., (2010) UK</td>
<td>To explore the factors that impact on UK-born ethnic minority women’s experiences and decisions around feeding their infant.</td>
<td>Theoretical framework not explicit. In-depth semi-structured interviews</td>
<td>34 participants of ethnic minority (which are; Black Caribbean, Pakistani, Bangladeshi, Indian and Irish origin) recruited from hospitals in London and Birmingham. Participants were both primiparous and multiparous. No mention of sample strategy for similar study to be replicated.</td>
<td>- Approach of analysis based on grounded theory (Glaser and Strauss, 1967), using constant comparative method.</td>
<td>B</td>
</tr>
</tbody>
</table>
Table 2.27: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope &amp; purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Critical Appraisal</th>
<th>Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thomson et al. (2015) UK</td>
<td>To provide a unique perspective on infant feeding by describing how discourses of shame are evident within the experiences of breastfeeding and non-breastfeeding women. Extensive of theoretical literature demonstrated.</td>
<td>Qualitative design. Utilized Focus Group discussion and individual semi-structured interview methods</td>
<td>No mention of sample strategy. A total of 63 of fully or partially breastfeeding participants within a duration ranging from few days to &gt;12 months. Description of demographic characteristics was presented in a table.</td>
<td>Description of the social, cultural context of infant feeding and participants’ personal experiences was made explicit using framework analysis and Lazare’s (1987) theory of shame event that enhanced the conceptual meaning of the study. Researchers made explicit the limitation relating to the lack of transferability of findings in settings where breastfeeding is a norm, rather than perceived as a shame inducing event. Very little evidence of rigor demonstrated. No account on researchers’ reflexivity.</td>
<td>B</td>
</tr>
</tbody>
</table>
Table 2.28: Summary Characteristics of Reviewed papers - Arranged in the Alphabetical Order

<table>
<thead>
<tr>
<th>Study</th>
<th>Scope and purpose</th>
<th>Design/methods</th>
<th>Sampling Strategy/Participants</th>
<th>Critical Appraisal</th>
<th>Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Williamson et al. (2012); UK</td>
<td>To extend understanding of the potential impact on women of finding breastfeeding challenging by focusing on a group who experienced considerable difficulties in the early postpartum period. Extensive literature showing clear link with aims demonstrated</td>
<td>Interpretive phenomenological analysis (IPA). Audio diary for the first seven days followed by semi-structured interviews</td>
<td>Purposive sampling of 8 first-time women. Age range 25 and 36.</td>
<td>IPA method of analysis and rationale extensively explored. Triangulation between participants’ audio-diary account and semi-structured interviews. Reflexivity reported by research team members. Sufficient use of verbatim quotes in findings to support interpretation of data. The research process is fully explained to demonstrate relevance and transferability of study.</td>
<td>A</td>
</tr>
</tbody>
</table>
Appendix 3: Participants Information Sheet

Participant Information Sheet (Version 3 August 2012)

Exploring the Lived Experiences of First-time Mothers on Breastfeeding

You are being invited to take part in a research study. You will be expected to share with me your views and experience of breastfeeding. I am interested in talking to women who are currently 36 weeks pregnant or more who have not been pregnant or given birth before and are over 18 years of age.

Please feel free to discuss this information with others (e.g. your family, your midwife or your doctor) before deciding whether take part. I can offer assistance in further explaining and translating to the local language for you to provide the necessary information.

Thank you for taking the time to read this information

What is the purpose of the study?
The purpose of this study is to explore your views of breastfeeding in terms whether baby has sufficient milk and whether you consider your breast milk is adequate. In addition, I am interested in exploring your attitudes and beliefs about breast feeding and the role of your family will play in relation to your experiences of breastfeeding; your belief and ability to exclusively breastfeed. It is anticipated that information from the research will help to develop an in-depth knowledge and understanding of women experiences of breastfeeding.

Why have I been chosen?
You have been sent this information sheet because you are at least 36 weeks pregnant, a first-time mother, aged over 18 years and have an intention to breastfeed your baby.

Do I have to take part?
No, it is up to you to decide whether to take part. Even if you agree to take part, you are still free to withdraw at any time, without giving a reason. A decision to withdraw, or a decision not to take part, will not affect the standard of care you receive now or in the future.

What will happen to me if I take part?
If you agree to take part in the study, you will be asked to take part in 3 informal interviews to ask you some questions about your experiences of breastfeeding. The interviews will last approximately sixty (60) minutes each. The interviews will take place in your home for your convenience and will only be conducted after you have given your consent. The three interviews will take place as follows; the first interview will take place before you give birth, then one week after the birth of your baby and then again when your baby is between at 4 months to 6 months old.

What do I have to do to take part?
If you are interested in taking part in this study you should complete, both the contact sheet and consent form and return them to me at the address below. However, you should note
that not everyone who agrees will be interviewed. These criteria for taking part have been chosen so that we can access women who can provide in-depth information of breastfeeding experiences from a board sample of women.

**What are the possible disadvantages and risks of taking part?**
The main disadvantage is that it will take some of your time and possibly raise issues for you to consider that you may not have thought about before, you may find this helpful or cause for concern. However you are free to withdraw at any time without giving reasons.

If you share anything related to the care you have received related to breastfeeding I may need to disclose this to regulatory authorities if this is the case I will always inform you of my actions before discussing the matter with anyone else.

**What are the possible benefits of taking part?**
At the end of the study, you will have had an opportunity to share your thoughts and feelings about breastfeeding so that a better understanding about the experiences of breastfeeding practises for women in Ghana. In this way, it may be possible to inform health care professional’s practice and influence breastfeeding policy to help improve infant growth and development in Ghana.

**Will my taking part in this study be kept confidential?**
All information collected about you during the research will be kept strictly confidential. Any information about you will be stored in a locked cabinet or on an encrypted computer. In any published report you will not be identified by name. Healthcare professionals responsible for your care will not be informed you have taken part.

**Is this research for an educational project?**
Yes this study is being undertaken as part of a PhD study at the University of Manchester which is being supervised by

**What will happen to the results of the research study?**
Information will be used for my PhD thesis. It will also be used as an academic papers and conference presentations. I will be careful to ensure that it is not possible to identify you individually in any reports, papers or presentations. If you take part, an information leaflet on breastfeeding will be provided to you, which will help you on good practices of breastfeeding and to be able to help other women who want to breastfeed.

**Who is organising and funding the research?**
The study is funded by the Garden City University College in Ghana.

**Who has reviewed the study?**
This study has been reviewed by the University of Manchester Senate Research Ethics Committee, who granted the approval for the study by the Ghana Health Services and the University of Manchester.

**What do I do now?**
If you would like to take part, please complete the consent form and return to me. If you agree to take part in an interview, I will arrange with you a time, and date that is best for you.
Appendix 4: Consent Form

CONSENT FORM FOR INVOLVEMENT IN THE STUDY
(To be kept in a locked cupboard by the research team)

Breastfeeding experiences of first-time mothers

Please indicate by putting your initials next to the statements below and then sign at the bottom of the sheet where it says, ‘name of participant’.

PLEASE RESPOND TO ALL OF THESE QUESTIONS

| 1. I confirm that I have read and understand the information sheet dated October 2012 (version 2) for the above study and have had the opportunity to ask any questions I may have about the study. |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. |
| 3. I am aware that the interview will be tape recorded (no one else, apart from the researcher, will have access to the tapes), which will be stored in a secure location and destroyed by the researcher once the study has been written up. I agree to this. |
| 4. I agree to the use of my direct quotes in any reports or publications, if they are used in such a way that I will not be identified. |
| 5. I agree to take part in this study |

Name of Participant ____________________________________________________________

Signature/thumb print _________________________________________________________

Date______________________

Returning this consent sheet is not necessary if you decline to take part

Contact details for Researcher: Georgina Afoakwah
Telephone: 0244 442577
Email: georgina.afoakwah@postgrad.manchester.ac.uk
Appendix 5: Permission Letter to Study Area

Manhyia District Hospital
Ghana Health Services
P. O. Box 1908

Miss Georgina Afoakwah
The University of Manchester
Manchester, United Kingdom
School of Nursing, Midwifery and Social Work

RE: PERMISSION TO RECRUIT PRIMIGRAVIDA WOMEN FROM THE MATERNITY UNIT AT THE MANHYIA GOVERNMENT HOSPITAL FOR A RESEARCH STUDY

I refer to your letter on the above subject, and write to inform you that permission has been granted for you to undertake the research study.

It is our hope that your research study would encourage breastfeeding mothers to practice exclusive breastfeeding as recommended.

Thank you.

DR. DANIEL ASANTE MANTE
MEDICAL SUPERINTENDENT

September 4th, 2012
Appendix 6: UoM Ethical Approval

Miss Georgina Afokwah  
PhD Student  
School of Nursing, Midwifery and Social Work  
University of Manchester

Georgina.afokwah@postgradmanchester.ac.uk

ref: ethics/12208

11 October 2012

Dear Miss Afokwah

Research Ethics Committee 1
Afokwah, Smyth, Lavender: Exploring the loved experience of first-time breastfeeding women: a phenomenological study in Ghana. (ref 12208)

I write to confirm that the amendments to the participant information sheet, ethics application form and consent form satisfy the concerns of the Committee and that the above project therefore has ethical approval.

The general conditions remain as stated in my letter of 19th September 2012.

Finally, I would be grateful if you could complete and return the attached form at the end of the project or by October 2013, whichever is earlier. When completing this form, please reference your project as:

We hope the research goes well.

Yours sincerely,

Katy Boyle  
Secretary to University Research Ethics Committee

Combining the strengths of UMIST and  
The Victoria University of Manchester
Appendix 7: Interview Guide

Exploring the lived experiences of first-time mothers on breastfeeding:
A phenomenological study in Ghana

Introduction:
- Thank you for taking time to be interviewed
- Please be reminded that you can stop being interviewed or refused any
  question at any time.
- Please be reminded that interview will be tape-recorded.
- Clarify concerns on issues relating to the participants role in the research
  project
- Renegotiate consent.

Questions and prompts

Interviews 1: What are women’s perception and expectation of breastfeeding?
- Can you tell me what you know about breastfeeding?
- How did you decide to breastfeed?
- Can you tell me how you expect to breastfeed your baby about birth?
- Can you tell me the support you have to enable you breastfeed?

Interviews 2: What are women’s experiences of early breastfeeding?
- How was it like breastfeeding your baby immediately following birth?
- How was your experience breastfeeding at the hospital?
- Did you receive any support to breastfeed?
- Can you explain to me how you were supported to breastfeed?
- How was your experience like breastfeeding at home?
- What are your plans for continuing breastfeeding?

Interviews 3: What are women’s experiences of breastfeeding within the
first four and six months?
- Can you describe to me how on a typical day you experience breastfeeding
  your baby?
- Comparing your perception during pregnancy, how do you think this has
  changed?
- Overall, how will you describe your experience of breastfeeding?
Appendix 8: Demographic Information

Please write in the spaces provided

**Contact address:**
Home address: ____________________________
________________________________________

Telephone number ____________________________________________

Please tick (✓) the box where applicable

**Maternal age (years)**
- 18 – 25 [ ]
- 26 – 30 [ ]
- 31 – 35 [ ]
- ≥36 [ ]

**Marital status**
- Married [ ]
- Not married [ ]

**Ethnic group**
- Akan [ ]
- Northern [ ]
- Ewe [ ]
- Ga [ ]

**Educational background**
- Tertiary [ ]
- Secondary [ ]
- Primary [ ]

**Employment**
- Government [ ]
- Private [ ]
- House wife [ ]
Appendix 9: Example Interview Transcript of Amanda

PSEUDONYM & AGE: AMANDA/28 years
She was in her ninth month of pregnancy at the time of interview
Date and place of interview: participant’s home
Duration of overall interviews: 120 min.
I: Interview

Brief history: She’s from the southern part of Ghana, has tertiary education and works as a records officer in a hospital. Lives with husband in a rented apartment

You told me before, at the clinic that you intend to breastfeed. Can you tell me your reasons for choosing to breastfeed?
AMANDA: I know I’m expected to breastfeed. Even before I got pregnant I already thought of breastfeeding, because over the years people talk about breastfeeding being good for babies and healthy as well...so that what I know. It [breastfeeding] makes them intelligent. My husband also shows much interest in breastfeeding our baby, he believes is good compared to the artificial milk.

I can see your husband likes the idea of breastfeeding?
AMANDA: that’s true, he believes breastfeeding is best. Initially I had the perception that when you breastfeed you feel tied down by the baby, you can’t go anywhere

Where did you get that information?
AMANDA: from my friends who has experience it before. When we meet together they do talk about their babies and how they feel tired all the time breastfeeding. Sometimes it feels discouraging to even attempt to breastfeed

So you were considering bottle feeding before?
AMANDA: Well you hear whole stories about bottle feeding, which also scare you compared to breastfeeding. They talk about the preparation of food and the bottles, for instance taking time boiling the bottles all the time and making sure is always clean, otherwise your child might get infection. So my husband thinks is easy and simple to breastfeed for the first six months as they claim is healthy for the baby.

Who are they?
AMANDA: the midwives and sometimes the nurses at my workplace also said the same

Can you tell me a bit more about why you think breastfeeding is best?
AMANDA: The nurse on the radio explained that breast milk serve as immunization and protects the baby against diseases and it also makes the baby strong all the time. The breast milk is a natural food for the baby and comes directly from the mother to the baby.

Can you think of any breastfeeding advantage to the mother that you know?
AMANDA: well, personally I think that every good mother should try and breastfeed her child since is healthy, you also save money, because you don’t also need to buy the artificial milk which are costly. And I know the mother is responsible for the well-being of the baby, especially to see the baby grow so well

Beside you and your husband listening to the radio, can you tell me where else you get information about breastfeeding?
AMANDA: and at the ANC, the midwives occasionally talk about breastfeeding

Anymore about what you learn from the antenatal clinic or was it just talking as you said?
AMANDA: well I think the nurse on the radio rather explain more about how breastfeeding helps the baby, but it seems like she only talk about it you don’t see any practical demonstration, for instance how to put the baby on breast well. So is like you only understand that is good for the baby, maybe the midwives will teach us after the baby is born

So you think you need help to breastfeed?
AMANDA: yes, because is going to be my first time and since I live with only my husband I’ll need some support to breastfeed.

Have you discuss with your midwife for their assistance?
AMANDA: can I do that? Because I know once a while the midwives come and give a general talk on breastfeeding, that’s all I know. After our routine activities then you go home

Did your mother breastfeed you and do you think that might influence you as well?
AMAND: yes, I believe she did, I’ve not to ask... I don’t know, but I know he really support the decision of me breastfeeding our baby. He admits that breastmilk is best for the baby’s health rather than given formula milk

Have you ever observe other female members breastfeed before?
AMANDA: I haven’t seen someone breastfeed before, but I know is a normal thing for women to breastfeed after birth, maybe when I was a child, but where my husband and I live now is a residential area so you don’t get to see people breastfeed and I also don’t have friends who have given birth

So beside your husband do you discuss your intentions to breastfeed with anyone?
AMANDA: No

Do you engage in any breastfeeding classes or support group that helps you to breastfeed?
AMANDA: well, I don’t know anything like that

Okay, so can you tell me about your expectation to breastfeed?
AMANDA: I wish it will be simple for me and my baby, able to manage it till it wants to stop breastfeeding. My mother will come around to support me, but she’s working so she can just spend only one month with us, which means I’ll need to manage the rest with my husband
**When do you intend to breastfeeding after your baby is born?**

AMANDA: well, I guess as soon as it’s born... or... well I can’t be so certain about this, is like you don’t have any clue of what might happen. Oftentimes, I know is the midwives who will help you to do it (breastfeed). And of course, I want to breastfeed soon as my baby is born.

**What do you intend to do about that?**

AMANDA: I’ve heard from people that after birth you need to eat enough groundnuts, taken soups prepared with herbs and fluids. I hope when my mom comes she will prepare some for me in order to get more milk for the baby

**Do you have any intention to practise EBF? That is, when you breastfeed your baby without water or food?**

AMANDA: yes, yes, because my husband and I have agreed that I breastfeed for the first six months without given water or infant milk. And maybe depending on how well I’m able to cope with breastfeeding my baby, we might extend it a bit longer than the six months

**Is that what was recommended to you?**

AMANDA: [laughs] no, that’s our own

**After the six months how long would you breastfeed?**

AMANDA: Maybe 2 years, or...I’m want to continue breastfeeding until it turns 2years t

**Can you tell me how much information you’ve received to help you breastfeed?** Like how to attach your baby to breast and managing other breastfeeding challenges?

AMANDA: Like I told you before that the midwives usually will give a general talk on breastfeeding, sometimes they will demonstrate by showing us a poster of a woman breastfeeding her baby, that’s all I know

**So how confident do you to breastfeed after birth?**

AMANDA: Well, I’m yet to give a try. I may need somebody to help me do it, at least for the first time

**What support do you have to breastfeed?**

AMANDA: My husband will be helping me, since he’s so interested about breastfeeding our baby and I’ve told you my mother too will come and help during the first

**So how well are you prepared to breastfeed?**

AMANDA: I don’t know about that, no one has told me about preparation. I thought you just breastfeed?
Tell me how you’ve considered breastfeeding in the public? That’s outside your home and family?
AMANDA: laughs. That’s a big question to answer now. Well I’ll see what to do when the baby arrives; I know I’m a shy person

Second interview
Tell me how it was like giving birth for this first time?
AMANDA: it was very painful experience. By God’s grace I was able to deliver safely

Was it something you had expected?
AMANDA: I don’t think I had a choice to decide what, it’s my first time but I was lucky that everything happened so fast, I started having contractions a week before delivery and some interrupted pains, it became so consistent that later broke at home before going to the hospital, I mean my water broke in morning when I wake up at home before I was taken to the hospital. Immediately we arrived at the hospital I was send to the delivery room and after the midwife has examined me she then ask me to lie on the delivery table, and I believe doing the pushing and all that took about an hour and she came crying so loudly. To me everything happened so fast and the midwife who assisted in my delivery was very gentle, she was an elderly woman so I believe she was much experience with, so was gentle with me and at the end I just had a minimal tear. Later the midwife me was that she was surprise herself and told me I’ve done well, saying that normally it always takes some time for most women to deliver for the first time, so I guess I was very lucky.... Actually I realise that my experience wasn’t as painful as I thought and you know, how people tells you about it’s been very difficult and painful to go through a natural delivery, to me it’s all part of the process of becoming a mother and we are made for that

So when was the first time you latched the baby to breastfeed?
AMANDA: well, I didn’t breastfeed immediately she was brought in and that was after about 15minute when I was back to my bed, I felt tired at that moment and needed some rest. So at the time when the nurse brought her she placed her next to me in bed and just left, she didn’t tell me whether I could breastfeed or anything of that sort, and she was also quiet just staring and looking calm so probably I thought the nurse might have feed her, so I was just keep admiring her and stroking the cheek. Then later I felt she might be hungry but just didn’t know how to get started, how to make her latched properly to start breastfeeding, thinking somebody could help me latched her on at that time, because I was scared to get it wrong and my baby also looks small so I really needed somebody to help me feed her so that I don’t hurt her or something like that. I managed to sit on my bed and the midwife later came to check on me and the baby, how I was coping with breastfeeding. So she carried her, and then put her on my labs and wrap my hands and arms around the baby like that and ask me to start feeding, and you know, it was a bit struggle for me because she has this little mouth so small that only my nipples could enter, but then the midwife just watching me took hold of my breast and forced it into the mouth and you could see her mouth was full and she began to suck and was able to suckle for about ten minutes which I think was good. It was my first experience and hasn’t had such experience before and though it was painful I still enjoyed it, the first feeding. And she looked normal and strong which you wouldn’t believe that she was born just 30 minutes ago
So that was within the first 24 hours?
AMANDA: umm, I guess so because it was within the first day after delivery

Did you enjoy the first feed?
AMANDA: yes I did, though it was painful the first time, I was happy my baby could breastfeed. It was a good time for us together, and I really enjoyed the first breastfeeding without much problem

How did you find the support that was offered at the hospital, since you talked about needing some assistance in our first conversation?
AMANDA: it was okay, once my baby was able to feed well; the midwife was gentle with me. Later when she needed to feed I could still figure it out on my own and helping my baby to latch so well.

Did you get positioning and latching right?
AMANDA: I wasn’t still sure of doing it right, but I kept trying, I know after birth the next thing the baby only need is to breastfeed. And I was able to do it as she also knows how to suckle so well.

Did you observe any breast milk coming on the first day?
AMANDA: yes it came the same day, but it wasn’t coming plenty as it used to come now, maybe because it was the first time. It came very small and looks very yellowish and thick, you might even think is not good for the baby.

You it wasn’t good for the baby?
AMANDA: not really what I mean, I know it was good, I do remember that nurse we listened to on the radio talked about it, saying that the first breast milk that comes is called colostrum and it contains antibodies that builds the baby’s immune system against diseases, so I knew it was good for the baby.

So how frequent were you breastfeeding?
AMANDA: well the first latch on the breast, she breastfeed for about 10minutes then she slept for a short while. We were actually discharged the same day after spending couple of hours, about three hours at the hospital and I could only feed her twice before going home. I enjoyed breastfeeding at the hospital the first time.

How would you describe your experience now compared to the expectations you had when we first talked?
AMANDA: well, it all started before I got married, I never gave it a thought, whether I’ll breastfeed when I give birth or not, and all these while I thought it shouldn’t be difficult, but now I know it doesn’t come automatic either. I realise breastfeeding is more than just seeing others breastfeed, especially if it’s your first time, but I’m still learning and hope it gets better with time...

Did you encounter any challenges or difficulties breastfeeding at the hospital?
AMANDA: we were getting along very fine at the hospital and thinking it will continue like that at home, but things are different now since we came home, I
found my baby bit sleepy and could not breastfeed for long and I’m worried if she’s getting enough food, but apart from that we are doing fine.

**How did you feel going home after birth? Did you feel prepared going home to breastfeed on your own?**

AMANDA: I was okay going home; I was doing fine and my baby too was well, we didn’t have any problem at all. We got to the house in the evening. So I just breastfeed for quite long and she fell asleep and we all went to bed, I continue breastfeeding her throughout the night. It just happens that around midnight she develop some hiccups which was a bit disturbing, we sat throughout the night to make sure she’s okay. I breastfeed her continuously for some time, it took a while though but she was okay. I remember throughout the night we cuddled her, breastfeed and wasn’t sure what to do again, both my and husband and I couldn’t sleep the first night, we were scared she might have it again if she lies down and you know, as newly parents we were worried and frightened about the slightest thing that happen to the baby and we weren’t ready for any emergencies. Actually we thought it might reoccur but she’s doing fine at the moment, it hasn’t occurred again and we hope it doesn’t.

**Do you get any form of professional support after you’re discharged home?**

AMANDA: I don’t know anything like, mostly is your relatives who provide support for you at home.

**Did you use the same bed together at home?**

AMANDA: the first two days she slept in a baby’s cot, but my husband thought is rather disturbing waking up to pick her, breastfeed and then take her back, he suggest I sleep with her on the same bed.

**And what’s do that mean to you?**

AMANDA: now it makes it easier for me to breastfeed, and because I feel more comfortable sitting up to breastfeed, usually I’ll just sit up on the bed to breastfeed.

**Tell me how you managed, especially, the within the first six days?**

AMANDA: it’s not been easy at all; I still find it difficult to help her get latched on properly, she I can’t get most part of my breast into the mouth and she seems not to readily open the mouth to feed, I mean she breastfeed anyway but not aggressive feeder, you know, those children will just open their mouth and starts feeding, so it makes it a bit difficult for me. She only latched on my nipples and begins to suck and no matter how I positioned her, she still ends up feeding on my nipples. Sometimes my husband will come and support the head and we try to make she latched well, because my breast is now becoming sore and it feels painful when she latched. I’m breastfeeding on demand, and sometimes even more frequent. I know my baby and I are still learning.

**Did you properly position and attached her well?**

AMANDA: maybe that’s why I said I’m still learning, because I struggle anytime I have to latch her to feed and I think she’s not helping me to latch on well.

**How did that effect on you?**
AMANDA: it made me feel stressful and I hope it gets better with time, because I want her to get the breast milk, I know it’s healthy for her so we will keep on trying. My breast milk properly came through on day four and it’s been coming plenty, I always have my breast full of milk so I want her to suck for me. So madam what should I do?

**Did you report to your midwife or sought for advice?**
AMANDA: not yet, well I’ve seen this local clinic close to us, so I’m planning to go there on Tuesday to see if they can offer me help or advice

**Can you tell me more how you got support to breastfeed?**
AMANDA: I had my mother-in-law with me and she is very supportive but unfortunately she hadn’t had very much experience with breastfeeding either, she’d had trouble breastfeeding her baby so and she had forgotten what she had learnt, but couldn’t offer much practical help. So she’s supportive in terms of cooking for me and keeping the house, she has been bathing the baby and sitting with me when my husband goes to work. My husband too is doing well, when he returns from work home from work he’ll sit with and make sure we’re doing fine. Occasionally he will wake up and sit with me when I’m breastfeeding in the night

**How frequent feeding is?**
AMANDA: they said we should breastfeed on demand or every 2 hours, but my friends who have breastfeed before tells me they are doing it every one hour, but sometimes I might even need to feed her again after about 30 minutes, so is like that between 30 minutes to one hour interval, unless she’s sleeping

**Who are ’they’?**
AMANDA: I mean the midwives, they told us to breastfeed every time the baby wants to feed or we can also do it every two hours

**You mean every 30 minutes to one hour?**
AMANDA: yes she’s getting

**How do you know she’s satisfied during a feed?**
AMANDA: I realise when she’s full she spill over some of the milk and because she’s still small she don’t feed for long, she’ll feed for a short while and stops sucking, maybe for about 10 minutes and she falls asleep. Sometimes when I attempt to latched her again she begins to suck small to top up. My breast milk has been coming plenty now and it becomes heavy and painful, so usually I allow her to feed on one breast for about two or three times before I change over to feed on the other one and is being helping me as well, so that my breast doesn’t feel too heavy and painful all the time

**How does that make you feel?**
AMANDA: is natural and amazing to know that you can produce food for your baby and that your baby’s life depends on you, I don’t see anything wrong. I think is something special and everything about breastfeeding is so natural, it makes me feel okay... that’s nature and I can’t do anything about it. In fact I love to see my baby breastfeed every day, I love the bonding and I enjoy it when I’m feeding her.
You told me earlier in our first conversation that you intend to do exclusive breastfeeding for six months. How do you feel about it now?
AMANDA: I think is still early and honestly haven’t giving it so much thought at the moment. I will be resuming work in three months’ time so maybe I can get someone to help me, so that she bring my baby for feeding during lunch time. I remember one nurse friend told me she was expressing her milk when she resumed work and her grandmother was feeding the baby at home and she also gets to close around 12 o’clock to feed the baby, well, I hope I can be closing early as well

Are there any policies supporting breastfeeding at your work place?
AMANDA: you know, is a hospital environment so if you’re a nursing mother usually they allow you to close half day,

So you cannot send your baby to work?
AMANDA: no, well I know some do, but our department doesn’t allow that, and we usually have both males and females on duty so is difficult to even use our common room to be feeding the baby, I think it will be best if I can express some milk and also get somebody to assist me

Is it because you may feel embarrass?
AMANDA: no, I mean yes in the presence of my male colleagues, I will feel very uncomfortable

How your thoughts is on mothers who breastfeed in public?
AMANDA: well, they think is part of parenting and is good that you breastfeed your baby after childbirth, but you have to do it discreetly, for instance if I’m to breastfeed in public then I’ll cover my breast with a cloth or something to cover my breast because I wouldn’t want anybody to see my breast. If I’m breastfeeding at home I don’t have any problem, is only my husband and mother in-law so I don’t need to be covering up anything.

Tell me more about your decision of breastfeed exclusively?
AMANDA: is a personal commitment really to allow my baby breastfeed that long. My mother in-law and my aunties have starts asking me to give water and ‘koko.’ But I feel that I’m the one doing it, and my husband and I have already agreed on it, so they can’t influence me in anyway. So far my mother in-law hasn’t complain of anything

I was told that usually in the course of bathing, the babies are giving water. How true is that to you?
AMANDA: well I know they normally do that, but my husband has strictly warn her mother not to do anything without our consent and I’ll be sitting beside her whilst she bath the baby, as much as I know she hasn’t done anything like that. At times she when the baby is crying so much she will tell me to breastfeed before she completes the bath. I know that we haven’t given any food or water yet

How do you intend to achieve your plans for breastfeeding exclusive for six months?
AMANDA: they said I should eat plenty all the time, drinking a lot of soup, groundnuts with mashed kenkey and taking a lot of water every day. And I was also told to breastfeed her frequently so that the milk will keep producing all the time.

_Third Interview_

_So the last time what has being breastfeeding like to you?_

AMANDA: [mother engaging baby in play] is good that I breastfeed, I couldn’t have done anything good for my daughter, because is good for her and she’s so healthy, strong and very active. I think to me it has been a learning experience, I mean learning to breastfeed for the first time, so I strongly believe that I can do it well with subsequent children that I will have. Though I’ve not enjoyed every minute of it, but overall I like it and my baby too is happy, it makes me feel happy, we play together and proud that I didn’t allow anything to discourage me. I know there were times I really felt like stopping it all together and will say to myself “why not try bottles so that you can be yourself, maybe somebody can take care whilst you visit the market or when you go to work, or maybe I can spend time doing other things, but you look at your baby and she feel so relax with you and seems to enjoy every minute feeding, I’m sure she seems to tell me that “mummy please don’t stop”.... Honestly I’m ready to tell every mother that I know to breastfeed because it makes the child strong and healthy. She just turned six months and she looks so well.

_How did you handle that (sore and painful nipples)?_

AMANDA: it took me a month before it healed and feeding became normal and less painful. Before, I visited one local clinic during the third week and I was able to talk to one of the nurses, she was willing to assist me and showed me how I could help my daughter to latched well, also they ask me to try lying down to breastfeed but I didn’t find that one helpful, it was still early and I couldn’t latched her properly onto the breast. I visited the clinic on two occasions and I think it helped. They recommend some cream which I bought from them and was applying on my nipples twice every day and it was good.

_Did you need to stop for a while or you continued?_

AMANDA: no I didn’t stop feeding her. Though it was really challenging I decided I’m not given up, I just want to have the experience of breastfeeding for the first time so that it will help me decide whether I will choose to breastfeed subsequent babies or not... and my husband has been there encouraging me all the time. To be honest I find things a bit normal and feeling no more pains when I breastfeed after the sixth week, and then all of a sudden my baby also decided to change her feeding pattern, they said she had a growth spurt and you know, everything changed, she’s always wanting more and more milk and wanting feeds more frequently, she was feeding more often than the routine kind of feed I was initially getting used to. Sometimes I got stressed out and feel like crying, she wouldn’t settle, she wants either to be attached to the breast or you carry her and I just feel tired all the time, you know, she doesn’t settled easily, rather wanting feed this minutes and another and very aggressive kind of feeding when she’s hungry. I remember telling my husband that it seems she needs more feed than just the breast milk, maybe she’s not getting satisfied so we should supplement with formula milk, but he also didn’t seem to like the idea and just said I should keep
trying and maybe observe her for some time or we may later go and see a doctor. I also complain to a nurse friend how I feel about my daughter needing feed constantly and she replied that is “normal at this time the baby is growing fast and her demand for milk is changing so just keep feeding”. I don’t know whether is a personal experience with my daughter or every child is like that, because if it’s your first time you just get overwhelmed and you might want to give up

With your experience so far and especially the change in your baby’s feeding, how do you receive support and deal with the pressure from your family?

AMANDA: lots of suggestions, I remember my mother in-law was very worried why I’m not supplementing with any infant food, but my husband will always tell her that we’re not and that the baby will be fine, and I also have some few friends when I complain initially they told me to add either SMA or any formula feed because that’s what they all did when they couldn’t cope with their child feeding, and sometimes I will confused and tempted, but my husband was so persistent that we keep trying and when the nurse friend also told me that it’s normal that usually children tend to want feed that way, it made me to relax and know that is nothing strange happening to my baby

Okay?

AMANDA: my only source of support has always being my husband. I like it when he tells me that I’m doing well and it makes me feel proud that I’m doing something good and is one thing that motivates me and keep doing it, my mother in-law is still with us, she has been very supportive, but you know, she can’t always do everything, I need to do the washing and cooking as well.... I remember before I started work I was able to adopt to a routin kind of her feeding and I learned to adjust knowing that she’s now part of me and depends so much on me for her food, so I make sure she’s doing okay first whilst later I manage to get things done within the day or some other time. Most often if she’s not sleeping after feeding I tie her at my back and continue with what I’m doing, even that is still not easy that you can get everything done. And now I realise she drink for three reasons, either she’s hungry, or for comfort and mostly when she wants to sleep

This means breastfeeding has helped you to know how to care for your baby?

AMANDA: yes...because she’s always with you so you learn to know when she’s crying because she’s soiled herself or when she’s hungry and normally when she wants to sleeping in the night she will have a long feed till she falls asleep, and then she could sleep almost all night, at times she might just wake up once to feed.

Can you tell me more about what it feels to be a breastfeeding mother and combining your career?

AMANDA: it wasn’t easy when you have to leave her and go to work after you’ve spend three months together at home and she is so much attached to you and doing so well this time, having to start work meant so much to me because is like been separated from your baby for a while, but I was lucky that she got into a more routine kind of feeding so I knew when she will need a feed and I know she usually sleep for a bit longer after the morning feed and then the afternoon feed as well, so I was able to cope. I make sure she feed and is full, and I was taught how
to express as well, so I was doing that every morning and keep it in a fridge before I go to work. At work I use to close at 12 o'clock so sometimes I will even come home and she’s not even taken everything, and I have my aunties daughter with me so she’s helping me anytime I go to work and my mother in law is also there so they make sure she’s okay. There were times if she’s not getting settled I just ask for permission from my boss and go home. Over the weekend too I’m always home so I don’t think she miss her feed. Though I realise is a lot of sacrifice you know, and takes time breastfeeding

Okay
AMANDA: I’m don’t know, but usually that’s what is done for every nursing mother, they allow you to close at half day so that you can take care of the baby

How long was that?
AMANDA: usually the first six months or sometimes if you’re lucky you can continue till the baby is nine months old

You mentioned about expressing breast milk, can you tell me your experience about that?
AMANDA: I use my hand to express it every morning immediately I woke up from bed, then I’ll keep it in the fridge so that they just warm it before she takes, then before I breastfeed her directly from the breast

Right, and have you encounter any challenges so far?
AMANDA: no, we were able to get along well and I had the support of everybody both at home and at the workplace

What about your baby, how is she coping?
AMANDA: no, I don’t remember a time she fell sick or something like that, is just that she cries when she woke up to find that I’m not there to latched her directly unto the breast. The first day they told me she refused to take the bottle, she just took a little and stopped, she want the real thing, she realise that wasn’t what she wants; beside that she never had any problem

So you feel happy with your baby’s growth and development?
AMANDA: Oh yes, my husband and I are very happy, she’s growing very well every day and gaining additional weight anytime we visit the clinic, but I know she could have grown bigger than this if I supplemented with formula milk. Anyway, I’m okay the way she’s so strong and she sleeps a lot, laughs and we play after feeding, most times she will make noise as if she wants to tell you something

Tell me what impact breastfeeding has had on your personal life?
AMANDA: well, it’s good for me as well; just that it takes a lot of time and always has to be there, which is good anyway

Most women talked about gaining weight, affecting their social life, what is your thought on that?
AMANDA: it’s true, that when you’re breastfeeding it influence every aspect of your daily life. And thing is that you can’t also enjoy full sleep, everything is about the baby, even the way you choose to dress, and you have to always make sure he’s
satisfied first before other things come. Your body is controlled to produce milk for
the child and always on you feeding by your baby, and like I said is time
consuming, you spend most of your time together and you don’t own yourself
anymore and because she depends on me so much for food you have to make sure
you eat to keep the breast milk coming every time....

_**Ok?**_

AMANDA: well I’ve put on a bit of weight; I’m just waiting for her to start feeding
so that I can begin to control my diet, but now I’m not too bothered because once
my daughter is getting what she needs then I’m okay, if she’s well fed she’s
healthy and happy. As for my menses it hasn’t started coming yet

_Has there being any family beliefs that you think has influence
breastfeeding?_

AMANDA: no, there wasn’t being anything like that since I started breastfeeding, I
always has support from my family and even some of my friends

_Do you miss a feed when you’re out with your baby?_

AMANDA: I’ve been feeding her, but I make sure I cover my breast or do it very
discreetly so that my breast will not be exposed. I remember I’ve feed her twice in
a public transport, at that time we were going to church and even at church I sit
among the nursing mothers at the back of the building so I b
reastfeed anytime she
needs a feed

_How long do you intend continuing to breastfeed?_

AMANDA: I don’t want to force her; I want her to gradually get use to the feeding
then maybe will continue breastfeeding alongside for one and a half year

_So, in all can you tell me how your feelings have change or anything that
you didn’t know before you started to breastfeed?_

AMANDA: Oh, I can say that is very good for the baby, just that the beginning is
not easy and is also challenging and time consuming, but I learn to adjust and it
became normal with time. Initially I thought it’s just a normal thing to breastfeed I
didn’t really know the benefits it has for the child and personally you feel satisfied,
you feel the closeness of your baby and you enjoy that always. It also makes me
feel proud and be a good mother to my daughter, I hope to breastfeed every child
I’ll have in the future.

_Can you give any advice to women who are breastfeeding for the first
time?_

AMANDA: I will tell them to breastfeed, breastfeeding is good for the baby. It
makes them strong and even you the mother and your family will be happy with
your baby

_Okay, anymore about what you’ve learnt or might want to share with
others if given the opportunity?_

AMANDA: well, I’ve enjoyed breastfeeding and it has also change my life, because I
could see that I’ve learnt to be patient with others, like I’ll do for my baby. And it
goes with determination, you should be determined to do it and every mother
needs support to breastfeed, you will certainly get tired along the way and might
want to give up if you don’t get enough support especially the first two months. I’ve also learnt that if you breastfeed well your baby will also make you happy, because she wasn’t getting sick, she was always healthy and laughing, her dad enjoy playing with her and he’s proud as well, everybody sees your child and they admire her they want to carry her

**Good, so anything else you want to share with me?**

AMANDA: I want to know whether you could become pregnant whilst you are breastfeeding, because my husband and I have discussed that we’re not going to use any contraception, we wanted to have another baby and we don’t mind how close that might come, because I heard from the nurse on the radio that if you’re doing exclusive breastfeeding is contraceptive and you wouldn’t become pregnant, but I know some colleague at my work place who was pregnant for three months and nobody knew, she was healthy until she delivered. So I don’t know if you can get miscarriage when pregnant and you’re still breastfeeding

**Is a good thing that you want to talk about, but I believe you should talk to your midwife; she will be able to help you to know exactly what to expect.** Hope that helps

AMANDA: ok, maybe when we visit the clinic next time
### Appendix 10: Exemplar participant constructs, codes, and emerged themes

<table>
<thead>
<tr>
<th>First order construct (Participant) - Amanda</th>
<th>‘Second order construct’ – Interpretation</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know I’m expected to breastfeed. <strong>Even before I got pregnant I already</strong> thought of breastfeeding. Over the years you’re being told that breastfeeding is good for babies... it’s [breastfeeding] healthy for newborn babies...so that what you believe</td>
<td>Already Knowing to breastfeed</td>
<td>Breastfeeding assumption</td>
</tr>
<tr>
<td>‘Well, it’s something that <strong>I haven’t given it much thought, I think is something that would just happen after birth</strong>... You just need to attach the baby to the breast and would begin to suckle...</td>
<td>Taken for granted</td>
<td></td>
</tr>
<tr>
<td>‘<strong>It’s not told what it feels like, there is no information</strong>...you simply assume that you will breastfeed. At the clinic, midwives only tell you that breastfeeding is natural. You don’t know much by the time you’re ready to give birth, even though you want to breastfeed’</td>
<td>Lack of information</td>
<td></td>
</tr>
<tr>
<td>‘<strong>[Breastfeeding] it’s just something that no one else can share with you</strong>; even my mother can’t and my husband also. I think that alone makes you feel needed all the time...it’s interesting that he knows who he want to be with when he’s hungry. I really enjoy the fact that he’s responding and growing. Just that it’s [Breastfeeding] tiring sometimes. And you also feel bound, making your movements not as easy as I could wish. <strong>Very tiring</strong>, stayed awake all night whiles he feeds... during day time as well.</td>
<td>Assumed responsibility</td>
<td>Breastfeeding as Women’s Business</td>
</tr>
<tr>
<td>‘When you breastfeed you just assume I’m breastfeeding...nothing could go wrong. <strong>There’s no information to tell you what you’re to do...</strong></td>
<td>Breastfeeding within women’s domain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Baby’s dependent on their mother</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being solely responsible/ Feels needed all the time</td>
<td></td>
</tr>
</tbody>
</table>

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It makes the whole thing so hard... later my mom and husband visited before I could do it

<table>
<thead>
<tr>
<th>Breastfeeding is tiring, feeling bound</th>
<th>Unpleasant experience of breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoys baby’s response to feeding and visible growth</td>
<td>Lack of midwives support,</td>
</tr>
<tr>
<td>Feeling tied down/bound</td>
<td>Struggling to breastfeed baby</td>
</tr>
<tr>
<td>Lack of support (professional)/ family support</td>
<td>Frequent engorgement of breasts</td>
</tr>
<tr>
<td></td>
<td>Oversupply of milk</td>
</tr>
<tr>
<td></td>
<td>Difficult latching baby</td>
</tr>
<tr>
<td></td>
<td>I’m having sore nipples</td>
</tr>
</tbody>
</table>

‘We stayed at the hospital for the night after the CS and had no luck breastfeeding. I actually had an unpleasant experience during the night and no midwife to care for us. He [my son] screamed and I was really upset. Even though I’d never done it [breastfeed] before I knew things weren’t working out...it was always difficult getting him to latch without struggling’.

‘Once my milk started coming in, I had frequent engorgement of both breast, which later I was told I was overproducing...my milk was coming plenty. And it made it difficult for my baby to hold on to it with his little mouth. My mother massage with Shea-butter, which was unbearable. Other people also advised using herbs and all sorts of things. But finally my doctor prescribed antibiotics that worked for a while. But when is like two hours or so without feeding, both get engorged.... and painful’.

‘[Breastfeeding] it was amazing to comprehend that I could even produce milk that was going to feed my baby... because my body

The breastfeeding body
- Ready-to-hand
- Unready-to-hand
wasn’t ready for about the first seven days, but just putting her on the breast as they advise... it [breast milk] started coming when she latched on... and here she is, doing well, being active and you know you’ve done the right thing...

‘I get engorged anytime she’s (my daughter) not feeding’

‘You become reliant on other people to say it’s OK, to say how things should be done, there’s a lot of pressure on you. Pressure to want to give food, because my mom thinks she’s not getting enough’.

‘My husband is so good as a father and helped me all the way through’

<table>
<thead>
<tr>
<th>Engorged breast</th>
<th>Reliance on others</th>
<th>Disabler</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good support by husband</td>
<td></td>
<td>Enabler</td>
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</tbody>
</table>
Appendix 11: Copy of Publication

Women’s experiences of breastfeeding: A narrative review of qualitative studies

By Georgina Afoakwah, Dr Rebecca Smyth and Professor Dame Tina Lavender

Abstract

Breastfeeding remains the primary method of infant feeding. Despite the indisputable benefits of breastfeeding, studies have identified both positive and negative aspects of women’s experiences. This article aims to enhance our understanding of these breastfeeding experiences. Methods: Using a narrative review approach, 26 papers using different qualitative approaches were synthesized in order to consider the findings of real-life experiences of breastfeeding women. Selected qualitative studies described women’s experiences of breastfeeding across international regions. This was intended to provide a critical review of the existing evidence and contribute to improving the knowledge of breastfeeding practice. Results: The inclusive studies yielded five main themes. The essence of breastfeeding was described in relation to a symbol of motherhood, feeling connected between the mother and baby, the dilemma of mother’s expectations versus reality of breastfeeding, and mothers’ need for consistent reassurance and support, and lastly social-cultural construct of breastfeeding. Conclusion: The findings identify the wider importance of breastfeeding experience that goes beyond simply providing the baby with nutrition.

Breastfeeding is an integral aspect of infant survival. It is well acknowledged for its importance in childhood growth and development (Kramer and Kakuma 2012; World Health Organization (WHO) and UNICEF 2003). Breast milk is considered well balanced and adequate for the infant’s needs for nourishment (WHO and UNICEF, 2003). Various guidelines recommend the early initiation of breastfeeding and its exclusivity for the first six months, after which time the infant should continue to receive breast milk in addition to supplementary feeding for one year or more (Kramer and Kakuma, 2002; WHO and UNICEF, 2005; American Academy of Pediatrics, 2005). Despite the fact that the guidelines support practices of exclusive breastfeeding, variations still exist within the narrative expressions of women’s breastfeeding experiences across different socioeconomic and cultural environments (Dykes and Williams, 1999; Modigliani et al., 2000; George, 2005; McFadden, 2006; Tavistock-Margiotta et al., 2008; Deka-Sharma et al., 2011). In order to complement previous work on breastfeeding, a deeper understanding of cumulative interpretations of women’s breastfeeding experiences is needed. This will help to strengthen the foundation for advocacy and tailored care, especially in the area of exclusive breastfeeding. As a result, this review aims to enhance understanding via consideration of the lived experiences of breastfeeding women.

Method

A narrative approach was adopted for this review. This approach provides a means for developing both interpretive and narrative synthesis from the broader perspective of the experiences of breastfeeding women (Nobles and Hart, 1988). The review method assists in generating a deeper knowledge of the nature of breastfeeding, rather than just summarizing a number of studies (Haucler et al., 1997). Additionally, it provides insight into the dynamics underlying the findings of the different approaches within the framework of qualitative research design (Creswell et al., 2009). The method allows flexibility in the review process, as well as the utilization of the descriptive phrases and metaphors found within existing studies, to create different perspectives about the world view (Creswell et al., 2009).

Data review

The data review was conducted between June and September 2012 using the following electronic bibliographical databases: Medline, CINAHL, PubMed, PsycINFO, Maternal and Infant Care, Scopus, and the World Health Organization (WHO) library. A manual search was also carried out using other relevant citations such as in the British Nursing Index and the International Breastfeeding Journal. The keywords used for the search were ‘breastfeeding’ or ‘infant feeding’ and ‘women’s experience’ or ‘qualitative’ studies. Synonyms were used where appropriate. Papers were included if they presented empirical qualitative research on breastfeeding experiences and were published in the English language. No date parameter was set.

Results

In all, 306 studies were initially identified, of which 260 papers were excluded (Table 1). The excluded papers were either duplicated or utilized a quantitative design. The abstracts of 66 articles were searched and examined for eligibility, from which 35 studies were excluded. Five papers were also excluded after reading them in full and evaluating them for credibility and
Databases: Medline, CINAHL, PubMed, PsycInfo, World Health Organization (WHO), Scopus, and Maternal and Infant Care

Inclusion criteria: Primary research using qualitative methods, reflecting participants' breastfeeding experiences and published in English

306 potentially relevant papers initially identified via the literature search

240 papers excluded after initial evaluation of abstracts

66 abstracts reviewed in full, applying inclusion criteria

36 papers excluded after full reading of paper

31 papers reviewed in further detail

Five more papers excluded after Critical Appraisal Skills Programme (CASP) approval

26 papers included in the review

26 papers included in the literature:
- 22 from developed countries (UK, USA, Australia, Canada and New Zealand)
- Four from developing countries (China, Turkey and Ghana)

Figure 1. Summary of the searches conducted during the data collection stage.
Quality assessment of studies

Detailed, repeated reading was carried out on the 26 studies included in the final synthesis. The intent was to determine the congruency within the studies, and their relationships. The characteristics of the various studies are represented in Table 1. The critical appraisal used 'yes', 'no' or 'unclear'. The various themes were developed by identifying frequently related concepts.

Findings

The emerging theme represents the experiences of breastfeeding according to the 26 studies considered in Table 1. Synthesis of the studies revealed five main themes, which consist of breastfeeding: a symbol of motherhood; feeding customised; dilemma of mothers' expectations compared to reality; assistance reassurance and support; and the effects of sociocultural influence on breastfeeding. A summary of the findings grouped together the metaphors and phrases used to describe the mothers' subjective experiences of breastfeeding. Direct quotations were drawn from the original studies to support each theme. The identified themes were found to be consistent within most of the studies.

<table>
<thead>
<tr>
<th>Author/year/country</th>
<th>Methods</th>
<th>Participants</th>
<th>Aspects of breastfeeding experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bittorf, (1990); Canada</td>
<td>Phenomenology, using interviews</td>
<td>n=3 woman</td>
<td>The decision to breastfeed after birth, learning to breastfeed, the personal choice of commitment and the need for encouragement and support for mothers</td>
</tr>
<tr>
<td>Left et al, (1994); USA</td>
<td>Phenomenology/semi-structured interviews</td>
<td>26 Caucasian breastfeeding women in northern New England, Aged 23–39 years</td>
<td>Mothers’ descriptions of successful and unsuccessful breastfeeding</td>
</tr>
<tr>
<td>Locklin, (1995); USA</td>
<td>Grounded theory based on face-to-face interviews</td>
<td>n=17 educated, low-income Latin and African-American women, supported by peer counsellors, Aged 18–37 years</td>
<td>Achieving breastfeeding success through the support of peer counselors and breastfeeding advocates</td>
</tr>
<tr>
<td>Dykes and Williams, (1999); UK</td>
<td>Phenomenological, longitudinal study/in-depth interactive interviews conducted at 6, 12 and 18 weeks following childbirth</td>
<td>n=10 primiparous Caucasian women, Aged 21–36 years</td>
<td>Women’s perceptions related to the adequacy of breast milk</td>
</tr>
<tr>
<td>Schmied and Barclay, (1999); Australia</td>
<td>Grounded theory</td>
<td>n=25 Australian women, Aged 23–35 years</td>
<td>Maternal embodied experience of breastfeeding</td>
</tr>
<tr>
<td>Mortgo et al, (2000); USA</td>
<td>Phenomenology</td>
<td>n=9 women who initiated breastfeeding but stopped at 2 weeks, Aged 20–32 years</td>
<td>Incompatibility between an idealised view of self as a ‘good mother’ and the reality of the breastfeeding experience</td>
</tr>
<tr>
<td>Rainier, (2000); USA</td>
<td>Ethnographic study using 7 focus-group discussions</td>
<td>n=42 women recruited from urban and suburban rural areas using mothers who participated in the women, infants and children (WIC) programme and supported by breastfeeding peer counsellors</td>
<td>Maternal breastfeeding experience, influence related to health-care systems and daily living</td>
</tr>
<tr>
<td>Schmied and Lupton, (2001); USA</td>
<td>Exploratory study</td>
<td>n=25 Australian first-time mothers</td>
<td>Mothers’ subjectivity and embodiment experience of breastfeeding</td>
</tr>
<tr>
<td>Tarrant et al, (2002); China</td>
<td>Exploratory, qualitative study as part of a longitudinal study</td>
<td>n=19 Hong Kong primiparous mothers at one-month postpartum</td>
<td>Sociocultural and environmental influences of breastfeeding practices, and lactation management in the immediate postpartum</td>
</tr>
<tr>
<td>Hauck and Hurta (2003); Australia</td>
<td>Grounded theory, individual and group interviews/postal questionnaires</td>
<td>n=33 Caucasian women, n=9 partners, n=12 child health nurses</td>
<td>Incompatibilities of mothers’ expectations and realities, influences on mothering, breastfeeding and weaning practices</td>
</tr>
<tr>
<td>Author/year/country</td>
<td>Methods</td>
<td>Participants</td>
<td>Aspects of breastfeeding experience</td>
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<tr>
<td>Dykas, (2005); UK</td>
<td>An ethnography study based on 97 observational encounters between midwives and postnatal women, 106 focus group interviews with postnatal women and 37 guided conversations with midwives</td>
<td>n=61 postnatal women n=30 midwives from two maternity units in the north of England</td>
<td>Postnatal women’s experiences and the influence of breastfeeding within the postnatal ward setting</td>
</tr>
<tr>
<td>George, (2005); USA</td>
<td>Grounded theory based on semi-structured interviews/field notes</td>
<td>n=10 primiparous women. Aged 18-36 years</td>
<td>Lack of preparedness for the postpartum period</td>
</tr>
<tr>
<td>Nelson and Sethi, (2005); Canada</td>
<td>Grounded theory</td>
<td>n=8 first-time breastfeeding teenage mothers. Aged 15-19 years</td>
<td>Continuous commitment to the journey of breastfeeding, along with the positive and negative experiences of breastfeeding</td>
</tr>
<tr>
<td>McFadden and Boile, (2006); UK</td>
<td>Exploratory study/focus group methodology</td>
<td>n=30 woman, aged 17-40 years in northeast England</td>
<td>Barriers and attitudes influencing breastfeeding, incompatible advice and support from health professionals</td>
</tr>
<tr>
<td>Marshall et al, (2007); UK</td>
<td>Observations and interviews</td>
<td>n=22 woman n=18 health professionals</td>
<td>Managing self identity as a ‘good mother’</td>
</tr>
<tr>
<td>McEldred-Herry et al., (2005); New Zealand</td>
<td>Reflective life-world</td>
<td>n=19 breastfeeding women</td>
<td>Objectification of the maternal breast</td>
</tr>
<tr>
<td>Tawiah-Agyeman et al., (2008); Ghana</td>
<td>65 semistructured interviews and 8 focus groups</td>
<td>n=62 purposive selection of recent mothers, 7 nurses and midwives from the study hospital, 6 policy-makers and implementers</td>
<td>Barriers and facilitators to early initiation of breastfeeding</td>
</tr>
<tr>
<td>Andrew and Harvey, (2011); UK</td>
<td>In-depth interviews (topic guide with 12 open-ended questions)</td>
<td>n=12 primi- and multiparous women with infants aged 7-18 weeks</td>
<td>Decisions regarding infant feeding choices, concerns about limited independence and self identities, along with social and cultural influence</td>
</tr>
<tr>
<td>Otoo et al, (2009); Ghana</td>
<td>Focus-group study</td>
<td>n=35 Ghanaian women aged 19-49 with 1 child less than 4 months old</td>
<td>Benefits, incentives and barriers to exclusive breastfeeding</td>
</tr>
<tr>
<td>Sheahan et al., (2009); Australia</td>
<td>Focus group study</td>
<td>n=37 women with infants aged between 1 and 9 weeks using snowball sampling</td>
<td>Mother’s expectations and experiences of health professionals’ support for infant feeding in the first 6 weeks postnatal</td>
</tr>
<tr>
<td>McEldred-Herry, (2010); New Zealand</td>
<td>Participatory life-world methodology/ interviews</td>
<td>n=19 woman currently breastfeeding or who had breastfed within the last 32 months. Aged 20-30 years</td>
<td>Societal influence and its effects on the interpretation of the breastfeeding experience</td>
</tr>
<tr>
<td>Palmir et al., (2010); Sweden</td>
<td>Reflective life-world study</td>
<td>n=2 primiparous woman n=6 multiparous woman</td>
<td>Mothers’ experiences of initiating and managing breastfeeding</td>
</tr>
<tr>
<td>Phillips, (2010); USA</td>
<td>Phenomenology</td>
<td>n=19 primiparous</td>
<td>Reflections on everyday experiences of breastfeeding</td>
</tr>
<tr>
<td>Domiritsas et al., (2012); Turkey</td>
<td>Descriptive, qualitative study based on in-depth, semi-structured interviews</td>
<td>n=24 women, with infants aged 4-24 months old</td>
<td>The influence of cultural, social and religious breastfeeding practices</td>
</tr>
<tr>
<td>Ryan et al, (2011); Australia</td>
<td>In-depth interviews</td>
<td>n=40 woman living in the UK, who are breastfeeding or had breastfed within the last 2 years</td>
<td>Maternal intraromood and interdependence experience of breastfeeding</td>
</tr>
<tr>
<td>Hodnett et al., (2012); UK</td>
<td>Qualitative serial interviews</td>
<td>n=72 woman/37 significant others</td>
<td>Female and family perspectives on infant feeding versus the idealism and realism of health services</td>
</tr>
</tbody>
</table>
Breastfeeding: A symbol of motherhood

Breastfeeding is both a biological process and a sociocultural activity (Borsoff, 1999; Dyken and Williams, 1999; Dyken, 2005). Evidence from the studies shows breastfeeding as a demonstration of motherhood, which includes nurturing and provision of nourishments (Schmidt and Barclay, 1999; Munirong et al, 2006; Marshall et al, 2007; McBride-Henry, 2010; Palmbe et al, 2010; Philips, 2010). The ability to manage breastfeeding has been linked to ‘womanliness’ and good mothering (Borsoff, 1999; Hauck and Inurita, 2003; Ono et al, 2009). For instance, one mother reported: ‘Breastfeeding gave me one link to a human, not a fruit’ (Borsoff, 1999:59). I felt that I was being a good mother in breastfeeding. It was rewarding, feeling satisfied within, being happy with your nurturing abilities at that stage’ (Hauck and Inurita, 2003:66). The idea of mothering entails a sense of duty for mothers towards the growth and development of their newborns (Munirong et al, 2000; Nelson and Sethi, 2006; McFadden and Toole 2006). As noted by Dyken (2005), mothers describe themselves as ‘milk-producing machine[s]’ in relation to providing food for their babies. This enhances their confidence and positive attitude towards breastfeeding.

Although breastfeeding is directly associated with mothering, some women feel overwhelmed by the early challenges of breastfeeding. Studies identify issues relating to painful breasts, sore nipples, and a lack of adequate preparation and support from health professionals (Nelson and Sethi, 2005; George, 2005). Women who fail to breastfeed may feel guilty. Some women describe their experience in relation to being a failure, and feeling ashamed and guilty (Munirong et al, 2000; McBride-Henry, 2010). One mother stated I ‘wanted to feel mothering. And I feel guilty for so long. It took me a long time to get over feeling guilty because I didn’t breastfeed’ (Munirong et al, 2000:127).

Feeling connected

Breastfeeding has been acknowledged as relating to more than just the provision of nourishment to the baby (Schmidt and Barclay, 1999; Munirong et al, 2006; Nelson and Sethi, 2005). Studies identify both a physical and an emotional connection between the mother and baby (Schmidt and Barclay, 1999; Schmidt and Lupron, 2001; Ryan et al, 2011). Feeling connected describes how mothers share their own bodies with their babies (Schmidt and Barclay, 1999; Nelson and Sethi, 2005). The experience was described as intimate and sensual (Schmidt and Lupron, 2001), as one mother explained: ‘There’s such a closeness with the baby and you feel when you’re feeding. You get that hormone. It just makes you feel motherly’ (Raider, 2000:258).

Breastfeeding promotes interdependency and physical bonding between the mother and baby (Schmidt and Barclay, 1999; McFadden and Toole, 2006). Several studies describe the mothers’ satisfaction and their emphasis on the closeness derived with their baby as a beautiful experience (Schmidt and Barclay, 1999; McBride-Henry et al, 2009). One mother described the feeling, the bond and closeness as being beyond words: ‘I just love every moment’ (Ryan et al, 2010:734). Breastfeeding success was viewed as a balance between the mother and her baby, mutually working together to enjoy moments of breastfeeding (Palmbe et al, 2010).

In several of the studies considered, mothers’ physical attachment to their baby were categorized in both positive and negative ways (Schmidt and Barclay, 1999; Munirong et al, 2006; Raider, 2000). Positive signs include security and protection of the mother over her baby (Raider, 2000), and the baby’s ability to navigate the mother and other family members (Schmidt and Barclay, 1999), which one mother described as ‘my baby is able to make me out among my friends’ side’ (Schmidt and Barclay, 1999:37). However, other mothers described being out of control and confused (McBride-Henry et al, 2009). For others, there was a feeling of being estranged in the demand of their babies’ breastfeeding needs and a wish for early separation (Munirong et al, 2000; Andrew and Harvey, 2011).

Dilemma of mothers’ expectations versus reality

The decision to breastfeed arises from specific goals and expectations regarding breastfeeding (Munirong et al, 2000; Phillips, 2010; Hoddinott et al, 2012). Importantly, women are motivated by the goodness of breastmilk in relation to the health of the baby (Marshall et al, 2007). The belief that breastfeeding is natural, easy and already available is prescribed as the norm (Marshall et al, 2007). This was described by one mother in the following terms: ‘I just thought it would come naturally, that it was just something that would be easy... I just expected it to be automatic’ (Munirong et al, 2000:122). For most women, the ideal way to breastfeed is something prior to or during pregnancy (Hauck and Inurita, 2003; Munirong et al, 2000; Marshall et al, 2007; McBride-Henry, 2010). For instance, one mother reported: ‘I had envisaged how easy and wonderful and natural it would be’ (Munirong et al, 2000:122).

In contrast to their idealized expectations, most mothers reported that the reality of breastfeeding was incompatible with their goals (McBride-Henry, 1999). Hence, other babies included in the study described mothers’ uncertainty about breastfeeding, feeling stuck about feeding, feeling overwhelmed and uncertain (Munirong et al, 2000; Hauck and Inurita, 2003; George, 2005; McFadden and Toole, 2006; Tawiah-Agyemang et al, 2008; Phillips, 2010). For instance, one woman stated: ‘I didn’t think it was going to be easy... I just expected it to be automatic’. Mothers’ breastfeeding experiences within the first 2-6 weeks are described as ‘overwhelming’ and ‘awful’ (Munirong et al, 2000; Ono et al, 2009). Studies identify problems such as positioning, latch and managing breastfeeding can be challenging (Munirong et al, 2000; Hauck and Inurita, 2003; George, 2005; Phillips, 2010). Palmbe et al (2010) identify early discharge from hospital as a significant issue that limits mothers’ preparation and the professional support they receive with respect to breastfeeding. Mothers perceive themselves as being handicapped in their breastfeeding journey due to the unrealistic and sometimes on-held information between health professionals and immediate families (Munirong et al, 2000; George, 2005).
Consistent support and reassurance

Support for mothers is expressed as crucial to their success at all levels of breastfeeding (Bromfield, 1990; Locklin, 1995; Dyken, 2005; Andrew and Harvey, 2011; Desmarais et al., 2009). For instance, mothers valued support based on 'practical guidance, encouragement and the reassurance of doing it right' (Desmarais et al., 2009:142). Mothers reported a sense of abandonment and frustration at the inconsistent information received in relation to their efforts to initiate and continue breastfeeding (Munoz et al., 2000; Grotea, 2005).

Both primigravida and multipara mothers expressed a desire for constant reassurance in a gentle and empathetic manner, to help them achieve their breastfeeding goals (Munoz et al., 2000; Schmidt and Layton, 2001; Desmarais et al., 2009). There is thus a need for health professionals to spend quality time and share information on techniques, as well as providing practical solutions to breastfeeding problems (Leff et al., 1994; Ralston, 2000; Hauck and Irizurieta, 2003).

Active support for mothers is given in various forms. Mothers within the traditional setting reported that they received support from their immediate families, as well as religious leaders and friends, while peer counsellors and breastfeeding advisors provided support for mothers within industrialized communities. Across the studies, support from health professionals was described using terms such as 'burden', 'trustee', 'judgemental', 'somebody who grabbed the mother's arm', 'incredulous' and 'incorrect advice' (Bromfield, 1990; Ralston, 2000; Hauck and Irizurieta, 2003; Dyken, 2005; Phillips, 2010).

Sociocultural construct of breastfeeding

Although breastfeeding is a natural act, it is also regarded as a social behaviour (Schmidt and Layton, 2001; Terraut et al., 2002; McBride-Henry, 2010; Andrew and Harvey, 2011; Desmarais et al., 2012). The sociocultural construct of breastfeeding was central to a woman's interpretation and experience of breastfeeding (Terraut et al., 2002; Tawiah-Agyemang et al., 2008; McBride-Henry, 2010). Sociocultural influences on breastfeeding are viewed as complex and diverse (Terraut et al., 2002; Tawiah-Agyemang et al., 2008; Desmarais et al., 2012). In the studies considered, the maternal immediate family and friends were prominently cited as sources of advice and support (Andrew and Harvey, 2011). Factors such as social, cultural, and religious activities were identified to impact on decision making, support and the management of breastfeeding (Terraut et al., 2002; McBride-Henry, 2010; Desmarais et al., 2011). Tawiah-Agyemang et al. (2008) also note the influence of Traditional Birth Attendants (TBA) and the performance of rituals for new mothers which delay initiating breastfeeding early. Women felt the need to breastfeeding if they were breastfed themselves, and the infant was likely to be introduced to formula feeds if the mother was not breastfed (Bromfield, 1990; Munoz et al., 2000; Dyken, 2005).

The women's experiences in relation to public breastfeeding emerged as a barrier to successful breastfeeding. Women repeatedly expressed the inconvenience and disapproval in the presence of others. For instance, a woman narrated: 'I was made aware of “blash” disapproval through critical facial expressions being directed toward me' (McBride-Henry, 2010:77). Similarly, Bannock (1990) noted that, breastfeeding challenges a mother's position in relation to the world, and thus, acceptance is extremely beneficial. Dyken (2005) further described 'bystander issues', relating to maternal feeling for exposing their breasts in public settings. Breastfeeding women in both industrialised and low socioeconomic communities face this as a challenge and find breastfeeding outside the home difficult. Studies therefore recognised the need for support and building infrastructure that ensure privacy to enable mothers breastfeed in public settings.

Discussion

The cumulative review provides insight into women's various experiences of breastfeeding. The findings reveal that the essence of breastfeeding goes beyond simply providing the baby with nutrition. Significant to women's experiences of breastfeeding are a blend of biological, social and cultural activities that shape their breastfeeding journey. Mothering involves the provision of nourishment and security for the infant, as well as bonding. Women consistently conceptualised their breastfeeding experience as an essential element of 'good' mothering, which transforms a woman's identity and role within motherhood, compared to women who use formula feeding. However, there is a sense of shame and guilt as mothers failed to achieve their breastfeeding goals.

Breastfeeding was revealed to be not just a physical activity, but an inseparable part of the body, soul and mind. Mothers who have a positive attitude towards breastfeeding expressed a sense of well-being and a feeling of being connected to their baby. Hodskins et al. (2012) argue that mothers who nurse, breastfeed on schedule and introduced complementary foods early often find it harder to experience the 'breastfeeding magic'. Mothers who have been unsuccessful in breastfeeding expressed negative feelings about their experiences, which often influence subsequent breastfeeding. WHO (2010) recommends early skin-to-skin contact and rooming-in with the mother, which facilitates bonding and effective breastfeeding. Mothers are encouraged to enjoy communicating with the baby during breastfeeding and taking time to allow the baby to breastfeed.

Limitations

Although narrative reviews focus on capturing a broader perspective on a given topic, in this review it is possible that other relevant citations may have been missed that might have influenced the conclusions of the review. For instance, breastfeeding and HIV transmission as well as the experiences of breastfeeding mothers in the maternal intensive care unit (NICU), another limitation is the fact that the findings cannot be generalised, except to provide insights into the reality of breastfeeding.

This paper provides insights into the experiences of breastfeeding women who is relevant to professional practice and helping mothers to reflect on their own experiences. About 90 percent of the studies considered were conducted in Western, industrialised countries, and aimed to depict the issues shaping women's breastfeeding experiences in order to help improve the quality of breastfeeding. However, African and most developing countries have recorded limited narrative...
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Key Points

- Breastfeeding is considered a symbol of motherhood, which is significant in enhancing mothers’ decisions to breastfeed and their devotion to it.
- The sensual feeling and beauty of the mother-baby connection promotes bonding, eliciting breastfeeding experiences and mutual interaction, which is important to breastfeeding women.
- Breastfeeding mothers need to be taught realistic and practical techniques to enhance their confidence in managing breastfeeding problems.
- Provision of sensible and tailored care is needed to assist mothers to breastfeed effectively.

Conclusion

Aspects of women’s breastfeeding experience were consistent using the themes identified during the review process. The findings of this study are important in helping to incorporate the actual experiences of mothers into professional care giving and support strategies aimed at enhancing effective breastfeeding.


