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It takes a mother to practise breastfeeding: Women's perceptions of breastfeeding during the period of intention

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ABSTRACT

Background: In the Netherlands, 81% of mothers initiate breastfeeding. After one month the percentage of mothers still breastfeeding drops, despite positive intentions. Little is known about women's perceptions of breastfeeding during the period of intention.
Aim: This qualitative study aimed to gain insight into these perceptions among first-time mothers from middle and high socioeconomic backgrounds in the northern part of the Netherlands.
Methods: We used the theory of planned behaviour as the deductive model. In 2008, 16 in-depth interviews were conducted with 8 mothers who intended to breastfeed. The interviews were conducted at two time points (prepartum and postpartum) and covered the same period (that is, from the time when the intention was formed until after childbirth). The interviews were transcribed verbatim and analysed using grounded theory.
Findings: Five inductive themes were identified: combining breastfeeding with work, learning about breastfeeding, making arrangements for childbirth, reflecting on the intention, and becoming a mother. During the extended period of intention, the women anticipated breastfeeding, but were cautious in expressing their intentions. They felt that the experience of becoming a mother would be critical to their breastfeeding outcomes.
Conclusion: The theory of planned behaviour has been widely used in breastfeeding research. However, the period of intention is relatively long for breastfeeding. Rather than recommending an intensification of antenatal breastfeeding education, recommendations must incorporate the awareness that practising breastfeeding should not be considered the continuous outcome of the intention to do so – it takes a mother to practise breastfeeding.

1. Introduction

In the Netherlands, 81% of mothers initiate breastfeeding when their babies are born. After one month this percentage is 48%, after three months 30%, and after six months 13%, according to figures reported in 2007.[1] In 2010, breastfeeding rates were 75% at birth and 46% after one month.[2,3] Although there are some variations in different countries and regions, these figures represent a common pattern in current breastfeeding rates in most countries in the Western world, with the highest drop-out occurring in the first weeks after birth.[4] National campaigns and guidelines that emphasise the health benefits of breastfeeding have been developed with the aim of extending the duration of breastfeeding.[5] These campaigns follow the World Health Organization (WHO) guidelines, which recommend exclusive breastfeeding until six months of age.[6] While these campaigns have been successful in increasing the initiation rate over the past decade, they have not extended the duration of breastfeeding.[1] Breastfeeding initiation rates reflect a high intention to breastfeed; the rapid decline indicates that this intention does not result in successful breastfeeding outcomes. The discrepancy between intended and actual breastfeeding duration is associated with low maternal satisfaction.[7,8]

Research on the determinants of the decline in breastfeeding rates in the first months has shown higher breastfeeding rates in

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women who are older[9] and who have higher socio-economic status (SES),[10,11] but also that in all SES groups, mothers often drop out before the end of their intended breastfeeding duration.[1] Early breastfeeding discontinuation is also common in primiparous mothers.[12] Cross-sectional surveys have shown that, in general, the main reasons for early weaning in the Netherlands are pain, insufficient milk and work; among women with high SES, the main reason is work.[1,13] Although this sheds some light on why women stop breastfeeding early, it does not reveal what underlies these reasons.[1]

The theory of planned behaviour (TPB), which had been developed by Ajzen and Fishbein,[14,15] describes how behaviour is preceded by behavioural intention. The intention is determined by attitude, social norms and perceived control.[14] The TPB has been frequently used in health-related studies in both qualitative and quantitative designs, including breastfeeding studies,[16–22] confirming that breastfeeding intention is a strong predictor of breastfeeding initiation.[17,20–22] Intention has been reported as one of the strongest predictors of breastfeeding initiation and duration.[23]

In the Netherlands, a mother's intention to breastfeed or bottle-feed is formed long before childbirth: 67% of women decide prior to gestation and 32% develop their intentions in the first trimester.[1,24] Consequently, there is a long period between setting the intention and initiating breastfeeding. Despite this extended period of intention, most studies have focused on this period only at one particular time point: either prepartum[25,26] or postpartum.[27,28] These studies have all been quantitative, focusing on breastfeeding attitudes or determinants of breastfeeding outcomes. Hoddinott and Pill[29] conducted qualitative research on perceptions of breastfeeding among women with low SES at two time points: prepartum and postpartum. Prepartum, they focused on intention, and postpartum, on breastfeeding outcomes.

None of these studies focused specifically on intention at two time points (that is, prepartum and postpartum). We proposed that using a qualitative design to study women's perceptions both prepartum and in retrospect would generate a deeper understanding of these perceptions, which would contribute to the appraisal of interventions that aim to support mothers in their breastfeeding intentions. For this reason, we asked women to share their breastfeeding perceptions both during the period of intention (that is, prepartum) and retrospectively (that is, postpartum).

To understand the motives underlying breastfeeding decision-making, the significance of biological, social and cultural conditions must be recognised.[30] Traditionally, giving birth was perceived as a natural and uncontrollable event.[31] With modernisation, pregnancy and birth have been medicalised in most parts of the world. This has resulted in a reduction in perinatal maternal and child mortality.[32] At the same time, it has changed the perception of birth from a natural event to a potentially risky endeavour that needs to be medically monitored. How and where to deliver has become a matter of choice and decision-making for both health professionals and future parents. In the Netherlands, although it is common for women to opt for a home delivery in the absence of contraindications, more and more women are choosing to deliver in a hospital or birth centre. Currently, about a third of mothers give birth at home.[33] Dutch reproductive care is organised within an integrated system of obstetric, midwifery and maternity care.[13] Antenatal care is provided by midwives or gynaecologists (depending on whether a home delivery is involved), while postnatal care is provided by midwives and maternity assistants at home or in a birth centre. Most health insurance companies cover eight days of maternity care at home. After one month, the baby clinics take over professional postnatal care.[13] No standardised services are provided by professionals between the eighth and thirtieth day after delivery.

According to two midwives (Campen, Kreulen 2008, personal communication), at 20 weeks of gestation midwives or gynaecologists usually inquire about the mothers' intentions to breastfeed or bottle-feed. In addition, these professionals may provide breastfeeding information, depending on the guidelines of their profession. Postpartum, the maternity assistants support breastfeeding initiation until day eight. Additional professional support may be provided by lactation consultants, which is not included in the integrated (funded) care system. As part of the campaigns to increase Dutch breastfeeding rates, many reproductive health and maternity care agencies have received Baby-Friendly Hospital Initiative (BFHI) certification, developed by WHO in 1991 and supervised nationally by the Dutch BFHI accrediting body. Virtually all maternity organisations in the Netherlands have been certified to date.[34]

The expectations associated with women's roles can be conflicting: women are expected to take care of their children (including breastfeeding) and at the same time participate in the labour market. Employment rates of Dutch women have increased considerably over the past decade. In the period 2005–2009, female labour participation was 71.5%, which is higher than the European average.[35] However, 75% of these women worked part-time, which is the highest rate of part-time work in Europe according to figures for 2009.[36] Because government policy aims to increase full-time female labour participation, [37] provisions for leave and facilities for childcare are high on the agenda. Mothers are eligible for 16 weeks of maternity leave, usually 4 weeks prepartum and 12 weeks postpartum.[38] Paternal leave is generally two days postpartum. Subsequent parental leave is allowed, but is usually unpaid (depending on employment agreements).

Until their child is nine months old, mothers are entitled to use 25% of their working time to express breast milk. The employer is obliged to provide a room for expressing breast milk and to arrange for storage facilities.[39] However, women report that frequently they have to organise this themselves.[40] The nature of their work does not always allow women to interrupt their activities during working hours.

The Dutch social and cultural background outlined above shapes the context of breastfeeding decision-making. In this context, we studied perceptions of breastfeeding during the period of intention in primiparous women in the northern part of the Netherlands.

2. Methods

We conducted qualitative fieldwork according to the 'Hutter–Hennink qualitative research cycle'.[41] This cyclic model provides tools for accomplishing a coherent process of defining research questions, collecting and interpreting data, and developing theory. The authors emphasise the importance of reflexivity, making inferences and linking empirical data to theory by inductive and deductive reasoning. The Hutter–Hennink cycle includes three stages: the design cycle, the ethnographic cycle and the analytical cycle. In our study, these three stages were accomplished by moving back and forth between these cycles, conducting in-depth prepartum and postpartum interviews, using the TPB as a deductive conceptual framework, and generating theory refinement, as explained by Snow.[42]

We selected a purposive sample of eight pregnant women from one midwife clinic in a mid-sized town in the province of Friesland, in the northern part of the Netherlands. The midwives invited women in gestation week 20 to participate in the research; they did this in person. Inclusion criteria for the prepartum interview: primiparous, capable of breastfeeding and able to speak Dutch or English. Criteria for the postpartum interview: mother and infant both healthy and no