Breastfeeding Experiences of Low-Income Women in the City of Winnipeg:

A Qualitative Study

by

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ABSTRACT

Low-income women are less likely to initiate, continue and exclusively breastfeed. Limited Canadian research exists regarding the lived breastfeeding experience. A phenomenological study, utilizing a feminist approach and Fishbein's Integrative Model of Behavioral Prediction was conducted. Women recruited via purposeful, criterion sampling, who were eligible for the Manitoba Healthy Child Prenatal Benefit and had breastfed participated in 1:1 interviews (N=18). The essence of the experience was breastfeeding is "amazing and tough". The themes of "life context", "tough work", and "persevering" emerged. Women who continued to breastfeed described breastfeeding becoming easier and ongoing breastfeeding variability in their experience. Those who discontinued breastfeeding noted it did not fit with their lifestyle, made the decision to breastfeed later, and interpreted breastfeeding problems differently. Researchers and practitioners need to explore the role of stress and consider this in providing individualized, coordinated breastfeeding and health care support to these women.

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CHAPTER 1: INTRODUCTION

Problem Statement

Low-income women are less likely to initiate breastfeeding (Public Health Agency of Canada (PHAC), 2009) and breastfeed for shorter durations than mothers living in higher socioeconomic situations (Amir & Donath, 2008; Dennis, 2002). Breastfeeding confers important health benefits to both infants and their mothers (Ip et al., 2007). Low-income women and their children therefore fail to receive the important benefits breastfeeding provides. It is, thus, important to understand the reasons behind this phenomenon, in order to promote greater breastfeeding adoption and continuance by this demographic.

In Winnipeg, as in other jurisdictions, the social and economic disadvantages experienced by low-income women and their children increases the risk of infant mortality and morbidity (Brownell et al., 2008; Martens et al., 2010b), hospitalizations and preterm birth (Brownell et al., 2008), developmental delays, and the risk of cumulative mental illness, premature death and other poor maternal health outcomes (Martens et al., 2010b). Breastfeeding, particularly, exclusive breastfeeding is an important strategy to ensure the health and wellbeing of these children and their mothers. Breastfeeding reduces infant mortality and morbidity (Chen & Rogan, 2004; Ip et al., 2007), enhances infant cognitive development (Kramer, 2010), and decreases the risk of gastrointestinal illness (Duijts, Ramadhani & Moll, 2009; Ip et al., 2007), respiratory illness (Duijts et al., 2009; Ip et al., 2007), sudden infant death syndrome (SIDS) (Hauck, Thompson, Tanabe, Moon & Vennemann, 2011; Ip et al., 2007) and otitis media (Ip et al., 2007). Breastfeeding also decreases the risk of developing Type 2 diabetes (Owen,

Martin, Whincup, Smith & Cook, 2006; Young et al., 2002) and the risk of hospitalization related to respiratory and gastrointestinal illness (Coulibaly, Seguin, Zunzunegui & Gauvin, 2006). In addition to the above mentioned factors upon which most researchers agree, other research points to even more extensive health benefits. For example, Horta, Bahl, Martines and Victora (2007) postulated that breastfeeding may decrease the risk of childhood obesity, overweight and high blood pressure. Some systematic reviews noted links between breastfeeding and the prevention of overweight or obesity (Weng et al., 2012). It must be noted, however, that other researchers found either no association and/or no causal link between breastfeeding and a decreased risk of childhood obesity and overweight (Cope & Allison, 2008). Breastfeeding has also been suggested, although no causal link has been determined, to decrease the risk of childhood cancers such as acute lymphoblastic leukemia, Hodgkin's disease, neuroblastoma (Martin, Gunnell, Owen & Smith, 2005) and the risk of allergies, asthma and atopic dermatitis (Ip et al., 2007). Breastfeeding affects the health of the breastfeeding mother by decreasing the risk of developing premenopausal breast cancer (Schack-Nielsen & Michaelsen, 2006) and Type 2 diabetes (Ip et al., 2007), aiding in postpartum recovery by promoting uterine involution, and acting as a birth control method (if the LAM method is utilized i.e., lactation amenorrhea) by delaying the return of menses and allowing for adequate spacing between pregnancies.

Our understanding of the extent of the issue of low-income women failing to breastfeed is adversely affected by inadequate statistical information regarding the parameters and extent of this breastfeeding initation and duration problem. National, provincial and local Winnipeg breastfeeding initiation rates are available. Some data

regarding breastfeeding duration and exclusivity rates at a national level exists but limited or no provincial or local regional health authority (i.e., Winnipeg Regional Health Authority or WRHA) data exists. Additionally, the majority of data regarding breastfeeding initiation and duration rates is not specified by income level. There are also discrepancies in some of the rates noted below due to who was included in the sampling and as a result of differences in data collection methods. The Public Health Agency of Canada (PHAC) (2009) statistics are based upon the Maternity Experiences Survey (MES) and therefore excluded all First Nations women living on reserve and institutionalized women. Statistics Canada (2010) results are based upon the Canadian Community Health Survey (CCHS) questionnaire data and excludes persons living on reserves and other Aboriginal settlements in the provinces; full-time members of the Canadian Forces; institutionalized populations and persons living in certain regions in Quebec and Nunavut. The exclusion of this portion of the population, would therefore result in the higher breastfeeding initiation and duration rates noted in the PHAC and Statistics Canada national and provincial data as compared to Brownell et al.'s (2008) and Heaman et al.'s (2012) provincial data presented below. The PHAC (2009) and Statistics Canada (2010) data is also based on self-reported data by women, as compared to third party reporting on hospital abstracts or midwifery forms, the reporting method utilized by the sources for Brownell et al.'s (2008) and Heaman et al.'s (2012) analyses. This self-reporting method could also potentially contribute to an over-estimation of initiation and duration rates in the Statistics Canada and PHAC statistics. The PHAC (2009) and Statistics Canada (2010) data is also based on survey data of a portion of the population general versus Brownwell et al.'s (2008) and Heaman et al.'s (2012) analyses

which is based on Manitoba Centre for Health Policy (MCHP) data of all women giving birth in the province of Manitoba. There is thus potential risk for the national and provincial data presented in the PHAC (2009) and Statistics Canada (2010) reports to not be representative of Canadian women if certain portions of the population fail to respond and be included in the MES and CCHS questionnaire data.

In Canada 91.1% (95% CI: 90.3 - 91.9) of women living in households above the low-income cut-off initiated breastfeeding as compared to 87.7% (87.7% CI: 85.8 - 89.6) of women living at or below this level (PHAC, 2009). Statistics Canada (2010) determined that significantly fewer mothers in the lowest income quintile (81.0%) initiated breastfeeding as compared to mothers in all other income quintiles (i.e., 88.7 to 92.6 %). (Statistics Canada notes data with a coefficient of variation (CV) from 16.6% to 33.3% -- interpret with caution due to high sampling variability). They also noted an increase in initiation rates with each increase in the income quintile (i.e., 81.0% for quintile 1/lowest to 92.6% for quintile 5/highest). Provincial data shows there is a significant positive relationship between income level and breastfeeding initiation rates in both urban and rural areas in Manitoba (Brownell et al., 2008; Heaman et al., 2012; Martens et al., 2008). From 2001 to 2006, in urban areas in Manitoba the breastfeeding initiation rate for the highest income quintile neighborhoods was 91.2% compared to 76.6 % for the lowest income quintile (Brownell et al., 2008). More recent data (2007/08 – 2008/09) determined that with each successive decrease in income quintile, fewer babies were being breastfed at hospital discharge (Heaman et al., 2012). It was also noted that those infants born to women on income assistance were significantly less likely to be

breastfed (59.9% initiation rate) as compared to those women not on income assistance (82.5 % initiation rate) (Heaman et al., 2012).

Limited information regarding Winnipeg's breastfeeding initiation rates by income quintile is available. For the time period of 1996 to 2006, the neighborhoods of Point Douglas, Downtown and Inkster in Winnipeg, known to have the lowest family incomes in the city, had the lowest breastfeeding initiation rates (Brownell et al., 2008). The rates for Point Douglas, Downtown and Inkster were 73%, 77% and 77% respectively (Brownell et al., 2008). These three most vulnerable areas in Winnipeg, did however note some of the largest percentage increases in breastfeeding initiation rates in Manitoba between the period of 1988 to 2004 (Martens et al., 2008). Martens et al. (2008) described a steady increase in initiation rates provincially and rapid increases in half of the neighborhood clusters of Winnipeg during this time period. There was also a decrease in disparity noted from 1987 to 2008 between the highest and lowest income quintiles in Winnipeg and other provincial urban areas (Martens et al., 2010b). Unfortunately, more recent data noted these three urban Winnipeg neighborhoods as continuing to have the lowest breastfeeding initiation rates in the city and as experiencing a decrease in overall initiation rates (Heaman et al., 2012). This more current data noted breastfeeding intiation rates in the neighborhoods of Point Douglas, Downtown and Inkster as having declined to 65.8%, 73.6% and 74.4% (Heaman et al., 2012).

Although there is data available at the national level regarding breastfeeding duration rates and exclusive breastfeeding rates, provincial and Winnipeg Regional Health Authority (WRHA) data in these areas is more limited and does not correlate breastfeeding duration or exclusive breastfeeding to income quintile. Overall, national

and provincial breastfeeding duration rates and in particular exclusive breastfeeding duration rates for women of all economic groups continue to remain poor (PHAC, 2009). In Canada, 52% (95% CI: 50.4 - 53.0) of women exclusively breastfed for 3 months; 67% (95 % CI: 66.5 - 68.8) breastfed any amount for 3 months; 15% (95% CI: 13.5 - 15.4) breastfed exclusively for 6 months; and 54% (95% CI: 52.6 - 55.2) breastfed any amount for 6 months (PHAC, 2009). National Canadian data determined, "significantly fewer mothers in the lowest (23.1%) and third income quintile (23.7%) breastfed their children exclusively for six months or more than did mothers in the highest income quintile (33.0%)" (Statistics Canada, 2010, p. 1). (Statistics Canada notes data with a CV from 16.6% to 33.3% -- interpret with caution due to high sampling variability). Research in developed nations found that women living in low-income situations and in circumstances of higher economic deprivation, who were breastfeeding at any level, had shorter breastfeeding durations (Amir & Donath, 2008; Flacking, Wallin, & Ewald, 2007; McMillan et al., 2008; Meedya, Fahy & Kable, 2010; Milligan, Pugh, Bronner, Spatz & Brown, 2000; Thulier & Mercer, 2009).

At the provincial level, the PHAC (2009) determined that 53 % of Manitoba women breastfed exclusively for 3 months; 64 % breastfed any amount for 3 months; 16 % exclusively breastfed 6 months; and 51 % breastfed any amount at 6 months. Although no provincial or Winnipeg Regional Health Authority (WRHA) hospital data regarding the duration of breastfeeding is available, the Manitoba Centre for Health Policy using information from three cycles of the CCHS was able to calculate provincial breastfeeding duration rates (Brownwell et al., 2008). (Note: concerns noted previously regarding CCHS data). They estimated that 62.8% of all infants were breastfed at 3

months of age; 38.5 % of infants were breastfed at 6 months of age; at 12 months the percentage of infants being breastfed was 16.1%; and only 4.2% of infants were breastfed beyond one year (Brownell et al., 2008). As previously noted, there is unfortunately no provincial or WRHA data available regarding income quintile and exclusive or any level of breastfeeding duration rates.

Research has been conducted related to the factors that influence why women, including low-income women, intend to and initiate breastfeeding. There is a body of quantitative research exploring the factors and interventions that determine or influence breastfeeding duration for women in general including low-income women. The majority of qualitative research about breastfeeding duration focuses on higher income women or a general cross section of all women. The quantitative and qualitative research pertaining to low-income women has largely been conducted in the United States or countries other than Canada. Limited qualitative research has been conducted as to why low-income women continue to breastfeed. Specifically, qualitative research that explores the lived experience of breastfeeding by low-income women from a Canadian perspective has not been completed. To foster longer breastfeeding duration and the exclusive breastfeeding of low-income women in the Canadian cultural and health care context, it is therefore imperative to conduct research that explores from the (low-income) woman's perspective the facilitators and barriers to breastfeeding and the overall experience of breastfeeding.

Study Purpose

The purpose of this qualitative phenomenological study was to describe the lived experience of breastfeeding for low-income women living in Winnipeg, Manitoba. This research is required to better understand the breastfeeding experience in terms of

challenges and enablers, how these women continued to breastfeed, how they conceptualized the experience and what effect they believe breastfeeding had on their lives and the lives of their children.

This study provides insight and information as to what factors enable low-income women to continue breastfeeding, what hampers their efforts and how they view the overall experience of breastfeeding. The results could be utilized to assist health care professionals in hospital and community settings to design and implement effective clinical strategies and programs to enhance breastfeeding duration rates in this population.

Study Definitions

Breastfeeding and Breastfeeding Duration

For the purpose of this study, breastfeeding refers to any amount of breastfeeding that a mother does after the birth of her child. The definition of breastfeeding needs to be further defined as there can be marked variability in the level (i.e., the frequency of breastfeeding and if products other than breast milk are provided to the infant) of breastfeeding that occurs. The duration of breastfeeding or length of time a woman breastfeeds for also needs to be considered when defining breastfeeding. In discussion with mothers the following classification of breastfeeding was utilized to classify level of breastfeeding:

Full Breastfeeding: This included infants that were exclusively breastfed meaning no other liquid or solid is given to the infant. It also included infants who were almost exclusively breastfed or that vitamin, mineral, water, juice, or ritualistic feeds

were given infrequently in addition to breastfeeds. No formula was given to these infants (Labbok & Krasovec, 1990)

Partial Breastfeeding: Consists of three categories – High, medium and low. High denoted 80 percent of feeds are breastfeeds; medium denoted 20 to 80 percent of feeds were breastfeeds and low denoted less than 20 percent of feeds were breastfeeds. (Labbok & Krasovec, 1990).

Token breastfeeding: This referred to minimal, occasional, irregular breastfeeds. (Labbok & Krasovec, 1990).

Breastfeeding duration: The length of time that an infant received breast milk (any amount). Women were asked the length of time they breastfed for and the length of the level of breastfeeding as noted above (e.g., Women could answer they breastfed exclusively for 2 weeks and then continued to partially breastfeed until their infant was 3 months old).

For women to be considered eligible for the study they had to have breastfed their infant at any level, for any length of time. This therefore included women who only breastfed once and then discontinued breastfeeding. It also included women who breastfed for a few days and then discontinued breastfeeding. Women who breastfed for months or years were also included.

The World Health Organization (WHO) (2008), Labbok and Krasovec (1990) and Blyth et al. (2002) and other authors have defined breastfeeding and breastfeeding levels and duration in a variety of ways. The purpose of this study was not to rigorously determine the level of participants' breastfeeding but rather to capture their breastfeeding experience. As a woman's experience of breastfeeding may be influenced by the

frequency in which she breastfed her child and the length of time she breastfed, a general quantification or measure of the women's level and duration of breastfeeding was important to gather for the purpose of providing context to her experience. Defining breastfeeding level and duration more simply as noted in the Labbok and Krasovec (1990) definitions provided a general idea of breastfeeding level and duration and allowed for this provision of context.

Low-Income

For the purpose of this study, low-income refers to families (women) who were eligible for the Manitoba Healthy Child Prenatal Benefit Program during the woman's pregnancy. Eligibility for this program required that a pregnant woman must live in Manitoba and have a net family income less than $32, 000 per year (Manitoba Government, 2001). The use of this definition ensured a uniform way to include participants and eliminated a potentially lengthy and inaccurate process of having potential participants determine their yearly income. It also potentially ensured a large cross-section of low-income women were included in the study in terms of employment. Woman who receive this benefit may be employed, unemployed, or may be receiving social assistance or disability benefits.

CHAPTER 2: REVIEW OF THE LITERATURE

Low-income women breastfeed for shorter durations than higher income women (Amir & Donath, 2008; Meedya et al, 2010; Thulier & Mercer, 2009). The factors that influence breastfeeding duration among low-income women have been explored in quantitative and to some degree in qualitative research. In the following literature review, where there is limited or inconclusive research regarding factors that influence low-income women's breastfeeding duration, a notation or discussion of this is provided and research regarding this variable's effect on the breastfeeding duration of all women, irrespective of income level, is discussed.

The following literature review spans 2001 to 2013 and examines the factors that influence low-income women's breastfeeding duration. Also included in this review is the research regarding the breastfeeding experience of women from varying socio-economic status groups as well as that specific to low-income women. The literature review was conducted utilizing Scopus, Pubmed and Psychlit and employed the key word or phases: breastfeeding; breastfeeding initiation and duration; breastfeeding duration; breastfeeding and low-income women; qualitative research and breastfeeding and low-income women.

Income and Breastfeeding Duration

Low-income women are more likely to discontinue breastfeeding compared to their higher income counterparts (Meedya et al, 2010). International studies completed suggest a positive relationship between income level and the breastfeeding outcomes of duration and exclusivity (Amir & Donath, 2008; Beale et al., 2006; Flacking et al., 2007). Women living in lower income quintiles (Amir & Donath, 2008) and lower income areas

(Beale et al., 2006) or exposed to socioeconomic status factors including receiving social welfare or equivalent disposable income in the household (Flacking et al., 2007) were significantly more likely to breastfeed for shorter durations as compared to their higher income counterparts.

Canadian studies show mixed results regarding the relationship between income and breastfeeding duration. Coulibaly et al.'s (2006) Quebec study noted that infants of low-income mothers were breastfed less often and for shorter periods of time. Other Canadian research found that although a mother's income was positively linked to breastfeeding duration and exclusivity the relationship was not statistically significant and that when other factors such as a mother's age and education level, breastfeeding intention, marital status, and immigrant status and the interrelationships between these variables were taken into account, family income was not as powerful a predictive factor for any level of breastfeeding (Dubois & Girard, 2003; Sheenan et al., 2001) or exclusive breastfeeding (Al-Sahab et al.'s, 2010; Millar & Maclean, 2005). The results of the Canadian studies suggest that a woman's or family's income level is linked to breastfeeding duration of any level and to exclusive breastfeeding but that other factors in these study models, such as education level or the other above noted variables, better explain the variance noted and have a greater influence on breastfeeding outcomes for these women.

Factors Affecting Breastfeeding Duration among Low-Income Women

Demographic and Socio-Demographic Factors

The effects of the following demographic and socio-demographic factors on breastfeeding outcomes are described: age, education, ethnicity and country of origin, marital status and cohabitation, parity, employment and school attendance.

Age

Age is a significant predictor of breastfeeding duration for low-income women (McMillan et al., 2008). Younger low-income women breastfed for shorter durations than their older counterparts (Bolton, Chow, Benton & Olson, 2009; England et al., 2003; Harley, Stamm & Eskenzai, 2007; Hurley, Black, Papas & Quigg, 2008; McMillan et al., 2008; Meyerink & Marquis, 2002; Milligan et al., 2000; Sussner, Lindsay & Peterson , 2008). A higher intensity of breastfeeding was associated with older age in low-income mothers (Bonuck, Trombley, Freeman & McKee, 2005). Older low-income mothers were more likely to exclusively breastfeed (Chevalier McKechnie, Tluczek & Henriques, 2009; Ziol-Guest & Hernandez, 2010).

Education

Low-income women with more education were significantly more likely to breastfeed longer than less educated mothers of the same socioeconomic group (Bolton et al., 2009; Hurley et al., 2008; Racine, Frick, Guthrie & Strobino, 2009; Simard et al., 2005; Ziol-Guest & Hernandez, 2010). Exclusive breastfeeding (Beale et al., 2006) and any level of breastfeeding were positively and significantly related to a higher education level in low-income women (McMillan et al, 2008; Sharps, El-Mohandes, El-Khorazaty, Kiely & Walker, 2003).

Ethnicity and Country of Origin

Ethnicity and country of origin affect breastfeeding initiation and duration. However, research in this area has often not specified the income level of the participants. Breastfeeding duration research for low-income women by ethnicity is limited and shows mixed results. Some researchers found that level of breastfeeding (Langellier, Chaparro & Whaley, 2011) and duration of breastfeeding (Hurley et al., 2008) were not significantly associated with maternal race or ethnicity, while others such as Bonuck et al. (2005) determined that ethnicity was linked to breastfeeding intensity.

Canadian data sources suggest the incidence of breastfeeding among the Aboriginal population, an economically disadvantage population, remains significantly lower than the general population in Canada. Off-reserve Aboriginal women, on-reserve Aboriginal women and Metis women were less likely to initiate breastfeeding and breastfeed for a shorter duration than other Canadian women (Statistics Canada, 2001; Turcotte, Martin & Zhae, 2004). Manitoba provincial data found lower breastfeeding initiation rates for registered First Nations (RFN) women (Martens et al., 2002) and Metis women (Martens et al., 2010a) compared to all other Manitobans living within the same regional health authority (RHA), including the Winnipeg Regional Health Authority (WRHA).

Country of origin and the immigrant status of low-income women are important factors in breastfeeding initiation and duration. Foreign born low-income women living in higher income countries were more likely to initiate breastfeeding (England et al., 2003; Kimbro, 2006; Lee et al., 2009; McCann et al., 2007; Simard et al., 2005; Ziol-Guest & Hernandez, 2010). Many researchers found that foreign born low-income

women were more likely to breastfeed for a longer duration (England et al., 2003; Langellier et al., 2011; McCann, Baydar & Williams, 2007; Ziol-Guest & Hernandez, 2010) and at a higher intensity level (Bonuck et al., 2005). Increasing years of residence in the new country (Harley et al., 2007) and increasing level of acculturation (Chapman & Perez-Escamilla, 2011; Singh, Kogan & Dee, 2007) was associated with a decreased likelihood of initiating breastfeeding and a shorter duration of exclusive or any breastfeeding.

Marital Status and Cohabitation

Marital status and cohabitation are positively linked to breastfeeding intention (Heaman et al., 2012; Khoury, Jarjoura, Carothers & Hinton, 2005; Kimbro, 2006; Lee et al., 2005; Sharps et al., 2003; Ziol-Guest et al., 2010) and breastfeeding duration in low-income women (Hurst, 2007; Racine et al., 2009). Married women or women who had a partner present in the home were more likely to initiate breastfeeding (Heaman et al. , 2012; Khoury et al., 2005; Kimbro, 2006 ; Lee et al., 2005; Sharps et al., 2003; Ziol-Guest et al., 2010) and breastfeed for a longer duration (Hurst, 2007; Raccine et al., 2009; Sharps et al., 2003; Ziol-Guest et al., 2010).

Parity

Parity influences breastfeeding initiation and duration in low-income women. Multiparous low-income women were significantly less likely to initiate breastfeeding (Kimbro, 2006; Sussner et al., 2008) than primiparous mothers of this population (Yun et al., 2009). Multiparous mothers were more likely to breastfeed longer than first time mothers (Kimbro, 2006; Martens, 2002; Simard et al., 2005). Parity did not significantly affect exclusive breastfeeding rates (Petrova et al., 2009).

Employment and School Attendance

Breastfeeding duration is negatively affected by a low-income mother's return to work in the postpartum period. Mothers who returned to work early (i.e., between 2 to 4 months) were less likely to continue breastfeeding compared to mothers who returned to work later (i.e., 7 months postpartum or later) (Langellier et al., 2011). Raccine et al. (2009) found that returning to work had a dose-response effect regarding breastfeeding duration. The risk of discontinuing breastfeeding increased based on increased hours worked (Raccine et al., 2009). Rojjanasrirat and Sousa (2010) found that low-income women anticipated challenges and substantial barriers to combining breastfeeding and work or school in terms of changes, role conflicts, priority shifts and financial impacts. Results regarding exclusive breastfeeding duration in low-income women were inconclusive. Petrova et al. (2009) found that low-income mothers' return to work in the postpartum period did not significantly affect exclusive breastfeeding rates. Conversely, Langellier et al. (2011) concluded that mothers who returned to work early were less likely to be exclusively breastfeeding and do so for a shorter period of time than those who returned to work later.

Maternal Characteristics

The effect of the following maternal characteristics on breastfeeding outcomes is described in the following section: previous breastfeeding experience; overweight and obesity; smoking; and stress and depression.

Previous Breastfeeding Experience

A low-income mother who had previously breastfed was significantly more likely to breastfeed for a longer duration than a mother who had not (Bolton et al., 2009;

Meyerink & Marquis, 2002). The effect of previous breastfeeding experience on exclusive breastfeeding is not conclusive. Petrova et al.'s (2009) RCT found that previous experience with breastfeeding did not significantly affect the exclusive breastfeeding rate of low-income women. Bonchuck et al.'s (2005) RCT determined that not having breastfed a previous child was significantly and positively related to low breastfeeding in low-income women.

Overweight and Obese

There are currently no studies specific to low–income women that explore the effect of obesity on breastfeeding duration. However research in this area conducted with women from across all income levels has found that maternal obesity is inversely linked to breastfeeding duration (Forster, McLachlan & Lumley, 2006; Thulier & Mercer, 2009; Wojcicki, 2011) and exclusive breastfeeding (Chevalier Mckechnie et al., 2009).

Maternal Smoking

Maternal smoking is negatively associated with exclusive breastfeeding (Kristiansen, Lande, Overby & Andersen, 2010; Li et al., 2008; McLeod, Pullon & Cookson, 2002; Scott, Landers, Hughes & Binns, 2006) and breastfeeding duration (Amir & Donath; 2002; Forster et al., 2006; Gilgia, Binns & Alfonso, 2006; Kristiansen et al., 2010; Li et al., 2008; Scott, Binns, Oddy & Graham, 2006; Thulier & Mercer, 2009) in research not specific to low-income women. Dennis (2002) in her breastfeeding initiation and duration literature review highlighted a relationship between "smoking dose" and the establishment of exclusive breastfeeding. Women who smoked the most were the least likely to establish exclusive breastfeeding (Dennis, 2002).

Although the research regarding smoking and shortened exclusive and overall breastfeeding duration is not specific to low-income women this association is of particular concern for this population as research has determined current Canadian smokers often occupy a marginalized social position (Greaves, Jategaonkar & Sanchez, 2006; Greaves et al., 2003) Smoking has been found to be associated with low-income and low levels of education, and with unemployment (Greaves et al., 2006; Greaves et al., 2003; Women's Health Data Directory, 2011). For women, socioeconomic status, as well as education and age were important factors related to smoking during pregnancy (Women's Health Data Directory, 2011). Women who were living on a low-income, were young, single mothers with a lack of social support, had a partner who smoked and/or had a high level of nicotine dependence before becoming pregnant were more likely to smoke during pregnancy and postpartum (Greaves et al., 2003). Therefore as low-income women are more likely to smoke and smoking is associated with shorter exclusive and any level of breastfeeding it can be postulated that low-income women, particularly those who smoke may be particularly at risk for premature discontinuation of breastfeeding.

Stress and Depression

In research involving breastfeeding women of varying income levels, it was found that social isolation decreased breastfeeding initiation (Heaman et al., 2012), and maternal stress (Li et al., 2008), maternal depression and depressive symptoms (Pippins, Brawarsky, Jackson, Fuentes-Afflick & Haas, 2006; Taveras et al., 2003) negatively affected breastfeeding duration. Li et al. (2008) found mothers who had experienced stressful life events during pregnancy such as divorce or separation, marital or

relationship problems, financial problems and residential moves in pregnancy were more likely to discontinue breastfeeding (Li et al., 2008). Higher levels of relationship distress (Sullivan, Leathers & Kelley, 2004) and psychological distress (Heaman et al., 2012) resulted in lower breastfeeding initiation rates and higher cessation rates.

There is limited research regarding the relationship between low-income women's stress and breastfeeding duration. Chung, McCollum, Elo, Lee and Culhane (2004) determined there was an overall trend toward a decline in breastfeeding rates with increasing depressive symptoms, although this finding was not statistically significant (Chung et al., 2004). Racine et al. (2009) found a significant association between maternal depressive symptoms and breastfeeding cessation throughout the infant's first year.

Breastfeeding Specific Factors

The role that breastfeeding specific factors such as intention; confidence or self-efficacy; and knowledge play in determining breastfeeding outcomes is described in this section.

Breastfeeding Intention

Maternal infant feeding intention is related to breastfeeding initiation and duration in studies that were not specific to low-income women (Blyth et al., 2004; Dennis, 2002; DiGirolamo, Thompson, Martorel, Fein & Grummer-Strawn, 2005; Donath, Amir, & ALSPAC Study Team, 2003; Donath, Amir, & ALSPAC Study Team, 2004; Sheehan et al., 2001). Women who did not intend to breastfeed or intended to breastfeed for a short period of time were less likely to initiate breastfeeding (DiGirolamo et al., 2005). Women who decided to breastfeed prior to pregnancy breastfed for a longer period of

time and the earlier the decision to breastfeed was made the greater the breastfeeding duration (Dennis, 2002; Digiorlamo et al., 2005; Donath et al., 2003). There was a consistently positive relationship between intended and actual duration of breastfeeding (Blyth et al., 2004; Dennis, 2002; Donath et al., 2003; Donath et al., 2004; Kronborg & Vaeth, 2004; Sheehan et al., 2001; Wilhelm, Rodehorst, Stepans, Hertzog & Berens, 2008) and between intended and actual exclusive breastfeeding duration (Bai, Middlestadt, Peng & Fly, 2010; Chezem, Friesen & Boettcher, 2003).

The limited research that has been conducted in this area specific to low-income women suggests that breastfeeding intention is a predictor of breastfeeding behavior (Bonuck et al., 2005; Tenfelde, Finnegan & Hill, 2011). Low-income women's feeding intentions during pregnancy predicted the feeding method used and the greater the intention to breastfeed, the more likely the mothers were to breastfeed (McMillan et al., 2009; Mistry, Freedman, Sweeney & Hollenbeck, 2008). The timing of this decision affected breastfeeding outcomes. Women who were undecided about their feeding choice prenatally had a greater risk of breastfeeding at a lower level and were less likely to breastfeeding exclusively than those women who decided to breastfeed prenatally (Bonuck et al., 2005). Researchers found that low-income mothers who reported a prenatal intention to breastfeed longer (Langellier et al., 2011) or exclusively (Langellier et al., 2011; Tenfelde et al., 2011) were more likely do so than their counterparts who did not report these intentions.

Breastfeeding Confidence/Self-Efficacy

Breastfeeding confidence or self-efficacy is defined as a mother's confidence in her ability to breastfeed her infant (Dennis, 1999). It refers to a "woman's belief or

expectation that she possesses the knowledge and skills to successfully breastfeed her infant" (Chezem et al., 2003). Research involving participants from a cross-section of incomes determined breastfeeding self-efficacy was positively associated with overall breastfeeding duration (Baghurst et al., 2007; Blyth et al., 2002; Dunn, Davis, McCleary, Edwards & Gaboury, 2006; Ertem, Votto & Leventhal, 2001; Martens & Young, 1997; Papinczak & Turner, 2000; Taveras et al., 2003; Wilhem et al., 2008) and length of exclusive breastfeeding (Dennis, 2006; Semenic, Loiselle & Gottlieb, 2008). Although there is limited research regarding breastfeeding confidence and its effect on low-income women's breastfeeding behaviors, studies suggest that breastfeeding self-efficacy is positively associated with breastfeeding intention and initiation (Hill, Arnet & Mauk, 2008; Hoddinott & Pill, 1999) and continued breastfeeding (Entwistle, Kendalll & Mead, 2010; Hill et al., 2008).

Breastfeeding Knowledge

The role that women's knowledge regarding breastfeeding has on breastfeeding duration in both the general population and low-income women is inconclusive. This may be due to breastfeeding research defining this knowledge in different ways. Some authors explored breastfeeding knowledge in terms of the advantages it offers. These researchers found that although low-income women knew the benefits of breastfeeding (MacGregor & Hughes, 2010) and believed that breastfeeding was the best way to feed their infants (Kaufman, Deenadayalan, & Karpati, 2010), their commitment turned to ambivalence and feeding practices were provisional due to their view of the virtues of formula when faced with the challenges of breastfeeding (Kaufman et al., 2010; MacGregor & Hughes, 2010). Andrew and Harvey's (2011) qualitative work with

breastfeeding women of undefined socio-economic status found that participants had detailed understanding of the specific benefits of breastfeeding for their infants but that few showed awareness of the length of time it is recommended that breastfeeding continue or the benefits for themselves. Their research found that higher degrees of belief in the reputed benefits of breastfeeding positively affected exclusive breastfeeding (Andrew & Harvey, 2011).

Other researchers have defined breastfeeding knowledge in terms of a combination of: a woman's knowledge of the advantages of breastfeeding; the physiology of breastfeeding; and breastfeeding management (Chezem et al., 2003). Research pertaining to women mainly from higher income brackets determined that breastfeeding knowledge, as defined above, was strongly correlated with breastfeeding confidence and actual lactation duration (Chezem et al., 2003).

Some authors have noted that it may be the knowledge that comes from the exposure to other women breastfeeding that may impact women's breastfeeding initiation and duration (MacGregor & Hughes, 2010). Prior exposure to breastfeeding was influential in a positive or negative way for low-income women depending on the context (Hoddinott & Pill, 1999; MacGregor & Hughes, 2010). They also found a women's history of exposure to breastfeeding was more strongly associated with breastfeeding initiation and less strongly associated with duration and exclusivity of breastfeeding (Hoddinott & Pill, 1999).

Supports

The following section discusses the effect that support from partners, family, friends, professionals and paraprofessionals has on breastfeeding outcomes.

Partner, Familial and Friends

Low-income women's partners, family and friends' influence on breastfeeding duration is not conclusive, largely due to the limited amount of research completed in this area. However, some researchers have found that lack of support, whether professional, paraprofessional or familial, hindered the breastfeeding process (Locklin, 1995). Heinig et al. (2006) determined that although low-income mothers relied on relatives and others for infant feeding guidance there was no consensus in the research as to which group was pivotal in providing support to low-income breastfeeding women. Heinig et al. (2009) noted that women relied primarily on experienced family and friends for advice and frequently use their own intuition to solve infant-feeding problems. Greathouse (2008) found that home based support from a participant's spouse, family or friends seemed to be the most beneficial means of assistance as compared to professional or paraprofessional support. Hurst (2007) determined mothers' reports of personal encouragement from their partner or primary support person was a significant predictor of breastfeeding duration. Barona-Vilar, Escriba-Aguir and Ferrero-Gandia (2009) found that among women from lower socio-cultural backgrounds, friends were the closest social network and had the greatest influence on feeding decisions for women.

Research conducted with women from varying socio-economic groups has shown the importance of partners, family and friends in influencing breastfeeding duration. Partners supportive of breastfeeding significantly and positively affect breastfeeding duration (Olayemi et al., 2007; Scott et al., 2001; Swanson & Power, 2005). Research found mixed results regarding this type of support (i.e., partner) on exclusive breastfeeding (Olayemi et al., 2007; Bai, Middlestadt, Peng & Fly, 2009). Support from

female relations significantly and positively influenced the total duration of breastfeeding and the duration of exclusive breastfeeding (Olayemi et al., 2007). The approval and support of friends and other family was determined to be a positive factor influencing a mother's decision to continue exclusively breastfeeding (Bai et al., 2009).

Professional and Lay Support

Professional and lay support (peer counselor support) was found to affect both exclusive breastfeeding and any level of breastfeeding in recent meta-analyses and systematic reviews (Britton, McCormick, Renfrew, Wade & King, 2007; Chapman, Morel, Anderson, Damio & Perez-Escamilla, 2010; Renfrew, McCormick, Wade, Quinn & Dowswell, 2012). Studies in this area were rarely specific to low-income women and therefore may not be representative of this population. The following section discusses the timing and the effectiveness of these two types of support in the antenatal and/or postpartum period and the effect of income level of the country where the study was conducted may have on exclusive breastfeeding and overall duration. Research regarding the delivery method of support as well as the limited research specific to low-income women and support is also discussed.

Postnatal breastfeeding support by peer counsellors and lactation consultants positively affected breastfeeding duration and exclusivity (Renfrew et al., 2012). The sole utilization of antenatal breastfeeding education from these groups and/or the use of formal antenatal breastfeeding education showed either a small effect size (Lumbiganon et al., 2012), or no effect on overall breastfeeding duration and exclusivity (Jolly et al., 2012; Renfrew et al., 2012). There is at present no consensus as to the intensity threshold of professional support that positively affects breastfeeding exclusivity and duration.

Jolly et al. (2012) found that peer support had a greater effect on any level of breastfeeding but not exclusive breastfeeding rates when provided in higher intensity.

Professional and/or lay support intervention was found to positively affect the duration of *exclusive breastfeeding* and *any level of breastfeeding* (Britton et al., 2007; Chapman et al., 2010; Renfrew et al., 2012). Research was inconclusive as to which type of support or combination of support was most effective at improving overall breastfeeding duration. Britton et al. (2007) found the effect size of support interventions such as professional and lay support on reducing the cessation of *any breastfeeding* was modest. They also determined that "professional support, lay support and combinations of lay and professional support did not differ significantly in their effect on the continuance of *any breastfeeding*, though there was a tendency for combined professional and lay support to be more effective" (Britton et al., 2007, p. 9). Conversely, Renfrew (2012) determined that support solely from non-professionals had a greater positive effect on increased overall *breastfeeding duration* as compared to the positive effect of professional support and combined professional and lay support. The effect of lay and professional support was greatest on the prolongation of *exclusive breastfeeding* (Britton et al., 2007). Britton et al. (2007) determined that lay support and combinations of lay and professional support were more effective than professional support alone in prolonging the continuance of *exclusive breastfeeding* (Britton et al., 2007). On the contrary, Renfrew et al. (2012) determined that support solely from non-professionals had a greater positive effect on breastfeeding *exclusivity* as compared to the positive effect of professional support and combined professional and lay support.

Peer support interventions had a significantly greater effect on any breastfeeding and exclusive breastfeeding in low or middle income countries compared to high income countries, such as Canada (Jolly et al., 2012). The delivery method of the support – predominantly face-to-face; predominately telephone; or both face-to-face and telephone -- was also noted to be important in its effect on breastfeeding duration and intensity (Renfrew et al., 2012). Receiving predominately face-to-face support positively affected women's exclusive breastfeeding (Renfrew et al., 2012). There was no significant positive effect on exclusive breastfeeding for women who received support predominantly by telephone or support that involved both face-to-face and telephone contact (Renfrew et al., 2012). Nor was there a difference between the effects of the three types of support noted above on overall breastfeeding duration (Renfrew et al., 2012).

Limited research regarding low-income women discusses primary care-based interventions, the weight breastfeeding women place on support, and the type, timing and adequacy of support received. One systematic review and meta-analysis of RCTs specific to low-income women was completed by utilizing only studies of primary care-based interventions that could be implemented by a general practitioner to promote breastfeeding (Ibanez et al., 2012). They found that educational programs were effective for encouraging breastfeeding initiation and breastfeeding duration for low-income women when multiple "short" follow-up appointments were included as part of the intervention.

Research regarding the value that low-income breastfeeding women place on professional or lay support was mixed. Hurst (2007) determined professional

encouragement of feeding choice was a significant predictor of breastfeeding duration for low-income mothers who initiated breastfeeding. Barona-Vilar et al. (2009) found women from lower socio-cultural backgrounds conceded less importance to formal health support as compared to higher income women.

The type, timing and perceived adequacy of professional support received by low-income women was also noted in the literature. Cross-Barnet, Augustyn, Gross, Resnik and Paige's (2012) qualitative U. S. research with low-income women found most mothers received breastfeeding education or support from a medical professional prenatally, at the hospital or during the child's infancy, but most also reported receiving no education or support at one or more of these stages. Low-income women reported the breastfeeding "education and support was cursory and inadequate", incorrect information was provided and that some of the practitioners they encountered were hostile or indifferent to breastfeeding (Cross-Barnet et al., 2012, p. 1). These women were not given referrals to available resources even after reporting breastfeeding difficulties and "received inconsistent messages regarding breastfeeding within and across institutions" (Cross-Barnet et al., 2012, p. 1). Professional advice was perceived by low-income women as credible when caregivers exhibit characteristics similar to those of experienced family and friends and are confident, empathetic, respectful and calm in their provision of this advice (Heineg et al., 2009).

Breastfeeding Practices and Policies

Certain hospital practices and policies have been linked to decreased breastfeeding level and duration (Dennis, 2002; Murray, Ricketts, & Dellaport, 2007). Although this research is not specific to low-income women, women in this socio-economic group

would be affected by these hospital and community practices and policies. Rooming-in and early breastfeeding initiation were positively linked to longer breastfeeding duration (Dennis, 2002). Conversely, supplementary feeding with formula decreased overall breastfeeding duration (Dennis, 2002; Howard et al., 2003) and exclusive breastfeeding duration (Haiek, Gauthier, Brousseau & Rocheleau, 2007; Howard et al., 2003; Semenic et al., 2008). The provision of commercially prepared hospital discharge packs also decreased overall breastfeeding duration (Dennis, 2002). Conflicting information regarding early hospital discharge and its effect on breastfeeding duration is noted in the literature (Brown, Small, Argus, Davis & Krastev, 2009; Dennis, 2002; Heck, Schoendorf, Chavez, & Braveman, 2003; Waldenstrom & Aarts, 2004). This may be related to the differences between studies in terms of the type of in-hospital and community follow-up received by breastfeeding women in these studies. The utilization of pacifiers has been found to be linked to breastfeeding duration. Jaafar, Jahanfar, Angolkar and Ho's (2012) Cochrane review determined that it is the timing of the introduction of pacifier use that affected breastfeeding duration; if the pacifier utilization started from birth or after lactation was established it did not affect the prevalence or duration of exclusive and partial breastfeeding. Conversely, other researchers consistently found pacifier use negatively affected breastfeeding duration (Santo, de Oliveira, & Giugliani, 2007; Victora, Behague, Barros, Olinto, & Weiderpass, 1997). However these researchers also noted that pacifier use may be a marker of breastfeeding difficulties rather than the direct cause of the reduction in breastfeeding duration or exclusivity (Santo et al., 2007; Victora et al., 1997).

Based on concerns raised in the literature regarding the negative effects of hospital and community practices on breastfeeding and concerns regarding the marketing of non-human milk substitutes, the WHO/UNICEF developed the Baby-Friendly Hospital Initiative (BFHI). Employing the World Health Organization's (WHO) BFHI as a healthcare policy strategy has improved breastfeeding rates (Kramer et al., 2001; Martens, 2012). The strongest evidence for the ability of the BFHI strategy to affect change in breastfeeding outcomes for women is found in the RCT, conducted by Kramer and associates (Martens, 2012). In their RCT the implementation of the BFHI resulted in intervention infants (i.e., infants born at hospitals where BFHI was implemented) being significantly more likely than control infants to be breastfed to any degree and more likely to be exclusively breastfed than those infants born at hospitals where the BFHI was not implemented (Kramer et al., 2001). The BFHI had a more a significant effect on breastfeeding exclusivity than overall breastfeeding duration (Martens, 2012). Other less rigorous research (studies that were not RCT) also found the implementation of BFHI affected breastfeeding outcomes. This research determined that infants born to women in Baby-Friendly accredited hospitals were more likely to be breastfed (Beake, Pellowe, Dykes, Schmied & Bick, 2011; Broadfoot, Britten, Tappin & MacKenzie, 2005; Merewood, Mehta, Chamberlain, Philipp & Bauchner, 2005), exclusively breastfed (Beake et al., 2011; Broadfoot et al., 2005; Dall'Oglio et al., 2007; Merewood et al., 2007) and breastfed for a longer duration (Camurdan et al., 2007; Merten, Dratva & Ackermann-Liebrich, 2005). Researchers however noted that the effect of BFHI was limited because many studies found its benefit limited to breastfeeding initiation (Bosnjak, Batinica, Hegedue-Jungvirth, Grguric & Bozikov, 2004) and that exclusive

breastfeeding and duration rates fell rapidly thereafter (Coutinho, Cabral de Lira , de Carvalho Lima & Ashworth , 2005). Coutinho et al. (2005) proposed that reliance on the BFHI as a strategy for breastfeeding promotion should be reassessed and that a combination of hospital-based and community based promotional systems be established. Bosnjak et al. (2004) postulated that to achieve better duration and maintenance of breastfeeding, continued support for mothers in the community was required.

Implementation of the WHO's BFHI policy at a national and provincial level is occurring. The Breastfeeding Committee for Canada (BCC) (2010), the Canadian National Authority for the WHO/UNICEF Baby-Friendly Initiative (BFI) developed practice outcome indicators for both Baby-Friendly Hospitals (the Ten Steps) and for Baby-Friendly Community Health Services (the Seven Points). In 2010 these documents were integrated into one document (Appendix A). This document outlines the measures required of hospitals and community agencies to become Baby-Friendly accredited. In Manitoba, the Breastfeeding Promotion Steering Committee of Manitoba has made recommendations for Manitoba hospitals to be more Baby-Friendly as per the WHO's BFHI (Martens, Phillips, Cheang, & Rosolowich, 2000). The provincial strategy for Manitoba regarding the implementation of the BFI, as coordinated by the Baby Friendly Manitoba Committee is contained in Appendix B. At present no provincial hospital or community health service agency has achieved Baby-Friendly designation. Health agencies and hospitals are in various stages of the assessment and implementation of the strategies outlined in the BFI (Ridd & Romphf, 2012). In 2013, an updated Manitoba Provincial Breastfeeding Stategy was released (Government of Manitoba, 2013). This document notes the following provincial target: achievement of Baby Friendly Initiatve

accreditation in 75 % of all Manitoba birthing hospital/centres that have more than 100 births/year and 75 % of all provincial community public health offices by 2018 (Government of Manitoba, 2013). Also noted in this 2013 provincial strategy is the need to address the gap between breastfeeding initiation, exclusivity and duration rates between different socio-economic groups and strategic actions to address this issue (Government of Manitoba, 2013).

Women's Experiences of Breastfeeding

Research regarding women's breastfeeding experiences has largely been conducted with higher income women or a cross-section of women with variable income levels. Burns, Schmied, Sheehan and Fenwick (2010) noted in their meta-ethnographic synthesis of women's experiences of breastfeeding that although the diversity and similarities of the experiences of breastfeeding for women across Western societies are highlighted, the research predominantly articulates the Caucasian woman's experience of breastfeeding. The following section synthesizes the literature regarding women's experiences of breastfeeding and is not specific to low-income women.

Meta-syntheses of qualitative breastfeeding studies found breastfeeding to be "an engrossing, personal journey, which is physical, and requires maternal commitment, adaptation and support from multiple sources" (Nelson, 2006, p. e13) and as determined by two central processes, namely making a personal choice and defending the choice (Nelson, 2012). Researchers also described the following breastfeeding experience themes: the physical and emotional aspects of breastfeeding (Burns et al., 2010; Nelson, 2006); perseverance (Avery, Zimmermann, Underwood & Magnus, 2009; Burns et al., 2009); confidence (Burns et al., 2010; Marshall, Godfrey & Renfrew, 2007; Williamson,

Leeming, Lyttle & Johnson, 2011); idealized expectations of breastfeeding versus the reality of the experience (Burns et al., 2010; Williamson et al., 2011); maternal identity (Burns et al., 2010; Marshall et al., 2007; McBride-Henry, 2010; Williamson et al., 2011); learning (Marshall et al. 2007), endurement of pain and uncertainty (Willliamson et al., 2011); support or lack of support by peers, professionals, family or partners (Burns et al., 2009; Marshall et al., 2007; Nelson, 2006); hospital to home transition (Marshall et al., 2007); breastfeeding in public and the difficulties or challenges associated with this (Nelson, 2006, 2012); and the inter-embodied experience of breastfeeding (Ryan, Todres & Alexander, 2011).

Experience of Breastfeeding: Research Specific to Low-Income Women

Nine qualitative studies of adequate quality have been completed in the past 20 years with low-income women as the source of research and information regarding their experience of breastfeeding. MacGregor and Hughes (2010) is the only review of breastfeeding experiences of mothers from disadvantaged groups completed to date. The authors defined disadvantaged to include both low-income women and adolescent mothers. Due to maturation and developmental factors, the experience of breastfeeding in adolescence may be markedly different than that of older, low-income mothers. Therefore MacGregor and Hughes' (2010) and McFadden and Toole's (2006) qualitative research, both of which included adolescent mothers, has not been included in the discussion below of the breastfeeding experiences of low-income women.

Due to the uniqueness of the health care systems and social policies (e.g., maternity leave length and benefits), the distinctive culture and subcultures of each country and the potential variability between nations as to breastfeeding beliefs and

practices, the breastfeeding experience of low-income women may vary between nations. It is therefore particularly important to consider Canadian based research in this area. The nine studies specific to low-income women were conducted in developed nations but none were completed in Canada. Prior to 1992 some qualitative research in this specific topic area, such as Bottorff's (1990) phenomenological research regarding the experience of breastfeeding of Canadian women, was completed. Bottorff's (1990) research unfortunately does not specify the socioeconomic status of its participants.

Research completed prior to 2000 may not reflect the current context that breastfeeding women experience in their lives in terms of maternity leave and maternity leave benefits, the nature of breastfeeding support and breastfeeding initiatives (e.g., Baby Friendly Hospital and Community Initiatives that have been or are currently being implemented) and the messages these women and their families and communities receive regarding breastfeeding. As the breastfeeding experiences of low-income women occur within, and therefore need to be considered within the social, cultural, physical and emotional context in which these women and their families live, utilizing research from 2000 and onward in this subject area is prudent. Unfortunately due to the limited number of qualitative studies regarding this topic and with low-income women, research from the past 20 years is included in this literature review of the breastfeeding experience of low-income women.

The following is a brief summary of the nine qualitative research studies that are included in this literature review. Table 1 provides an overview of each of these studies, their purpose and limitations.

Table 1: Overview of Qualitative Research Studies of Low-Income Women

Citation	Type of Study & Purpose	Population Size and Description	Limitations
Bailey, Pain & Aarvold (2004) UK	Exploratory; purposive sampling; Examine cultural expectations & experiences of breastfeeding in low-income women	N=16 1:1 interviews antenatally and 3-9 wks. postpartum	Limited sample demographic information provided. Did not specify low-income criteria. Ethnographic qualitative approach would be a better fit for this research question.
DaMota et al.(2012) USA	No approach noted; Convenience sampling; Understand the facilitating factors and decision-making process surrounding maternal request for formula in the early postpartum period	N=12 focus groups (total N=96) English and Spanish speaking WIC mothers	Limited geographic population; only included women who intended to breastfeed; Did not ask why requested formula was not used
Greathouse (2008) USA	Phenomenological; purposeful and extreme sampling; Identify factors affecting the breastfeeding experience of low-income who breastfed successfully to 6 months postpartum.	N= 6 Hispanic and Caucasian WIC mothers; breastfed > 6 months & contact with peer counselor; 1:1 interviews	Small sample/potential for saturation not to be reached – risk to transferability of result
Hoddinott & Pill (1999) UK	Grounded theory; purposeful sampling; Understand how low-income primiparous women make their infant feeding	N=21 Caucasian 1:1 interviews antenatal and 6 - 10wks postpartum; & N=2 focus groups with sources of	Some 1:1 interview conducted with other family members present – women less likely to share true experience and choices. Did not specify low-income criteria.

	choice.	support (N=10 in total)	
Johnsen (2002) USA	Phenomenological; extreme & deviant case sampling; Identify factors or characteristics of low-income women that aid in increasing the average breastfeeding duration in women with breastfeeding difficulties	N=14 women currently breastfeeding; 1:1 interviews via telephone or in person	Some interview conducted by telephone as opposed to in-person so risk for poorer quality data. Author developed own criteria of breastfeeding hardship and excluded participants on her subjective interpretation of breastfeeding difficulties. Limited demographic data collected.
Locklin (1995) USA	Grounded theory; theoretical sampling; Generate substantive theory regarding phenomenon of breastfeeding among this population (minority women)	N=17 Latin and African American WIC participants receiving peer counseling; 1: 1 interviews	Failure to define breastfeeding (exclusive or partial) Reliability issues as participant's recollection of early breastfeeding event/ experiences influenced by later breastfeeding events
Locklin & Naber (1993) USA	Grounded theory; Convenience sampling; To examine the breastfeeding experiences of a small group of educated, low-income, minority women.	N=10 Hispanic and African American WIC eligible participants who were also peer counselor recruitees; 1:1 interviews	Small sample – risk of not reaching saturation and risk to credibility and transferability of results. Not generalizable to all low-income population as well educated, low-income women and only included those that had long term breastfeeding experience (i.e., 6 months to > 2 years).
Raisler (2000) USA	No noted research approach; Convenience sampling; Determine experiences of low-income women's breastfeeding care	N=7 Focus groups (N=42 total WIC Black or Caucasian)	Unclear if research approach matches methods as same not noted. Participants recruited by peer counselors and focus groups held in WIC offices – could inhibit criticism of this portion of the breastfeeding

	in the health care system and their integration of breastfeeding into their daily lives.		experience
Scott & Mostyn (2003) Scotland	No noted research approach; purposeful sampling; Explore the breastfeeding attitudes and experiences of low-income women breastfeeding in an environment where bottle-feeding was the cultural norm; Other goal was to evaluate the acceptability and effectiveness of peer-support breastfeeding intervention.	N=4 focus groups (19 total participants) who had contact with peer counsellor	No demographic or descriptive data of participants provided. Small number of participants in focus groups. Unclear how authors decided to discontinue offering focus group (small total number of participants). Did not include women who did not have contact with peer counselor so unable to compare cultural differences between these 2 groups. No notation of the research approach so unclear if methods match approach. Multiple research goals that would require different approach or methods. Did not specify low-income criteria.

Critique of Qualitative Breastfeeding Studies Specific to the Breastfeeding Experiences of Low-Income Women

The main concerns applicable to some of the qualitative studies noted in the above table are the failure to define low-income, the sole utilization of focus groups (e.g., Raisler, 2000; Scott & Mostyn, 2003) and the use of telephone interviews (i.e., Johnsen, 2002). The US based studies clearly define income level. Other studies do not provide criteria as to the definition of low-income and how their participants met these criteria. These studies either did not specify an income cut off or described eligible participants

merely as living in low-income areas. The absence of a clear definition of what low-income is and who was included in these studies therefore affects the findings and the applicability of the results of this research.

The data collection method most appropriate for low-income women is face-to-face communication of a 1:1 nature. One to one interviews with this vulnerable population regarding a sensitive and personal subject -- their experiences of breastfeeding care in the health system and the integration of breastfeeding into their daily lives – would be more likely to gather accurate, unencumbered and reliable data (Holloway & Wheeler, 2010). This method allows for the collection of detailed and rich data regarding a sensitive topic among low-income women, a potentially marginalized population that may be reluctant to provide written feedback or complete questionnaires or speak candidly in a group setting. Some of the above noted studies, namely DaMota, Banuelos, Goldbronn, Vera-Beccera and Heinig (2012), Raisler (2000) and Scott and Mostyn (2003) solely utilized focus groups as a data collection method. Focus groups can result in one or two individuals dominating the discussion and influence the outcome or even introduce bias, as other participants may be compliant and not voice their experiences or true feelings and ideas (Holloway & Wheeler, 2010). This would therefore potentially affect the quality, in terms of accuracy and trustworthiness, of the data collected. The quality of the data collected in an in-person qualitative interview is also superior to that collected via a telephone interview with this particular population due to the sensitive and personal nature of the topic in question. Telephone interviews do not allow for deeper interaction, as the interviewer does not get to know the participants (Holloway &

Wheeler, 2010). This would therefore affect the quality of the data collected in Johnsen's (2002) research that employed both 1:1 in person interviews and telephone interviews.

Themes and Results of Qualitative Breastfeeding Studies Specific to the Breastfeeding Experiences of Low-Income Women

Among the nine qualitative studies specific to low income women, similarities and differences are noted in the findings. This occurred for a variety of reasons. The objectives of the research, the questions asked by the researcher, the type of participants, the country where the research was completed, and the type of health care system in the country where the research was conducted affected the responses of the participants and therefore the findings. Table 2 outlines the results or general themes noted in these nine studies.

Table 2: Results of Qualitative Research Studies Specific to Low-Income Women

Author	Overall Theme/Findings	Other Themes/Comments
Bailey et al. (2004) UK	Decision regarding breastfeeding cessation made within first few days after birth as women negotiated the pathways of informal cultures of feeding and availability and quality of formal care. Overall theme: "Give it a Go culture" of breastfeeding	Themes: Informal cultures of feeding (or "give it a go" breastfeeding culture); A pervasive bottle-feeding culture; Experiences of formal support (breastfeeding support in hospital and the transfer from hospital to home); The first few weeks: negotiating a successful breastfeeding trajectory
DaMota et al. (2012) USA	"Lack of preparation" for what the early postpartum period would be like.	Decision to formula feed fell into 3 categories: inadequate preparation for newborn care; lack of preparation for the process of breastfeeding; formula feeding as a solution to breastfeeding problems. Cultural factors were not noted

		as reason to supplement.
Greathouse (2008) USA	3 common themes identified by women that successfully breastfed to 6 months postpartum	3 themes: maternal characteristics of successful breastfeeding women; obstacles breastfeeding women need to overcome; vehicles of breastfeeding support
Hoddinott & Pill (1999) UK	Decision to initiate breastfeeding is influenced more by embodied knowledge gained from seeing breastfeeding rather than by theoretical knowledge about its benefits. Women who had regularly seen a relative or friend successfully breastfeed and described this experience positively were more confident about and committed to breastfeeding and more likely to succeed	5 categories of breast feeders according to confidence in their feeding intention and their commitment to a particular feeding method (and influenced by positive or negative exposure): committed breast feeders; probable breast feeders; possible breast feeders; probable formula feeders; committed formula feeders
Johnsen (2002) USA	4 main themes or characteristics that aided women in continuing to breastfeeding when they experienced breastfeeding difficulties: the problem; a reason to continue; some source of helpful support and believable advice; pride in their accomplishment.	Subthemes of the 4 themes: 1. The problem – types of difficulties faced to breastfeed, their need to talk about this problem and have others realize the problem was not insignificant; 2. Reason to continue – usually due to mother seeing breastfeeding for baby's health and because a. viewed infant as helpless and b. mother acting in a way that was selfless -- reason they were able to endure physical and mental pain; 3. Source of helpful support and believable advice – source helped strategize, take action and provided follow-up care and did so in caring way; 4. Pride in their accomplishment – wanted to let other know about their experience and help other

		mothers
Locklin (1995) USA	Successful breastfeeding can have an empowering effect on women when support for their endeavors are gender and culturally appropriate.	5 themes: Making the discovery; seeking a connection; comforting each other; becoming empowered; telling the world.
Locklin & Naber (1993) USA	Successful breastfeeding can have an empowering effect on women. 5 themes identified are factors that enhance successful breastfeeding	5 themes: Against all odds; personal motivation; support; attachment; telling the world.
Raisler (2000) USA	Women identified characteristics of helpful breastfeeding care providers and unhelpful care providers in their contact with the health care system in their antenatal, intrapartum and postpartum period. Incorporating breastfeeding into daily activities was challenging and related to ambivalence about physical bond of nursing; personal modesty/breastfeeding in public; and getting on with life at home, work or school	Helpful care provider characteristics: knew correct information; established supportive personal relationships; referred them to lactation specialists for problems; showed enthusiasm for breastfeeding; supported nursing through concrete actions in the prenatal, intrapartum and postpartum period Unhelpful care provider traits: gave misinformation; encouraged supplementation; provide routine breastfeeding care, were hard to contact when problems arose
Scott & Mostyn (2003) Scotland	For majority of women: no prior exposure to breastfeeding and received little or no support or advice from family or friends; peer was only source of breastfeeding support or guidance; preferred feeding in private and went to lengths to avoid public breastfeeding	Themes identified: Prior exposure to breastfeeding; Social support for breastfeeding; Importance of support provided by trained peer volunteers; Breastfeeding in public

The following themes were identified in the breastfeeding experience of low-income women: role of culture; prior exposure to breastfeeding; prenatal intention to breastfeed and good mothering; expectations versus the reality of breastfeeding;

breastfeeding obstacles or problems; reason to continue breastfeeding; persistence; bonding; breastfeeding in public; breastfeeding and returning to work or school; pride and empowerment; rationale for supplementation and breastfeeding cessation; and support (familial, peer professional and paraprofessional). Authors noted the informal and formal cultural aspect of the breastfeeding experience (Bailey, Pain & Aarvold, 2004). They noted the roles of the informal culture as the influence of partners, family, friends and the mothers' social networks and the formal culture as the hospital and home support provided by health care professionals, and how each culture shaped the feeding trajectory and the duration of breastfeeding (Bailey et al., 2004). Researchers found that some low-income women lived in communities where a bottle-feeding culture existed (Bailey et al., 2004) and that a current and historical tradition of breastfeeding did not exist within their family or community (Scott & Mostyn, 2003). This cultural context limited the women's prior exposure to breastfeeding (Scott & Mostyn, 2003) and their breastfeeding knowledge (Bailey et al., 2004), and allowed for the development of a "give it a go" breastfeeding culture (Bailey et al., 2004) and other breastfeeding cultural myths (Scott & Mostyn, 2003). Formal culture, in terms of maternal ethnic background and cultural heritage was also noted by Greathouse (2008) as an influential factor in terms of successful breastfeeding.

Prior exposure to breastfeeding was an important factor noted by researchers' qualitative interviews with breastfeeding women (Hoddinott & Pill, 1999). Researchers found that the history of women's exposure to breastfeeding in their family or community was associated with duration and exclusivity of breastfeeding and even more strongly associated with confidence in their own ability to breastfeed (Hoddinott & Pill, 1999;

Scott & Mostyn, 2003). Exposure to breastfeeding could be either a positive or a negative influence on breastfeeding, depending on the context (Hoddinott & Pill, 1999). Women who had seen breastfeeding only by strangers often described this as a negative influence particularly if other people were present (Hoddinott & Pill, 1999). Women who had regularly seen a relative or friend successfully breastfeed and described this experience positively, were more confident about and committed to breastfeeding, and were also more likely to succeed (Hoddinott & Pill, 1999).

Researchers identified prenatal intention to breastfeed and perception of good mothering as resulting in women's continued breastfeeding (Greathouse, 2008). The literature determined that the decision to breastfeed was made before pregnancy or in the prenatal period and seemed to be influenced by the mother's past experience with breastfeeding, prenatal education and the financial savings and benefits associated with breastfeeding (Greathouse, 2008). Women associated breastfeeding with being a good mother and indicated that by breastfeeding they fulfilled their obligation or duty to provide the best start for their babies (Greathouse, 2008).

Women's expectations regarding breastfeeding versus the reality of breastfeeding was a theme noted in the literature (DaMota et al., 2012: Scott & Mostyn, 2003). Researchers found that the majority of women were unprepared to encounter problems with breastfeeding although most did experience difficulties (Scott & Mostyn, 2003). Authors found that women perceived the message that breastfeeding is natural and interpreted this message to mean that it would come naturally and without difficulty (Scott & Mostyn, 2003). DaMota et al. (2012) noted that low-income women lacked

preparation for what the early postpartum period would be like in terms of newborn care and the process of breastfeeding.

Women described obstacles to overcome or problems encountered with breastfeeding as a common theme in their breastfeeding experience of low-income women (Greathouse, 2008; Johnsen, 2002). The physical demands of breastfeeding (e.g., sore nipples) and breastfeeding barriers were identified in terms of who or what the problems were centered around (Greathouse, 2008; Johnsen, 2002). The immediacy of breastfeeding or the need for immediate resolutions for breastfeeding issues were identified (Greathouse, 2008). Women also acknowledged the "learning curve" regarding the mechanics of early breastfeeding was a breastfeeding obstacle that required both baby and mother to practice in order to become proficient with feeding techniques and to gain a level of comfort between mother and baby (Greathouse, 2008). Mothers described the process whereby, after initially experiencing a time of stress and uncertainty, they made discoveries about their own bodies' capabilities and their newborn's competencies and they realized that once learned breastfeeding is easy (Locklin, 1995). The length of time required to master this "learning curve" varied from a few feedings to six weeks (Greathouse, 2008).

Researchers identified "a reason to continue" as an important finding in the research regarding the breastfeeding experience of low-income women (Johnson, 2002). This theme, referred to the mother choosing to initiate and continue breastfeeding for the infant's health (Johnsen, 2002). It also referred to mother's views of their infants as "helpless" and dependent; and the mother as acting in a way that was "selfless" (Johnsen, 2002, p. 2).

Persistence was a theme identified by researchers of women who continued to breastfeed or had longer breastfeeding duration (Greathouse, 2008; Hoddinott & Pill, 1999; Locklin & Naber, 1993). Researchers noted that "persistence appeared to be the major behavioral indicator resulting from personal motivation" or a strong sense of determination and commitment (Greathouse, 2008; Locklin & Naber, 1993, p. 32). The women who were most likely to continue breastfeeding, were more apt to mention perseverance and overcoming and coping with problems and did not bring up anticipated problems or doubt about their own or other women's ability to breastfeed (Hoddinott & Pill, 1999). Persistence exhibited itself in mothers' seeking of information and guidance to deal with problems, perseverance despite receiving no encouragement and in their approaches to problem solving that often involved trial and error (Locklin & Naber, 1993). It also referred to women continuing to breastfeed even when faced with medical complications, system barriers and other hurdles (Locklin & Naber, 1993).

Research identified the physical bond of breastfeeding or attachment as an important characteristic of low-income women's breastfeeding experience (Locklin & Naber, 1993; Raisler, 2000). Many women demonstrated their deep satisfaction and emotional investment in their infants via poignant definitions of attachment as part of breastfeeding (Locklin & Naber, 1993). Other mothers viewed "the physical bond of nursing as both an asset and a liability" in terms of the "special closeness that they felt that breastfeeding engendered" and conversely the downside of this bond was feeling restricted or tied down by nursing (Raisler, 2000, p. 258). Low-income women spoke of the "ambivalence about the physical bond of nursing" and commented that while they

thoroughly enjoyed nursing, “it held them back from getting on with their lives” in terms of resuming activities at home, work or school (Raisler, 2000, p. 258).

The literature regarding the breastfeeding experience of low-income women consistently identified these women as expressing concerns regarding breastfeeding in public and modesty about exposing the private act of breastfeeding (Greathouse, 2008; Hoddinett & Pill, 1999; Johnsen, 2002; Raisler, 2000; Scott & Mostyn, 2003). They went to great lengths to avoid having to breastfeed in public and employed careful planning when preparing for excursions (Scott & Mostyn, 2003). Some women even confined themselves to their homes or restricted their movements while breastfeeding to avoid having to nurse in public (Scott & Mostyn, 2003). The distinction between private and public breastfeeding was highly variable and individual (Raisler, 2000), as was in whose presence women felt comfortable to breastfeed (Hoddinott & Pill, 1999; Raisler, 2000). Some women reached the stage where they finally overcame their embarrassment and breastfed at home in front of others or breastfeeding a public setting (Scott & Mostyn, 2003).

Researchers identified the importance of returning to work or school and its effect on the breastfeeding experience of low-income women (Greathouse, 2008; Johnsen, 2002; Raisler, 2000). Women agreed that working made breastfeeding much more difficult (Raisler, 2000) and credited staying home to care for their infants and not working as an enabler for long-term breastfeeding, identifying “accessibility to their infants around the clock as an enabler for sustained lactation” (Greathouse, 2008, p. 56). Female students described situations that were more conducive to continued breastfeeding such as family members caring for their infants while they attended classes

and flexible schedules that allowed them time to pump (Raisler, 2000). Women noted that their workplaces contained no breastfeeding amenities to express or store breast milk and because of busy home schedules they found it difficult to build up a supply of expressed breast milk (Raisler, 2000).

Pride and empowerment were themes described in the literature when women achieved and experienced successful breastfeeding (Greathouse, 2008; Johnsen, 2002; Locklin, 1995; Locklin & Naber, 1993). Low-income study participants considered breastfeeding successfully an accomplishment (Greathouse, 2008; Johnsen, 2002). "Becoming empowered" was evidenced by the mothers' reliance on "their own intuitive and critical judgment" and their ability to assert themselves (Locklin, 1995, p. 289). A desire by low-income women to share their accomplishment and their experience of breastfeeding was also noted (Johnsen, 2002; Locklin, 1995; Locklin & Naber, 1993).

The rationale for the initiation of artificial milk and breastfeeding cessation was also noted in the literature (Bailey et al., 2004; DaMota et al., 2012). Researchers found the main reasons participants initiated the use of artificial milk were: they were not producing enough milk; their infant was losing weight or was very unsettled; their partner wanted to be more actively involved in feeding; exhaustion/anxiety; and pain or sore cracked nipples (Bailey et al., 2004); inadequate preparation for the experience of caring for their newborns; lack of knowledge about the process or physiology of breastfeeding; and the belief that formula was the solution if breastfeeding was perceived as ineffective (DaMota et al., 2012). Researchers determined there were many influences on women's decision-making regarding breastfeeding cessation , that these influences were interconnected and contingent upon each other, could not be reduced to a single factor

and were influenced by women's social context, background and feelings before giving birth, the nature of their early experiences and the support they encountered (Bailey et al., 2004).

Support for their breastfeeding effort was identified by low-income women as a major influencer of their breastfeeding experience (Greathouse; 2008; Johnsen, 2002; Locklin, 1995; Locklin & Naber, 1993; Scott & Mostyn, 2003). A lack of support, whether professional, paraprofessional or family support hindered the breastfeeding process (Locklin, 1995). Research noted potential sources of advice and support as including partners, mothers, family, friends, obstetricians, pediatricians, lactation consultants, La Leche League, doulas, visiting nurses, WIC (Women, Infants and Children) program and peer counsellors (Greathouse, 2008; Johnsen, 2002; Locklin, 1995; Locklin & Naber, 1993; Scott & Mostyn, 2003). There was no consensus in these qualitative studies as to what group was pivotal in providing support to low-income breastfeeding women.

Supportive people were identified by women as those that upheld the mother's wish to breastfeed and were a source of helpful and believable advice (Johnsen, 2002). Helpful advice referred to a source of advice who was readily available and reflected caring and compassion for the mother who was in need (Johnsen, 2002). Advice given in a way that was construed as rude or uncaring caused the mother to look for help elsewhere (Johnsen, 2002). Believable advice was seen as advice coming from a person who was already trusted or had proven themselves in some way (Johnsen, 2002). This type of person or support helped the mother; strategize; lay out an intentional plan to handle problems; helped her come up with an order of steps to see if they would help;

take specific actions and follow-up; and find a plan for continued breastfeeding (Johnsen, 2002). The importance of individualized support and care specific to a mother's needs and circumstances was also identified (Greathouse, 2008).

Experiences with formal support or the health care system and health professionals were described by low-income women in varying ways. Although women in most instances appreciated the support received from health visitors and lactation consultants, they were often seen as being pressed for time, their visits as not always coinciding with a breastfeeding episode (Greathouse, 2008; Scott & Mostyn, 2003) and providing a less individualized quality of support (Raisler, 2000) as compared to the support provided by trained peer volunteers. Many women described positive feeding experiences during the initial postpartum hours but described mixed experiences after transferring to postnatal wards (Bailey et al., 2004).

The experience of breastfeeding as it related to health care professionals after hospital discharge varied depending on the country where the research was conducted. In the United Kingdom, although participant's positively described postnatal community midwife support, they also noted breastfeeding difficulties that became acute at a time when they felt they had limited access to formal support (Bailey et al., 2004). American research found that when mothers and their infants left the hospital, the support of lactation consultants and others was not readily available to them (Greathouse, 2008), their contacts with the health system decreased, and positive comments regarding the effect of the health system on breastfeeding during the post-partum period were limited and such comments largely related to interactions with physicians (Raisler, 2000). Mothers reported turning to peer counselors to learn more about breastfeeding and

resolve problems rather than health care professionals (Raisler, 2000). This may be a reflection of the American health care system and support provided to breastfeeding women in that country as well as the specific type of program women were participating in, namely, federally funded Special Supplemental Nutrition Program WIC (United States Department of Agriculture (USDA), 2012), a program where participants were also receiving assistance from breastfeeding peer counselors.

Summary of Rationale for the Study

In summary, there is limited qualitative research regarding the breastfeeding experience of low-income women and none of this research has been completed with Canadian women. Research that has been completed in this area, as noted in the previous critique, is limited by a failure to define low-income and the inappropriate use of focus groups and telephone surveys with this research population. Only Greathouse (2008) and Johnsen (2002) employed phenomenology as the methodological approach. It is however only Greathouse's (2008) research that considered low-income women's experience of breastfeeding by exploring the factors that influenced the breastfeeding experience of women who breastfed successfully for six months postpartum. It is therefore imperative that a Canadian phenomenological research study exploring the breastfeeding experience of low-income women be completed.

CHAPTER 3: METHODS

This chapter delineates the study purpose, the research question and the research approach, conceptual framework and research design utilized. Sampling procedure, data collection, data analysis, and ethical considerations are also explained.

Study Purpose

The purpose of this qualitative phenomenological study was to describe the lived experience of breastfeeding for low-income women living in Winnipeg, Manitoba. This research is required to better understand the breastfeeding experience and how challenges and enablers influenced continuing or discontinuing breastfeeding, how these women conceptualized the experience and what effect they believe breastfeeding had on their lives and the lives of their children.

Research Question

What is the lived experience of breastfeeding for low-income women living in Winnipeg, Manitoba?

Research Approach and Conceptual Framework

A feminist research approach and the Integrative Model of Behavioral Prediction (Fishbein, 2009) were the research approach and conceptual framework or model utilized in this qualitative research study.

Feminist Research Approach

This breastfeeding research study benefitted from and was a "fit" with the feminist research approach in a number of ways. A feminist research approach aims to provide a lens that considers gender as a basic organizing principle that shapes our consciousness and the context of women's lives and brings into focus particular questions (Creswell,

2007; Fox-Keller, 1985). Breastfeeding is gender specific. The act of breastfeeding itself and the physical and emotional experience that accompanies this act is for the most part only experienced by women. Therefore it is prudent and necessary to consider the experience of breastfeeding through a research lens that acknowledges and requires that the research be considered from a gender stance and the type of questioning and consciousness that this research approach can bring to bear on this topic area.

This approach aims to establish "collaborative and non-exploitative relationships, to place the researcher within the study so as to avoid objectification and to conduct research that is transformative" (Creswell, 2007, p. 26). Women in low-income circumstances have in many cases been exploited in their personal relationships and also by the larger society because of their gender and due to their economic circumstances. It is therefore imperative to develop a collaborative approach with low-income women in completing this breastfeeding study. In addition to preventing exploitation and fostering the development of a respectful relationship between the principal investigator and the women participating, the feminist approach will assist in ensuring the accuracy, richness and validity of the information that these women share, as women will feel more comfortable to share all parts of their breastfeeding experience and their lives. If collaboration in this research is successfully achieved, it is likely that the results of this research may be transformative for participants, providing the opportunity to share their experience/their story of breastfeeding and the challenges and/or rewards that this experience brought to their lives. It may also be transformative by the nature of the disclosure and validation of their experience as being similar to others or unique to themselves. This research may also be transformative for participants because of the

knowledge that their cumulative experiences will be shared at a local level with health care professionals and policy makers for the purpose of improving the experience of breastfeeding for women in similar circumstances.

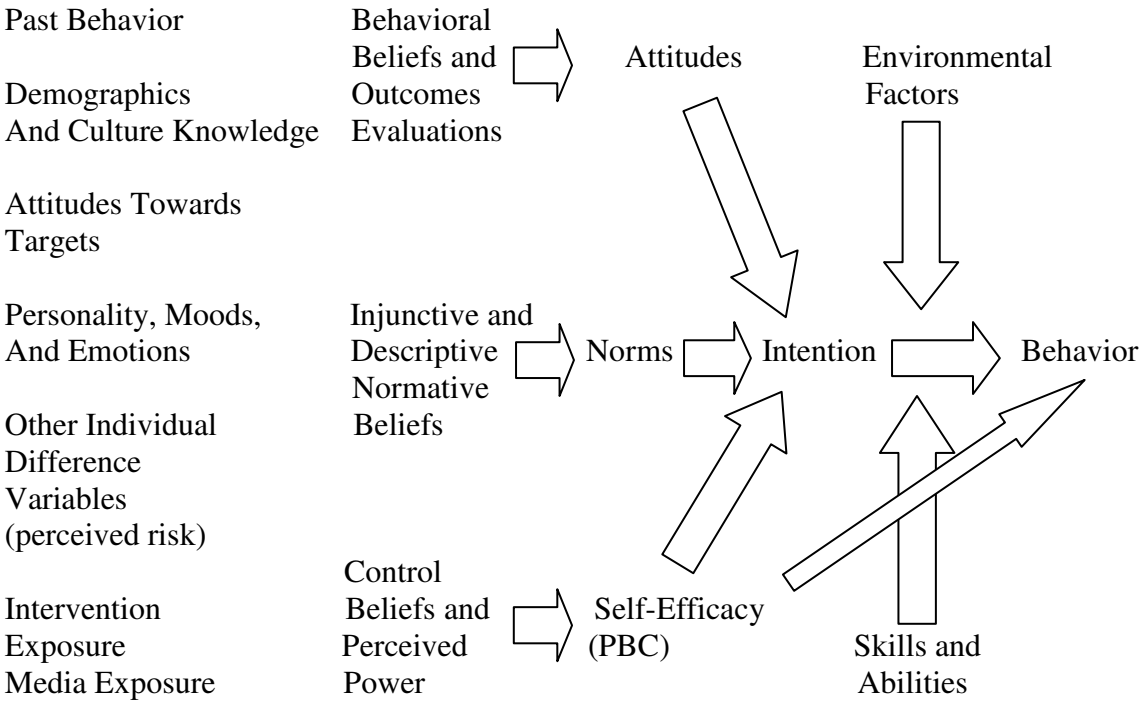
The feminist research approach also highlights the importance of studying power relationships and individuals' social position and how this impacts women (Creswell, 2007; Stewart, 1994). The women participating in this study are affected by power relationships via their gender and by their economic circumstances and social position. It is therefore critical that a research approach, like feminist theory be utilized in shaping this research.

Integrative Model for Behavioral Prediction

Fishbein's (2009) Integrative Model of Behavioral Prediction is a model applicable to health promotion that aims to predict and understand human behavior. According to this model, a person's intentions are the best predictors of whether one will or will not perform a given behavior (Fishbein, 2009). The integrative model also recognizes that intentions do not always predict behaviors and that a lack of necessary skills or abilities or unanticipated barriers or environmental constraints may prevent people from carrying out their intention (Fishbein, 2009). As noted in Diagram 1, there are three primary determinants of intention: the attitude toward performing the behavior; the normative influence or the amount of social pressure one feels vis-a-vis performing the behavior; and one's sense of personal agency or self-efficacy with respect to performance of the behavior (Fishbein, 2009). This model also recognizes the role environmental factors (family; community and other social factors) may have in influencing human behavior. The model as noted in Diagram 1 also considers how background influences behavior,

such as an individual's past behavior, his/her demographics and culture; attitudes toward a target (person or situation); emotions, personality and mood and other individual characteristics; and exposure to media or other intervention exposure can influence the three types of beliefs (behavioral, injunctive and control beliefs) which in turn affect an individual's attitudes, norms and self-efficacy as outlined and indirectly influence behavior (Fishbein, 2009).

Diagram 1: The Integrative Model of Behavioral Prediction (Fishbein, 2009)
(reproduced with permission from John Wiley and Sons, June 13, 2013).

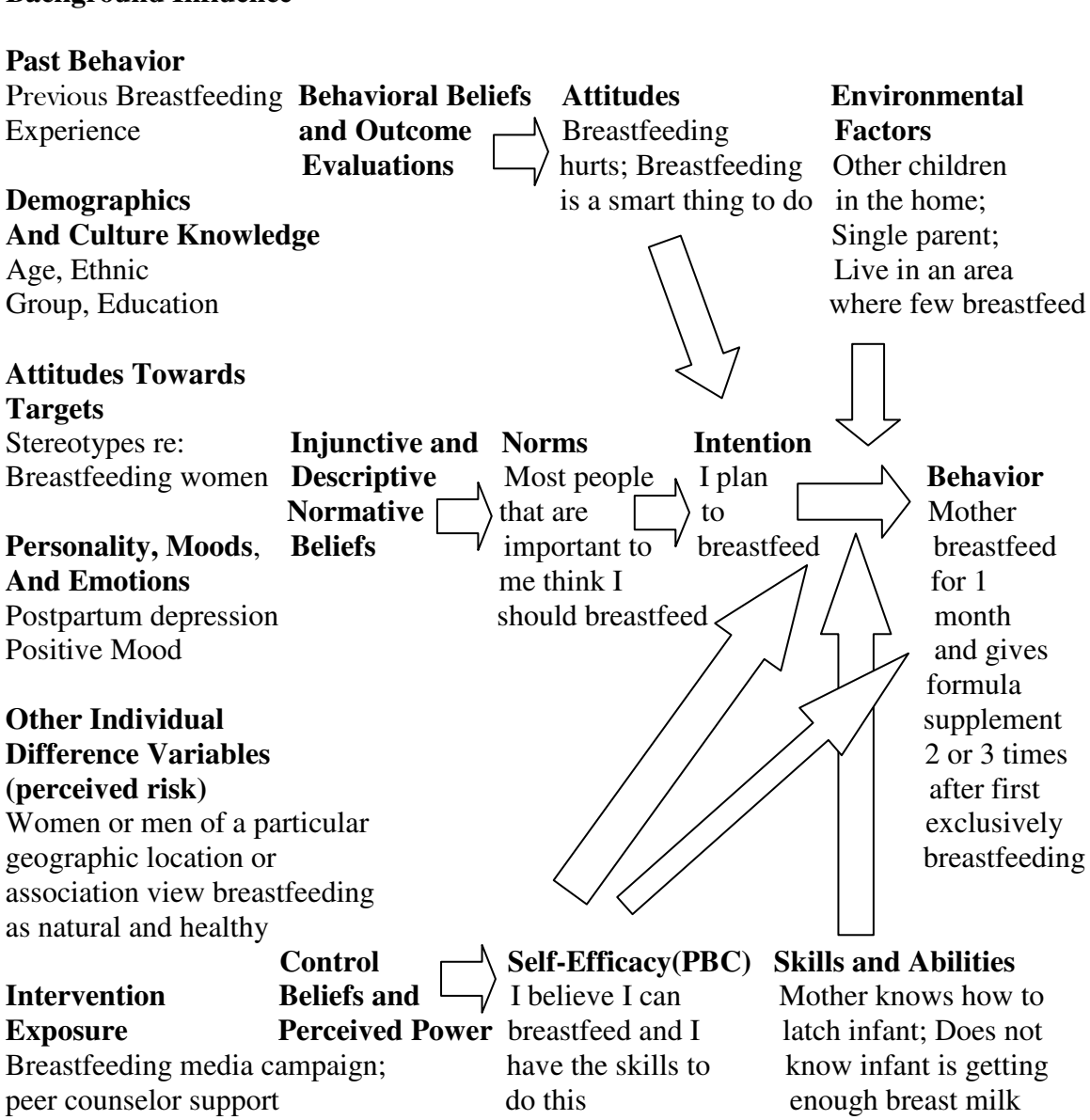


This model is particularly applicable to breastfeeding initiation and duration. As noted in the literature review, a woman's intention to breastfeed and breastfeeding self-efficacy or her confidence in her ability to breastfeed are important factors in determining

if a woman breastfeeds (DigGirolamo et al., 2005; Martens & Young, 1997). Her breastfeeding confidence is also a significant factor in how long she breastfeeds (Blyth et al., 2002; Dunn et al., 2006; Ertem et al., 2001; Papinczak & Turner, 2000). A woman's skills and abilities regarding breastfeeding – e.g., her ability to assist her infant to latch and to manage breastfeeding challenges – are also predictors of breastfeeding initiation and duration. This model also considers environmental factors such as her family and her supports that breastfeeding research confirms are important in a woman's decision-making regarding breastfeeding initiation and continuation. The background influences noted in the model also allow for the consideration of a woman's cultural context, her age and income, personality, and exposure to breastfeeding interventions such as media campaigns, peer counselor support, or health care professional support and other factors. See Diagram 2 for the model's application to breastfeeding behavior prediction.

The purpose of utilizing Fishbein's model was for it to serve as a guide in the development of the study. It assisted in formulating the demographics form and the interview guide. This model, in addition to the breastfeeding research completed in this area, assisted in the development of the discussion of the findings of this study. This study also qualitatively tested Fishbein's model, in terms of the presence or absence of the constructs in the model. It did not test Fishbein's model quantitatively, as the study purpose and methodology does not fit with testing the model in this manner.

Diagram 2: Application of Fishbein's (2009) Integrative Model of Behavioral Prediction to Breastfeeding Initiation and Duration
(reproduced with permission from John Wiley and Sons, June 13, 2013)



Study Design

This study utilized a phenomenological qualitative research approach (Creswell, 2007; Moustakas, 1994) guided, as note previously, by a feminist research approach and Fishbein's model. Spencer (2008) noted in her discussion paper of research methodologies to investigate the experience of breastfeeding, that a hermeneutic phenomenological approach that is informed from feminist methodologies is deemed the most appropriate in researching mothers' views of breastfeeding. Hermeneutic phenomenology is "essentially a philosophy of the nature of understanding a particular phenomenon and the scientific interpretation of phenomena appearing in text or written work" (Speziale & Carpenter, 2007, p. 88). Phenomenology is the lived experience and hermeneutics is the interpretation of the essence of life (Munhall, 2012; van Manen, 1990). The purpose of hermeneutic phenomenology, as a human science is to explore being in and on this world by creating meanings of expressions of how humans exist in the world (van Manen, 1990). It explores human phenomena in order to understand the structure or essence of the lived experience (Dowling, 2007; Munhall, 2012; Speziale & Carpenter, 2007). Employing this type of approach ensured that the objective of determining and better understanding the lived experience of breastfeeding for low-income woman residing in Winnipeg was achieved.

To ensure accurate and representative data was gathered for this often difficult to reach, potentially marginalized population, one to one interviews of participants were utilized as the data collection method. These interviews were conducted in participant's homes or locations in the community where these women felt comfortable and safe and at

a time convenient to the participants. Sixteen of the 18 interviews were conducted in the participant's homes.

Sample

The following inclusion and exclusion criteria were utilized in recruiting participants for the study.

Inclusion Criteria

Low-income women who were breastfeeding at any of the levels noted in the breastfeeding definition section of chapter one (i.e., full, partial or token) were eligible for this research project. Women had to be 18 years or older, to have delivered a live infant and speak English. The women were required to have a telephone number where they could be contacted. Participants had to live within the boundaries of the Winnipeg Regional Health Authority (WRHA) in Manitoba. Women (and their families) must also have been eligible for the Manitoba Healthy Child Prenatal Benefit Program during the woman's pregnancy.

Exclusion Criteria

Mothers who were exclusively formula feeding right from birth (i.e., never attempted to breastfeed or never gave pumped breast milk), did not speak English, whose child had been or was currently apprehended by Child and Family Services and who had delivered a premature infant (i.e., less than 37 weeks gestation) were not eligible for the study participation. Mothers whose infants were born with congenital abnormalities (birth defects) were also precluded from participation in this study.

Sampling Method and Recruitment

Purposeful, criterion sampling was utilized to recruit participants who met the eligibility criteria. As noted by Creswell (2007) criterion sampling works well when all individuals studied represent people who have experienced the phenomenon. In this case, the common phenomenon was breastfeeding. Purposeful sampling was appropriate to ensure the specified criteria was met and also for the recruitment within a specific defined area. In this situation, women living within the WRHA jurisdiction were invited to participate.

Low-income mothers in the early postpartum period and those having older infants were included in the study to capture both the early postpartum and later breastfeeding experience. Low-income women from all areas of the WRHA could potentially be recruited for this research project (See Appendix C for letter of support for this study to ENREB from the WRHA). This recruitment occurred via two methods. A study invitation pamphlet (See Appendix D) that invited interested women to contact the principal investigator was provided by WRHA Public Health Nurses to all women they had either phone or home visiting contact with in the postpartum period. These study invitation letters were also included in the Public Health Infant Feeding Class notice mail outs that were sent to all new parents 3 to 4 months after the birth of their child. To ensure there was no overlap or duplication in the women who receive invitations from these two recruitment methods the postpartum provision of letters by Public Health Nurses (for a 4 month period) commenced at the same time the monthly infant feeding letters were mailed out (for a 3 month period). The recruitment period was anticipated to last a minimum of 3 to 4 months but was dependent on the response rate. It began in

November 2012 and ended in March 2013. Adequate participant numbers and data saturation was achieved during this time period.

Interested potential participants who contacted the principal investigator were initially screened for eligibility. More than 65 women contacted the principal investigator. Forty-five of these women were ineligible for the study. If eligible for the research study, arrangements were made with the potential participant for a one to one in person visit in their home or in the community. Prior to participation in the one to one interviews the principal investigator reviewed the consent form with the potential participant on the face to face visit. If informed consent was achieved and the participant agreed to participate the interview continued. All participants who kept their one to one appointments and were seen face to face agreed to participate in the study. For women who completed the interview $25.00 was provided to the mother as recognition for their time as participants for this study.

Sample Size and Saturation

Creswell (2007) states that a sample size of 10 participants in one to one interviews would be required to reach data saturation for a phenomenological study. Other researchers note sample size may range from four to 40 informants (Holloway & Wheeler, 2010). However, as data saturation had not been reached after interviewing 10 participants, recruitment and data collection continued until this was achieved. After several months of recruitment, 10 women had volunteered and participated. As only one participant had discontinued breastfeeding, the researcher contacted the WRHA to provide an update regarding the study and to request a more focused recruitment effort. The concern was that women who had discontinued breastfeeding, particularly early on

in their breastfeeding experience may have a different lived experience than woman who breastfed for a longer period of time. A focused recruitment was discussed with Public Health colleagues to develop opportunities or strategies to engage more "short term breast feeders" (i.e., women who had breastfed for less than 1 month). During this period of time, the researcher requested that Public Health Nurses provide the invitation to potential participants who had discontinued breastfeeding within the first month postpartum. This more targeted effort allowed for the recruitment of a participant who had discontinued breastfeeding prior to one month.

In total, 18 women participated in the study. Saturation of the lived experience of low-income women living in the city of Winnipeg was attained overall. Saturation was achieved based on the fact no new themes developed as of the 18th interview. Further discussion of "short term breast feeders" is noted under study limitations.

Data Collection and Analysis

Interviews were conducted utilizing the semi-structured interview guide (Appendix E). Interviews also included collection of the demographic characteristics noted in this guide. Interviews with the participants were recorded and transcribed verbatim by transcriptionists who signed a waiver of confidentiality. Texts were read and reread and margin notes and initial codes were developed (Creswell, 2007), as each interview was completed. After the initial three interviews, the interview guide was revised to include questions about what was occurring in the participant's life during the pregnancy and while breastfeeding. This was included after the initial three participants spoke of contextual stressors and concerns that were occurring during this time period. A question asking them to summarize their breastfeeding experience in a few words or sentences, if

they felt this was possible, was also added to aid the researcher in theme development and allow women a greater say in the development of the essence of the experience. Some women answered this and for others it served as a reminder to add further insight into their experience or other original thoughts that had not already been shared with the researcher. A summary question at the end of the interview requesting any further information they wished to share about their experience was added as a prompt or reminder, as this allowed women to share any other thoughts they had forgotten to share earlier in the interview. Probing and follow-up questions, based on information each individual woman shared were also utilized as appropriate in the interview. An example of this is: "You spoke of sore nipples and a lot of pain with breastfeeding and wanting to quit. What helped you continue breastfeeding when that was happening?"

The first two interviews were coded independently by both the student and the thesis advisor, an experienced qualitative researcher, to ensure reliability and accuracy. The thesis advisor and the student then compared and discussed codes developed as interviews continued. There was consensus on the coding for the initial interviews. Based on the coding of the interviews significant statements and subsequent meaning units were determined (Creswell, 2007; Moustakas, 1994). Both a textural ("what happened") and a structural ("how the phenomenon was experienced") description were developed (Creswell, 2007, p. 157). Based on these two descriptions the "essence of the experience was described" (Creswell, 2007, p. 79). From 18 verbatim interview transcripts, significant statements were extracted, and then coded into meaning units, subsequently themes and finally the essence of the breastfeeding experience of low-income women was determined.

The essence and themes developed from the transcripts and reflective notes were verified with the participants who previously agreed to provide this verification feedback. During the interview process, 15 of the 18 participants had agreed to provide this feedback via telephone contact. Attempts to contact the 15 participants were made on at least 2 occasions. Nine of these 15 participants were reached. The verification guide in Appendix F was utilized when participants were contacted to affirm or dispute the validity and trustworthiness of the data. These participants concurred with the essence of the experience and the subthemes developed. They noted they saw their own experience mirrored in the findings.

Creswell (2007) recommended, as part of the data analysis and representation of the phenomenological approach, that the researcher describe personal experiences through epoche or bracketing. This bracketing, in which investigators set aside all preconceived experience as much as possible, allows the researcher to take a fresh perspective toward the phenomenon and to best understand the experiences of participants in a study (Creswell, 2007; Moustakas, 1994). Although the principal researcher has no personal breastfeeding experience, extensive experience as a nurse and practitioner supporting breastfeeding women needed to be acknowledged and set aside prior to engaging in interviews with participants. To increase awareness of biases and preconceptions regarding breastfeeding as a phenomenon and her work with low-income breastfeeding women, the researcher completed written synopses of these thoughts. This bracketing was completed prior to the first interview and after each of the first 8 interviews and then discontinued as the researcher was identifying similar themes and thoughts in this process.

Ethical Considerations

Ethical approval to conduct this study was obtained from the Education/Nursing Research Ethics Board (ENREB) at the University of Manitoba and the WRHA ethics committee (See Appendix G). The women who were interested in participating in the study were provided with both written and verbal information concerning the purpose and nature of the study (See Appendix H). If the woman volunteered to participate, she was required to sign two consent forms (the same version). The researcher kept one signed consent form and the participant retained the other signed consent form. Participants were informed that they could receive a summary of the results if they wished by providing, as noted on the final page of the consent form, their name and their mailing address or email address. Seventeen of the 18 participants requested a summary of the results. The voluntary nature of the study was emphasized and participants were informed that they could withdraw from the study at any time or decline to answer any questions with no untoward consequences.

Due to the employment of the principal investigator by the WRHA as a Public Health nurse there was an identifiable risk of double agency (Edwards & Chalmers, 2002). To circumvent this issue, the principal investigator, when working as a Public Health nurse did not provide study invitations. In the event any patients/clients she provided care to, requested to participate in the study, these individuals were advised of the issue of double agency and were excluded from participation in the study. This occurred on one occasion and the potential participant was advised during the phone inquiry regarding the study of the double agency and excluded from participation.

The confidentiality of the participants was protected by removing the name and identifying information on the taped interviews or transcripts. Participants were identified only by a subject number. Fictitious names were assigned to participant #1, #2, #3 etc. For example, Participant #1 was assigned the fictitious name of x. The researcher maintained a master list of the participants' names, addresses and phone numbers which will be destroyed at the completion of the study utilizing the University of Manitoba's protocol for destroying confidential information. The remaining de-identified data from this study will be stored in a locked filing cabinet in the advisor's office for seven years and then will be destroyed via confidential shredding at the University of Manitoba.

Participants were not exposed to any experimental treatment. There were no anticipated negative or harmful emotional or physical consequences for women who participated in this study. The researcher clarified with the women who participated in this study, any questions regarding the study and provided information regarding various resources (e.g., breastfeeding support resources, mobile crisis or mental health resources, medical services). A copy of a list of information resources offered and provided to all participants is included in Appendix I.

If participants had disclosed during the course of the interview, information (e.g. a child in danger or need of protection; threats made against another party; threats of suicide or harm to other) that required as per provincial legislation that confidentiality could not be maintained, the researcher would have as per the Mental Health Act or the Child, the Family Services Act or the appropriate act, disclosed this information to the appropriate agency or professional (e.g. the local Child and Family Services Authority; the City of Winnipeg Police Department or physician or health care provider). As per the

consent form participants were advised of this requirement prior to participation in the interview. No participants disclosed information that required a referral under any of the above noted acts.

CHAPTER 4: FINDINGS

Demographics

The following section describes the characteristics of the study sample. Demographic information regarding participants' ages; education level; ethnicity; place of birth; marital status and living arrangement; parity; and breastfeeding histories are discussed. In addition the exposure of the participant to familial breastfeeding and/or a friend's breastfeeding is reviewed. The timing of participants' decision to breastfeed; employment and return to school; smoking history; and breastfeeding level and duration is delineated. Table 3 provides an overview of the range in age; education; ethnicity; place of birth; marital status; parity; timing of the women's decision to breastfeed; employment and return to school.

Table 3: Demographics of Participants

Variable	Frequency (# of Participants)
Age (Range by Years)	
18 - 23	3
24 - 29	7
30 - 35	5
36 - 40	3
Education Level (Achieved)	
Grade 9 or less	4
Grade 10 to 11	6
Grade 12	6

Post-Secondary Education (Community College Certificate or Undergraduate Degree)	1
Graduate Degree	1
Ethnicity	
Aboriginal	4
Caucasian	11
Other	3
Place of Birth	
Canada	15
Other	3
Marital Status	
Single	10
Common Law	3
Married	5
Employment or Schooling Status	
Had Returned to Work	1
Had Returned to School	1
Specific Plan to Return to Work or School	5
Non-Specific Plan to Return to Work or School	6
No Plan to Return to Either	5

Parity	
First Child	8
2nd Child	4
3rd Child	2
4th Child or more	4
Decision to Breastfeed (Time Period)	
Pre-Pregnancy	7
First Trimester	6
2nd Trimester	2
3rd Trimester	2
At Delivery/In Hospital	1

The 18 women who participated in the study ranged in age from 21 years of age to 36 years of age (Mean = 29 years; Median = 29). More than half of the participants (n=10) had not completed Grade 12.

The majority of women (n=15) who participated in the study were born in Canada and three identified being born outside of the country. These participants noted their birth places as Africa, Pakistan and the United States. Women also identified their ethnic or cultural group affiliation. (See Table 3). The 11 women who identified themselves as Caucasian but also noted a cultural or ethnic group association included: American; Canadian; German; Russian; British; French; Irish; Metis; Swedish; and Scottish.

The majority (n=10) of the women in the study described themselves as single. However two of these women noted having a boyfriend who did not live with them but who was involved in their and their infant's lives. Three women described themselves as living common law and five stated they were married.

Women's work history during pregnancy and their plans to return to work and school was discussed during the interviews as part of the demographics portion of the interview (See Table 3). The majority of women had not returned to work or school, however the majority planned to, some with a specific time line and others with no concrete plan.

Participants' parity varied. More than half of participants had more than one child. The remainder (45 %) identified themselves as first time mothers.

Breastfeeding History

Eight of the participants had no previous breastfeeding experience, as this was their first child. The majority (9) of the other 10 women had some previous breastfeeding experience, however the duration varied between women and even between the children of a particular mother. Five women identified breastfeeding a previous child for 1 year or more. One mother noted having breastfeed a previous child for 10 months; 2 women discussed breastfeeding their older children to between 2 and 4 months of age; and 1 mother breastfeed her previous children for a few days to a week. The length of time women had breastfed a previous child did not appear to consistently influence the length of time they breastfed their current child. Both participants who discontinued breastfeeding had breastfed previous children, in some cases for an extended period of time (i.e., one year). Some participants identified no breastfeeding history or short term

breastfeeding history (days or weeks) and were, with their current child, continuing to breastfeed 4 months or longer.

Family or Friends Who Have Breastfed

Seventeen of the participants identified having close family or extended family or friends who had breastfed. The proximity of the relationship to them and the success of those individuals varied greatly. Only one mother identified knowing only one recent friend or acquaintance who breastfed. She met this person after she had initiated breastfeeding.

Decision to Breastfeed

The majority of participants made their decision to breastfeed pre-pregnancy or in their first trimester. Four women shared they decided to breastfeed during their second or third trimester. Only one woman stated she had planned to bottle feed and then decided at the time of her delivery and during her stay in hospital to breastfeed (See Table 3).

Smoking

Eight women stated they either have never smoked or quit prior to becoming pregnant with this child. None of these 8 women smoked during their pregnancy or after the birth of their infant. The majority of smokers were not able to change their smoking habits during their pregnancy or postpartum period. Four participants smoked the same amount during their entire pregnancy and in the postpartum period. Two women quit smoking in their pregnancy, however one woman resumed smoking later in her pregnancy and the other resumed smoking in the postpartum period. Three women's smoking patterns varied from remaining the same or decreasing in pregnancy and then during the postpartum period they continued to smoke to varying degrees. Only one

participant was able to quit and continue to remain smoke free during her pregnancy and ongoing in the postpartum period.

Table 4: Smoking Level of Participants

Level of Smoking	Number of Participants
Very Heavy (25 cigarettes/day or more)	1
Heavy (12 cigarettes/day)	3
Medium (8 cigarettes/day)	3
Low (2 – 4 cigarettes/day)	1
Very Low (1 – 2 cigarettes/week)	1

In terms of smoking habits and breastfeeding level and duration, there did not seem to be a relationship between breastfeeding level or exclusivity and smoking, as 3 of the 7 women who were exclusively breastfeeding were smokers. Smoking did not appear to affect the level of breastfeeding (i.e., high, medium or low) of those women who were partially breastfeeding. Of those women who were partially breastfeeding 7 were smokers and 4 were non-smokers. More smokers had a high level of breastfeeding (4) as compared to non-smokers (1). Equal numbers of smokers and non-smokers had an overall medium breastfeeding intensity level (i.e., 3 in each category). Of the 2 participants who discontinued breastfeeding, one woman was a smoker and the other was a non-smoker.

Breastfeeding Level and Duration

There was variety in the level of breastfeeding and the breastfeeding duration of the participants. Seven women were exclusively breastfeeding their infants and were therefore categorized under Labbok and Krasovec's (1990) definition as full breastfeeding. The majority of the other participants met the criteria for partial breastfeeding. Classifying women's breastfeeding level proved challenging as the level of partial breastfeeding – high, medium or low – varied greatly over the course of some women's breastfeeding trajectory. Classification was also difficult as some women did not recall when their level of breastfeeding changed over the course of their experience. Two women noted token breastfeeding during the course of their breastfeeding. One woman described this as being part of the beginning of her breastfeeding experience. The other participant noted it occurred at the end of her breastfeeding duration and after a period of partial breastfeeding.

All but two women were still breastfeeding at the time of their study interview. One woman discontinued breastfeeding when her infant was 3 months and 3 weeks of age and the other women finished breastfeeding at 3 1/2 to 4 weeks after her child was born. See Table 5 below for the breastfeeding duration of participants. It is important to note that the breastfeeding duration for 16 of the participants is accurate only up to the time of the interview. Their continued breastfeeding duration is not known.

Table 5: Breastfeeding Duration of Participants

Breastfeeding Duration	Number of Participants
Less than 2 months	1

2 months to less than 4	5
4 months to less than 6	7
6 months to less than 8	1
8 months to less than 10	1
10 months to less than 12	1
12 months or more	2

Essence of the Experience

The essence of the experience as described by participants is *breastfeeding is amazing and tough work.* Women specifically used these words in their discussion of their breastfeeding experience. They also, as noted in the themes discussed below, described in detail the difficulties and challenges they faced in breastfeeding, as well as why they felt it was such an amazing type of work to do for their children.

Women acknowledged the dichotomy of amazing and tough in their comments of joy and satisfaction in breastfeeding, and the difficulty and challenges they faced.

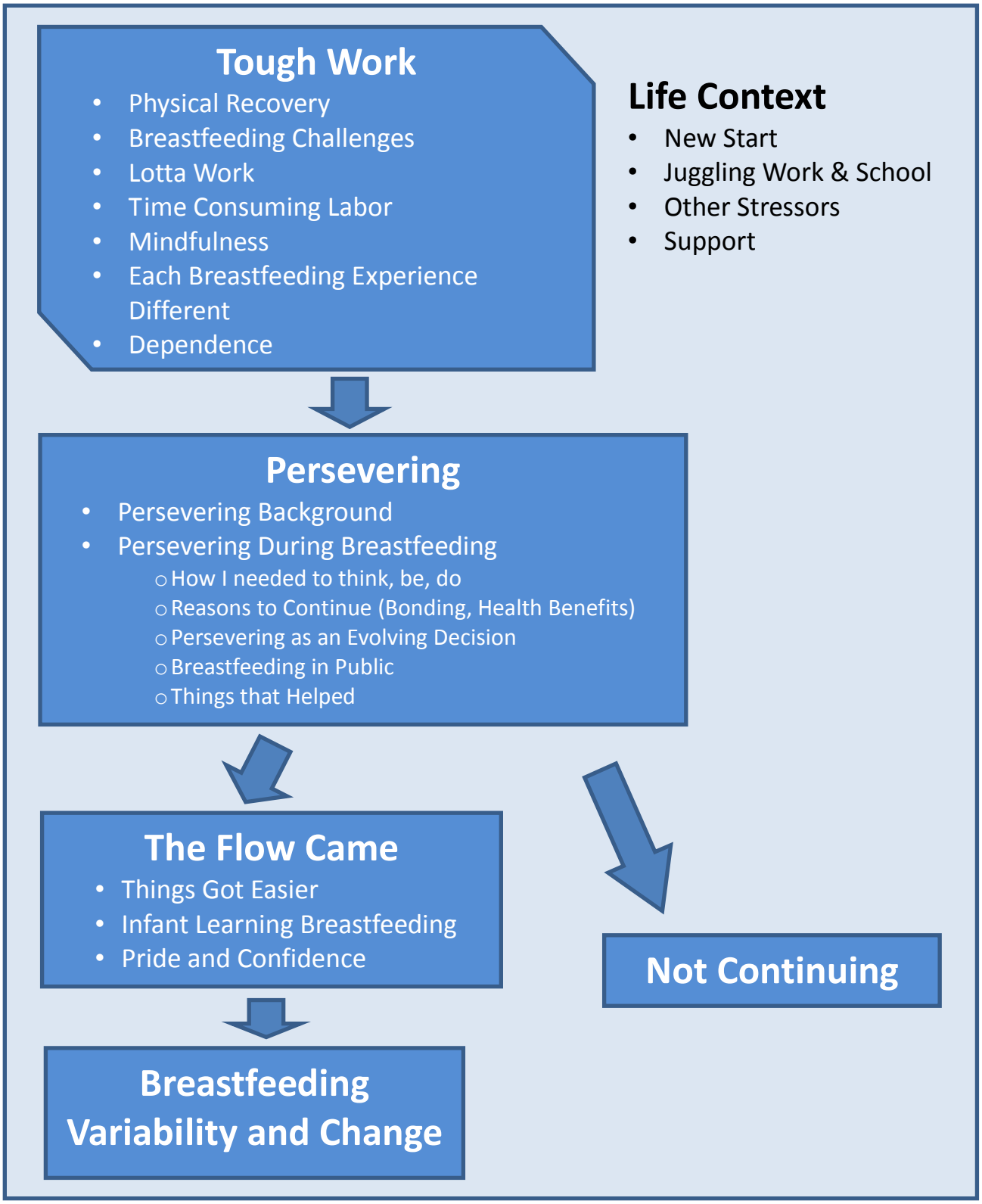
> Well I think breastfeeding like, is amazing...It's awesome. Like it is... it's hard...But it's also... great on the other side of it. Like it's a lotta work- But....It's so beneficial for them, and for you. ……So I think the breastfeeding like the experience it was pretty awesome....Once you got past all the little... little kinks in it. But it is definitely something you have to work at, it's not like it just comes easy. Yeah. Like i- it's a roller coaster it is stressful....But it's worth it. (Carol)

> I just thought it would be like really uncomfortable and ta- like so time consuming and... like... yeah... and that it I don't know maybe it would hurt. Ahuh. Well it's t- it's still time consuming but it's I enjoy it so. …..That it's like a lot better than I thought it would be (laugh) and it's really beautiful and... just the loving and... and... happy experience and... just pretty amazing too. (Phoebe).

Diagram 3 offers a visual depiction of this essence of the breastfeeding experience

described by low-income women who participated in this qualitative research study. It also shows the path or trajectory through the course of their breastfeeding experience. The 6 themes that comprise this trajectory and the essence of the breastfeeding experience are: Life Context; Tough Work; Persevering; The Flow Came; Breastfeeding Variability and Change; and Not Continuing. See Table 6 (pg. 71) for a description of all of the themes and subthemes identified in the breastfeeding experience of low-income women.

Diagram 3: Amazing and Tough Work: The Path or Trajectory of the Breastfeeding Experience of Low-Income Women in the City of Winnipeg



Life Context refers to the world of the low-income breastfeeding woman, her environment during her pregnancy and the course of her breastfeeding, and her circumstances leading up to the breastfeeding experience, and throughout its course. It is this backdrop or under these circumstances or influences that women are living their breastfeeding experience. It reflects the participants' interpretation of their environment and their lives in terms of their breastfeeding experience and their overall life circumstances. Life context also refers to the other stressors occurring in these women's lives and their perception of these stressors. In addition, this theme reflects the supports in these women's lives and their perspective on the support they received regarding breastfeeding.

Tough Work denotes the difficult work of breastfeeding for the mother and her child. It refers to the breastfeeding challenges encountered by the dyad, the woman's physical recovery from childbirth, the early work of breastfeeding, and the fatigue associated with breastfeeding. It also reflects the time consuming nature of breastfeeding and the other experiences women associated with the "tough work" of breastfeeding outlined in Table 6.

Persevering refers to what occurred as women were working through breastfeeding challenges and the tough work of breastfeeding. It refers to the *Persevering Background* or what women brought to the table in terms of their thoughts and beliefs about breastfeeding and persevering and the role of culture in breastfeeding perseverance. Persevering also refers to *Persevering during Breastfeeding* or women's perspectives and descriptions of their breastfeeding bodies, what they learned they needed to do to successfully breastfeed. It refers to coping strategies employed. It includes women's

views of what helped them to continue to breastfeed, including the important role of bonding. This theme also highlights breastfeeding continuance as an evolving decision and the role public breastfeeding plays in the ability to persevere for these women. *The Flow Came* refers to women's experiences of breastfeeding becoming easier, or the progression to where at a certain point "things got easier". It refers to the women's perspectives of how their infants' abilities and learning contributed to this improvement or progression. It also denotes how the women changed, in terms of pride and confidence, by persevering through their challenges and reaching this point of discovery and ease in breastfeeding. This theme in the breastfeeding trajectory applied to those women who continued to breastfeed or pump beyond a certain point, were having success and were able to persevere to where breastfeeding became, for most women, easier. It also refers to the pride and confidence women felt as they continued to breastfeed and achieved success.

Other women that never reached the point where *The Flow Came* or breastfeeding became easier instead identified with the theme of *Not Continuing*. This theme denotes that for some women breastfeeding did not become easier and that these women discontinued breastfeeding. For these women, breastfeeding was in some cases not the original choice for feeding. Some of their reasons for breastfeeding and continuing to breastfeed included rationale not in keeping with other participants' rationale. Women spoke of breastfeeding going its own path as noted in Table 6. Participants also noted that breastfeeding did not work with their lifestyle.

The theme of *Breastfeeding Variability and Change* applies to those women who continued to breastfeed and for whom the *Flow Came* or breastfeeding became easier. It

reflects women's comments that even after breastfeeding became easier that there was still change and variability in their breastfeeding that posed challenges and made breastfeeding difficult.

Table 6: Themes and Subthemes of Amazing and Tough: The Breastfeeding Experience of Low-Income Women

Life Context (The world of the breastfeeding woman or her environment)	New Start	Women's description and perspective of breastfeeding and their lives after having left abusive relationships or having made other healthy changes in their lives.
	Juggling: Work and School	Women's experiences with juggling breastfeeding and school or work or their perspective of what this might be like.
	Other Stressors	Women share the stressors and what was occurring in their lives during their pregnancy and during their breastfeeding. Some women commented about how they felt this impacted their breastfeeding.
	Support	Women's perspectives of the support they received (or lack of support) from their families, friends, partners and the professional and paraprofessional support received.
Tough Work (The difficult work of breastfeeding for the woman and her child)	Physical Recovery	Women's perspective on the role and impact of a woman's physical recovery from child birth on her breastfeeding
	Breastfeeding Challenges	Women's perspective on the breastfeeding difficulties

		that they encountered during breastfeeding (eg. Sore nipples, difficulty latching, etc.). It refers to the mother, infant and dyad challenges that occurred.
	Lotta Work	Women's perspective of the difficult work involved in breastfeeding. Included the early or beginning work of breastfeeding, the fatigue associated with breastfeeding, and their lack of confidence and knowledge about breastfeeding, learning a new skill, how to know they are "doing it right" or that it is progressing well.
	Time Consuming Labor	Women's discussion of the time consuming nature of breastfeeding and the element of time involved in their breastfeeding work.
	Mindfulness of the Woman	Women's discussion of the thought they put into or how mindful they were of what they ate and did and how this might affect their breastfeeding and their child.
	Each Breastfeeding Experience Different	Women's discussions of how each breastfeeding experience is different even if they have breastfed a child before.
	Dependence	Women's discussion of the dependent relationship of breastfeeding and their interpretation of this dependence and how it impacts their lives.
Persevering	Persevering Background (What women bring to the	Breastfeeding is Something you do.

	table in terms of thoughts and beliefs about breastfeeding and persevering)	Culture Supportive of Breastfeeding
		Beliefs About other Women Breastfeeding
	Persevering During Breastfeeding (What women thought and did to continue breastfeeding. It refers to how their persevering was evolving versus static in nature, what things helped them to continue breastfeeding and the role breastfeeding in public held.)	How I needed to think, be and do (This refers to how women thought, how they were and what they did all for the purpose of persevering with their breastfeeding or as a way to cope.)
		Reasons to Breastfeed or Continue Breastfeeding. Reasons that women cited as to why they initiated and continued breastfeeding.
		Persevering as an evolving decision. This refers to women's views of breastfeeding and the length they would breastfeed as being dependent on other factors or how the experience evolved.
		Breastfeeding in Public. This refers to women's experience of breastfeeding in public.
		Things that Helped. Women discussed the items, concepts, things they did or the experiences that helped them to persevere with breastfeeding.
The Flow Came	Things Got Easier	Women's description of how breastfeeding (i.e., for the majority of those women who continued breastfeeding) became easier at a certain point.
	Infant Learning Breastfeeding	Women's perspective of how at a certain point their infant's abilities and

		learning made breastfeeding easier
	Pride and Confidence	This refers to the pride and confidence the women developed as they had breastfeeding success. What the women shared about breastfeeding as a learning experience and the advice they then felt they could share with other mothers based on their experience.
Breastfeeding Variability and Change	Women's discussions of even after breastfeeding became easier (or the flow came) that there was still change and variability in their breastfeeding that posed challenges and made it difficult.	
Not Continuing (The differences noted between women who did not continue breastfeeding or pumping versus those who continued breastfeeding)	Did not originally plan to breastfeed	A woman's description of her original plan to bottle feed and how this was altered and its possible effect on her discontinuation of breastfeeding.
	Breastfeeding went its own path	A woman's description of how her breastfeeding experience went its own path and her interpretation of her breastfeeding trajectory and the role of choice and control in this breastfeeding experience.
	Breastfeeding did not work with our lifestyle	Two women's description, who discontinued breastfeeding, of how breastfeeding did not work or fit in with their lifestyle.

Life Context

Life context or the world of the breastfeeding woman consists of the subthemes of: new start or doing things differently; juggling working and/or school; other stressors; and support.

New Start

Some of the participants envisioned this pregnancy and birth and subsequent breastfeeding experience as a new start in their life or an opportunity to do things differently. These women disclosed that they had left abusive relationships (N=3) or ended unhealthy habits or lifestyle choices (N=3). They provided a description and perspective of their breastfeeding and their lives after having left these abusive relationships or achieved success in leaving behind unhealthy behaviors.

> ... I've had a history of uh drugs and alcohol. And I've been clean for a year and a half. So as I was um, moving forward with my life I finished treatment centres I was trying to get into a program like this. .... to protect me and my kids and move forward. Um. Because I put all that stress and stuff behind me, I wanted to do everything the right way, and, feel, everything, you know what I mean? And so... just transitioning, and, and knowing that I wanted to move ahead with this baby and do everything I possibly can for the good… that's what kept me like... where I'm at you know?…So. I don't know it was hard because... my other children never had this got this and it's you know what I wish that now I wish because I went through this and I'm going through this... I think it's a really really really really really good thing. (Candace)

Juggling: Work and School

Women discussed the real or anticipated juggling or difficulties they faced in returning to work or school and managing to continue breastfeeding. As noted in the demographics section of the paper, only 2 women had returned to work or school at the time the interviews were conducted. Some women were delaying their return to school due to concerns about this juggling of demands and responsibilities with breastfeeding.

> And now like I'm at school she has, she drinks formula 'cause, I-... (child' name). When I went back.....to school that's when I went to.....When I went to start it in September...So I was before I went to school I made sure there was milk (i.e., pumped milk).....And that, I just, I was so tired I couldn't do it anymore. So in the middle of September... I... we just did half and half. As much as I can do it... or when I'm home, when I was home, I fed her the form- like I f- breastfed her, and the rest was formula. (Beverly)

Other Stressors

Other stressors refers to the milieu of life stressors currently occurring in the lives of interviewees, as well as past life stressors such as addiction histories that still impacted their stress and lives. The majority of participants identified life challenges or stressors and were experiencing some degree of stress. Only one participant did not report stressors occurring in her life. The stressors being experienced varied in type, number and degree. Many participants were experiencing multiple stressors simultaneously. Eleven of the eighteen women participating in the study disclosed multiple stressors in their lives. Participants identified the following as stressors or as issues that were occurring in their lives: alcohol or drug use or recovery from an addiction; being a new mother (first time); mental health or depression concerns; maternal illness concerns; family and infant health issues; financial or income concerns; frequent moves; housing challenges or homelessness; immigration issues; job loss, work stress or stress leave challenges; unplanned pregnancy stressors; single parenthood or lack of support at home; relationship stress or split and reunion; custody and visitation issues; Child and Family Services involvement; incarceration; and spousal abuse concerns. Women noted how these stressors affected their lives overall and their impact on their breastfeeding.

> It's been hard, living here though. No. No I just thought about it ... just like when I had, when I had to go apartment hunting that what I'm supposed to do so... but it's like winter and it's like kinda hard so. Yeah. Is like... if I had a place I would

> probably still be breastfeeding. If I had my own place it would be all right. Because I would be at home in my own place. Wouldn't be running around living in emergency shelter. (Francine)
>
> For those days I, in those days I had a some sort of, depression of loneliness that I am so alone it's, it's over it's going on with me... and I at that time I was thinking that I am the most... yeah what would I say that most, pitiable person, in the world ... nobody's there to help me. ….that was for very depressing and top of that when she was not taking my milk from the breast that was also depressing. So for those days I was and during those days I was really depressed.…..In the beginning I used to cry a lot. (Constance)
>
> I don't drink. I don't party. I don't, yes I do smoke cigarettes, but that's the only vice that I really have…And um, I don't spend my money. I'm very frugal…And so, and it's very humbling to have to go to a food bank every two weeks you know…In order to just have something in the house to eat… Because, the money that I do get, I really want for my son. And for food, formula, you know diapers. He gets before I do. Which is kind of unfair because I am the mom and that I do need to have my strength and energy as well…To be able to, deal with him on a daily basis. Right? (Beatrice)
>
> Being alone and... And the fellow that I have this kid with him... He's not he's not in....So he's left me with my kids. You need somebody to help you out yeah it has been..... There are stress like….Missing, the people around you.....You need somebody to take care of you like now I'm living alone... …But, there's nothing I can do about it. I just, let it go. (Ethel)

Support

This subtheme refers to women's perspectives of the support they received or lack of support from their families, friends, partners and professional and paraprofessional supports. It is best understood in the context of the tough work and persevering that women endured and the breastfeeding trajectory that ensued. They noted partners, family, friends, and professional and paraprofessional supports as part of their breastfeeding experience. Women discussed the support they received as often helping them with the tough work of breastfeeding and as helping them persevere in their breastfeeding journey. They also discussed experiences that were not supportive or

helpful. Only one participant, Ethel, noted she did not need help or support with actual breastfeeding, and noted her past success with breastfeeding her 3 previous children and only minor problems as the reason for not needing assistance.

Partner.

As discussed during the demographics portion of this paper, many women who participated in this study did not have partners. Those that did identify a partner (i.e., husband, common law partner or boyfriend) commented about their partner's role in supporting or not supporting their breastfeeding. Many identified their partners as supportive. Six mothers described a variety of ways in which their partners were supportive of their breastfeeding. Women noted supportive partners as being encouraging of their breastfeeding efforts and during breastfeeding difficulties.

> Well his dad's really supportive. So that definitely helps. Well he just like agrees it's the best for him like he went with me to the prenatal classes and everything and... just... s-... like if he's like upset oh, he needs his boob. (laugh) (Phoebe)

Women also shared how their partners encouraged them to continue breastfeeding for a longer period of time.

> ……my boyfriend also he just said just keep at it for a little bit longer. He said, you know just... go past two, three months... you know try to, try to give yourself a target point and just try to go past it and I said okay...we'll take it from there and we'll see how it is…(Joan)

A few women also noted their partner's support of their breastfeeding in terms of the childcare or household support they provided. This type of support was instrumental in their breastfeeding perseverance.

> Just my husband. He took a few days off from his work... and he, mm- took care of me, ... take care of her. So that's what the help I had. Mm- nobody else was there. …He takes care of me and he's good with the kids too….. (Constance)

Even though some partners initially encouraged breastfeeding, as an infant grew their encouragement in some cases changed to questioning the length of time their partner should continue breastfeeding for.

> I'm going stage by stage. 'Kay? 'Cause, my... my initial goal was until Halloween. Okay? And then I made it there... and now... I'm thinking, I'm startin' to think, even my boyfriend said, where are you gonna stop? (Joan)

Some women described their partner not supporting their breastfeeding, described only scenarios where breastfeeding was a source of conflict between them and their partner, or noted they did not receive any feedback, positive or negative from their spouse.

> Uh-hum. My boyfriend he didn't really discourage it but he just, told me that... you know you'd be a little less stressed if you brought the on the bottle but he knew I really wanted to breastfeed so. (Taylor)

> Uh. I don't know if there was something that didn't really help. Well the boyfriend in a sense...'Cause any time he'd cry oh he's hungry, oh here, put him on the boob oh here put him on the boob. It's like he's not always hungry you know? Maybe he just needs attention. (Carol)

> When it comes down to it is what... like I didn't get any feedback.....Yeah I didn't get much feedback at all when, they s- knew she was on the bottle. Not much feedback just...Kind of an everyday occurrence. (Francis)

Family.

Women discussed the support or lack of support they received from their family. They discussed the type of support they received including encouragement to breastfeed; breastfeeding support or advice; and physical support in the form of household or

childcare assistance. Participants also noted when this support was lacking or when it was not helpful.

Encouragement to breastfeed and continue breastfeeding occurred in a number of ways by family members. Having someone in the family who had breastfed, particularly if it was someone who had breastfed long term, was helpful for a number of reasons. It served to create a normalcy to breastfeeding and planted the idea that it could be done and done for an extended duration. "I have one niece that, breastfed I think until eighteen months? So. Was like oh well so people do do it." (Carol) Long term breastfeeding examples in the family and having pro-breastfeeding family members was also critical as part of the overall encouragement of breastfeeding.

> Um, my sister was a big influence. My sister's very um, actively...pro-bre-breastfeeding. Um she uh, she has gone out of her way, from the moment she found out I was pregnant... 'til now...To support me in ...Purely breastfeeding....(Barbara)

Some women also noted a mixed response or a dichotomy in terms of familial support of breastfeeding, some supportive and other not. They also described how if they had not received some family support and professional encouragement they may have discontinued breastfeeding.

> If I would've kept getting the negative responses from friends, and certain family members... I might have cut it off....I tend, to get a little bit overwhelmed as well when..I hear people say, 'oh my God he's still on your boob?' like that's just disgusting and it was like... it's almost a deterrent... and I don't wanna let it be. (Beatrice)

Women described how family members provided breastfeeding advice, practical tips and emotional support that assisted them to continue breastfeeding and resolve breastfeeding issues.

> I have a very big supportive family here …three of my older siblings have all had babies so they kind of... talked me through questions if I ever had any. …It was a little stressful at first ....I think the support, outweighed that because if I ever was stressed or had questions I could call, my sisters or my mom...And they'd come over. (Hunter)

This advice and guidance from family regarding breastfeeding encouraged women to view breastfeeding as normal and what to expect in the experience.

> The first time when I breastfeed my son it wasn't...Quite well because I'm not used to it...And my aunt say, you're gonna get used to it. Though it's hard for you to concentrate on it... Just focus.....And then you will be okay ..I say okay, I'll listen to your advice and I will do that...And I did it…. my aunt say….First it hurt...And the pain will be normal to you. I say okay. ...And it was fine… (Ethel)

Women noted that input from a practical perspective was not as helpful if it was not based on recent experience.

> Uh, my sister. It um... and my mom a little bit but...I feel like when a women is gone so long... Without breastfeeding they're like ahhh they can't really remember those fine details. So, that book, in particular, my sister because her... it's been only been a coup- it's only been a year and a half maybe. (Barbara)

Participants described hands on breastfeeding support from family and how family assisted in household, childcare or housing support and its positive impact on their breastfeeding perseverance and parenting.

> ..when I was having trouble…we was like this is ridiculous she has to latch on.... like we sat in my mom's bed and put her, like right there we put my mom's like f- try Vitamin D 'cause she know we know she loves that thing……So she latched on that way. …my mom is like amazing like, it, she helped she helped she's a great support for me. (Beverly)

> Yeah I mean there was distraction, too. You know around the kids, you know having... their immediate needs ne- being, met. But my mom was around like she, her and my sister were here so they... could at least tend to that. (Roberta)

Even though some family members were initially supportive of breastfeeding, with time and as the infant grew, they often discouraged continued breastfeeding. "Hum. Maybe my mom but, even she thinks we should be weaning her off so." (Beverly)

Some participants noted a neutral response, a lack of feedback or limited or no encouragement regarding their breastfeeding in addition to a lack of hands on support.

> ...like I didn't get any feedback...Yeah I didn't get much feedback at all when, they s- knew she was on the bottle. Not much feedback just...Kind of an everyday occurrence. …..And things like that. Um, the family and friends says... that is like I said no feedback really. They just, were, happy with whatever I did and whatever she wanted. (Francis)

> I have family that aren't very breastfeeding friendly… they be like no just put him on the bottle it's okay. Formula's okay. …They support the idea, but they don't support the fact that it takes up my time. Right? 'Cause then they're like oh well you can't go out with us because we can't, take the baby…. (Monica)

> Uh just his granny. …she came with me during the labour ... then she just helped me after to get into cab and then the staff here and another resident helped me, carried, him up and carried my bags... and then that was it.... (Francine)

Friends.

Women identified their friends as influencing their choice to breastfeed and continue breastfeeding, with both positive and negative support. They noted experiences where their friends encouraged and supported their breastfeeding efforts, acted as role models, and provided practical advice and childcare support, as well as friends who actively discouraged breastfeeding. Having a friend who had or was currently breastfeeding encouraged participants to continue breastfeeding and served as a role model to them.

> …I have a lot of friends right now like …they, told me like, the breastfeeding and I guess, if you know how, if a group of friends are are breastfeeding it helps. It

> really helps with..going through that hurdle.…….They tell me the importance of it the bonding experience of it... and how important it is… (Beverly)

Women also discussed how friends helped them address breastfeeding challenges such as public breastfeeding.

> I think it just being around people who do it too, you know? And being around my friend …. she does it and knows, and like..going through every stage I'm going through so we can discuss it and be like, ahhh okay so that will stop you know?....A lot of it was being with my other friend who breastfeeds and her being able to just like pull it out in public and not care about what anybody thinks and I was like wait a second…. I should be like that yeah. (Monica)

Participants noted the practical advice and hands on support their friends provided regarding breastfeeding, and how their assistance with childcare contributed to their breastfeeding perseverance.

> My girlfriend also told me, like a new like, even though I knew all the positions, she said... try holding it this way or try holding him this way or try, leaning back a little bit like this and that so, it was actually my friend that gave me a lot a lotta help ….(Joan)

> ….And I know my, I went to go stay with my best friend one one night and... that was the best thing ever for me was to have her watch over my baby for that one night... she was there and just gave me that break that I needed from him. That one day was the whole difference. (Joan)

Two participants specifically noted negative reactions or discouragement from friends in regard to their breastfeeding. They described the way they responded to this discouragement and persevered with their breastfeeding.

> Just all the negative reactions...Because a lot of my friends are absolutely against it.They think it's gross…I don't look at, my breasts as a sexual thing. Whereas my girlfriends actually do....Because I do have girlfriends, that, will, actually leave my apartment, or, you know go and hide in a different room..... they're not comfortable with it.……I pretty much um stayed... strong.. because....as influential as my friends can be.... It was like no no. This is about... me and my son now. … Because he comes first, and I come, first. (Beatrice)

Professional and Paraprofessional Support.

Women who participated in the study shared experiences of positive, helpful support from professional and paraprofessional personnel as well as unsupportive and unhelpful exchanges. Participants described their interactions with nurses; physicians; lactation consultants; the Family First program; breastfeeding drop in support groups; prenatal classes; other parenting programs; health care phones lines; and La Leche League.

Nurses.

Nurses were the professional group who women referred to the most in their discussion of their breastfeeding experiences. The majority of women spoke of positive experiences and support in their interaction with nurses. There were however also mixed experiences, and unhelpful and unsupportive experiences noted by some women.

Those women that described positive, supportive experiences discussed nursing personnel's support of their birth or birth plan and their encouragement of breastfeeding. They also discussed the timing (e.g. prenatal, postpartum) and availability; practical advice; hands on breastfeeding support; and problem solving and assistance in resolving breastfeeding challenges that was provided by nursing personnel. They valued and described the benefit of consistent information, advice and support from nursing personnel. Women noted ongoing breastfeeding support from nurses provided reassurance and helped them anticipate potential issues.

Encouragement and advice to breastfeed occurred in the prenatal, intrapartum and postpartum period. It helped women feel optimistic about persevering and about the challenges they faced.

> Encouraging words where okay the this is the way he'll do it this is this and that and I can't think of everything right now. Pretty much. I I guess, not prepare I wouldn't say prepare but...Kinda give me the to be optimistic like...You know what I mean? Like more of um... just kinda stick with it it'll you'll get through this kinda thing. And I did. (Candace)

> Definitely from the hospitals and the nurses. All the advice was helpful. Yeah. Um. To just continue the breastfeeding... and, give me pamphlets on how it's best and, what it does for baby. How it's cheaper. ….But, when I first started... um was in the hospital. So. It, it was, kind of encouraged by the nurses...So. It wasn't originally planned...But, uh it, did come, to us as, we were in the hospital and it was more encouraged there at the women's hospital.….They really encouraged it. (Francis)

For women, who did not have a partner, family or friends that were actively encouraging breastfeeding having nursing staff encouraging her and providing advice and support was particularly important.

> Definitely the public health nurse. She was the only one that cared...About my breastfeeding... Pretty much. She was, uh she came here twice in...A matter a month or couple weeks, just to ask about my breastfeeding. They she really really condoned it…(Francis)

Women spoke of the availability of nursing care as an important part of this breastfeeding support and encouragement. Easily available care was perceived as important.

> Yes and then there was the uh... the... public health nurses come out to visit. So if you have any questions then they're there too they can give you, advice and then there are baby groups. There's always... A consultant there that you can talk to so. So anytime like if there's anything I, can go through her and then she'll tell... the nurse that works in the building and then she'll come out so. (Carol)

Participants also noted that ongoing (versus limited follow-up) nursing support was beneficial not only in allaying fears, increasing confidence, providing encouragement and solving current breastfeeding challenges but it also aided women in anticipating changes that would occur in their breastfeeding.

> Um a working with my public health nurse she came almost... every week...I've been working with my public health nurse and getting all kinds of information but...I still, do... And uh, my nurse that come and, she constantly was helping me with information showing me, making sure everything was right and, I just kept getting encouragement where it just felt right and... Like I don't know I was just being paranoid I think but, every time I would have those thoughts I would phone my nurse to come and see me and to talk me out or talk it through with me... and to show me that he is doing right and it is the best thing for him and... and I just, I would change my mind right? Eh but um yeah. It did help. (Candace)

Women specifically commented about the practical and hands on support they received from nursing staff. They described experiences where advice and assistance was provided regarding breastfeeding challenges related to latching or milk supply concern. Participants also described the setting and manner of delivery of this support as being important. Women further noted the importance of the support provided being shared by a calm practitioner who was respectful and respected their preferences.

> Well the nurse probably. She helped… she'd come out... couple times, to make sure that she's latching okay and... you know help me, you know go through those... steps. She was really helpful... when it came to..... understanding, what's going on you know having her experience 'cause I think she's been..... 'cause she c- she, recognized you know what was wrong... and... she tried to correct it. Like she gave me some options but she was also... she understood that I, I also... you know had a preference, you know what position I liked and... …..She had the different, techniques, you know, down. (Roberta)

> Uh well the nurse practitioner helped. ... getting him... to... nurse directly on the breast. Like taking... the nipple shield off. Yeah but she, had left us with that 'cause I was having... That was when I got home and...She would come, to the home... To see how we were doing. And uh... that it was hard for, that, he would feed with the nipple shield but not without it. So…she had helped, uh, with that….. (Fanny)

Women identified limited and inconsistent breastfeeding support and discouraging interactions with nursing staff as unhelpful and not aiding them in persevering.

> No. I, wanted to do the breastfeeding I don't know why I was doing it in the hospital but... I wasn't getting any kind of support from the nurses for

> breastfeeding. Really like they, helped me once or twice and then that was it. (Candace)
>
> So it, takes time and the nurses at the hospital help then...This time 'round though I felt that I was kinda just left in the dark like... To do it on my own.....(Anna)
>
> ….she, when she was born she, latched...But then unlatched right away. So she didn't really, get the concept of it and the nurses, didn't help. (laugh) No they didn't at all. They were just very, um... aggressive I guess the word is above it and they're like you should l-, she shouldn't hap- she shouldn't have problems... latching. ……Uh they didn't give me a pump at the hospital at all. And I asked for one and they wouldn't give it to me. So. I was upset. (Beverly)
>
> I called the Public Health Nurse and then she... she said uh yeah he looks like he's getting dehydrated. Um you might wanna switch him to formula. (laugh) Co- could be you're not keepin' up but then yeah. Um she just gave me papers to breastfeeding support groups and it's like uh uh, I d- I don't have time for that. (laugh) No. (Francine)

Physicians.

Women described supportive and unsupportive experiences with their physicians in regard to breastfeeding. Many women noted their physician discussed the health benefits of breastfeeding and encouraged them to breastfeed. Some also noted the practical advice their physicians shared. No hands on support by physicians was described by participants. Women discussed how their physicians encouraged them.

> Was useful. Hmm. I….. the doctor say they breastfeed are good for the kid...You know it's the last one that the doctor say...If you breastfeed your baby it's... Much better than giving them formula. That's, what, what I had from the doctor. (Ethel)

Physicians also provided practical breastfeeding advice as well as suggestions to address breastfeeding challenges.

> Which my doctor told me you don't have to be a zombie get her up every few hours. She'll tell you when she's hungry. So. It, it was difficult that way but now like when you're, breastfeeding it's so much easier. Just put her on the bed and …. she'll eat. (Beverly)

Some women noted unsupportive comments from or experiences with physicians.

> Mm. Just, if I could do it, any mom can. Mm- 'cause I... I have a lot of mental problems wrong and I... even my doctor said that breastfeeding and no- being tied down might not be a good idea but, it, if I can do it they, everybody can. (Taylor)

Lactation Consultants.

Two participants identified utilizing lactation consultants for support specifically related to breastfeeding issues. Overall they described positive experiences with this practical support.

> And then on... um, I guess the fifth day they had a, breast feeding, uh, con-, uh, consultant...Come in to...Um, help get him, latched on...'Cause he was used to the, the bottle now. So it... so she helped with getting him latched um it didn't really take at first so she recommended...The, nipple shield. (Fanny)

Family First Program.

Women discussed the breastfeeding encouragement, advice and support provided by the Family First program and how this helped them choose to breastfeed or persevere in their efforts. This program is a provincially funded home visiting program offering support to families with children from pregnancy to school entry. Its goal is to support positive child growth and development; assist parents in building a strong relationship with their child; prevent child abuse; provide information on health safety and nutrition; and connect families with their health care and resources in their community (Healthy Child Manitoba, 2013a). A public health nurse and Family First home visitor provide ongoing support to families to achieve the above noted goals (Healthy Child Manitoba, 2013a).

> They're very encouraging. Um, so we have our weekly visits, and, it's really, nice to have, someone here that's comfortable with me breastfeeding....Oh (mother's name) that's such a wonderful thing and it's such a beautiful thing to watch .... Just

> very encouraging. You know? You're gonna keep up with it? You know the longer you do it the healthier it is for both of you? Just really encouraging, positive words. So. That made a big difference for me… (Beatrice)

Women spoke particularly of breastfeeding suggestions and strategies provided by Family First and the nursing personnel that were part of the program.

> Well, um if it wasn't for the ladies from, the Family First program especially one woman ….who is a breastfeeding, specialist nurse.... she was so encouraging like because , I was just... at my wits end with this hourly breastfeeding thing ... and she was just ... you know?... try switching from breast to breast you know? Two hours on one breast, two hours on another... and fun little things that she would add to it like, you know stick a little pin on one side of your shirt so you know? (Beatrice)

Other participants noted being involved with the Family First program but either specified only the nursing support as being supportive of their breastfeeding effort which was noted under the nursing support section of this paper or made no comment regarding their support.

Breastfeeding drop-in support groups.

Only one woman expressed awareness of breastfeeding drop-in support groups. The support groups she referred to were available at various locations throughout the urban setting she lived in and provided through the local regional health authority. No participants described attending these support groups.

> If I, if I had joined the, I read about the ... support group... different breastfeeding mothers they come and they come up there with their, problems and issues to... I wanted to join that but because of the weather it was cold, and she was very, little. I couldn't take her out... and I... didn't have you know my car is…..I don't, have my my husband has. He takes it to his work. So I don't drive…It's very difficult for me to... take her in this cold weather, through the bus there, you know you have to wait there for the bus... and for the baby it is difficult. (Constance)

Prenatal classes.

Three participants discussed the influence of prenatal classes on their

breastfeeding. Two of the women had positive experiences. One participant expressed mixed feelings regarding her experience. Some women commented about receiving accurate and important information regarding breastfeeding benefits and prenatal instructors encouraging breastfeeding.

> ….when I went to prenatal they said that there's should no, the baby should not, there should be no problems with babies having to latch on. It's instinct. .... I, I was really upset when she wasn't latching on so. … they sh- they should've told you. They should've tell tell you that if some babies do some babies don't. And that would've been helpful. (Beverly)

Other parenting programs.

Four women discussed other parenting programs they were involved in that supported or discouraged their breastfeeding efforts. Two of the women discussed formal support programs they were involved in as part of their living arrangement and spousal abuse counselling program involvement, as impacting their breastfeeding perseverance in positive and negative ways.

> … honestly being here helped to improve the experience just we can not with their perspective on it but just being able to, focus solely on kids and feeding and, worrying about, family things as opposed to outside influences, helped a lot. Because sometimes peer pressure causes things to happen where you just don't... where you stop ….. so a lot of it was being here helped.……Mean I've had a lotta difficulties being in this program 'cause they're not very breastfeeding friendly, or they haven't been. So it'd be like, well, if it takes you fifteen minutes to breastfeed we expect you back in group in ten minutes well, you need to cut him off and come. (Monica)

Two participants described their involvement in Health Baby Community Support Programs. This drop-in parenting support group is fund by the Manitoba government and has outreach workers, Public Health nurses and dieticians on site to provide information and support to parents during their pregnancy and to those with infants less than one year

of age regardless of their feeding method (Healthy Baby, 2013b). Both women noted the encouragement and positive support of this program regarding their breastfeeding.

> I go to a baby group and pretty much all the girls there breastfeed. .... and when I was pregnant like I went to the prenatal class … just get at all the information on it and, how good it is for them and... Yeah just like being around 'em even when I was pregnant and, just them telling all the information and... just saying that they'd really be there if you need anything like there's the outreach workers and they're super nice and actually there's a health nurse there and she's a lactation consultant and she's always there for any questions we need and, she actually gave me a huge box a nursing pads too. So that's really nice. (Phoebe)

Health care phone lines.

Two participants discussed their experience with the above noted phone lines. The Breastfeeding Hotline and Health Links are publicly funded government health lines staffed by registered nurses. The La Leche League phone line is staffed by La Leche League volunteers. Participants noted receiving good advice and encouragement that assisted in their breastfeeding perseverance. Less satisfying and unhelpful experiences were also noted by women in their use of healthcare phone lines.

> ..... when I did call for help, like I called the breastfeeding line and I called...Health Links was, not very much help. Like they usually just tell you to go into the hospital or go and see someone.... the breastfeeding hotline did help a little bit but, they said, they told me not to stop, feeding him..... and still continue with it ….. And even the breastfeeding hotline they, their, automated messages I just I kept going in circles...Was very confusing. (Joan)

La Leche League.

One participant spoke positively of the support she experienced from La Leche League.

> Was useful? I got in touch with a La La Leach (La Leche) person, and, she gave me her, her cell phone number and, any time I had any questions or concerns, I could call her any time a day and she would answer them and that was the best for me because, for me I've never breastfed this long so, I'm not, used to the whole

> process of it so for to have that one person that you can rely on and is always gonna give you information that they feel is beneficial to you as opposed to getting... hundreds of information that aren't working for you that was good. (Monica)

Tough Work

Tough work consists of a woman's physical recovery from child birth; the breastfeeding challenges the mother, the infant and the dyad encountered; the "lotta work" associated with breastfeeding; the time consuming nature of breastfeeding; and the mindfulness of the breastfeeding mother. It also encompasses the belief and realization by women that each breastfeeding experience is different for each individual woman and for each child she has. This theme also includes a woman's acknowledgement of and feelings about the dependent nature of breastfeeding.

Physical Recovery

Women discussed the impact their physical recovery had on their breastfeeding experience and their ability to breastfeed. They shared issues of fatigue, pain and complications from delivery. Two women stated they believed this impacted their breastfeeding success and duration while others commented about continuing to breastfeed despite these difficulties.

> So... you know after C-section it is a really difficult to, sit and to put the baby on breast. But mm-, it was a nurse who... first put her on my breast... and I would say that was... Yeah. That that was the, main problem and I had C-section and it was difficult for me to get... up again and again and... put her on my breast. So... but if she didn't latch on with my, breast then, they gave me a nipple shield and they said that use this. (Constance)

Breastfeeding Challenges

The majority of women described breastfeeding challenges for themselves, their infants or the breastfeeding dyad during the course of their breastfeeding experience.

Some women perceived the challenges as numerous and as difficult to overcome. Others spoke of them as something that needed to be resolved and described success in overcoming these challenges. In some instances women noted how these challenges affected their breastfeeding behavior in terms of their level of breastfeeding, their supplementation and their breastfeeding duration. Some women discussed the emotional impact breastfeeding challenges had on them and their breastfeeding continuance. Other participants, despite challenges, described their experience as meant to be. A small number of women (N = 2), stated they had no breastfeeding challenges. Women spoke of the following breastfeeding difficulties: latching issues (N = 7); engorgement (N = 6); perceived or actual milk supply concerns (N = 9); too much milk or a fast flow of milk (N = 2); one breast producing more than the other (N = 1); leaking (N = 1); thrush (N = 1); and teething and biting (N = 8).

> …..she was like a month and a week or so... it was like this is ridiculous because we were se- we were gonna go to (name of country) so we needed her to breastfeed. So, on... we put Vitamin D on it on the breast and she just latched. At a month. …I think it's like the...Best thing ever. Like I...Was the happiest person when she latched on. (laugh). (Beverly)

> It was really difficult because …... I was always sore and it hurt all the time like all the time, my, nipples actually peeled right off. Like the whole couple layers of skin came off. The first couple days were really bad, first couple weeks were really bad. And then, slowly but surely it got better...Oh at least a month. Least a month of craziness. Yeah. Af- now it's fine. I don't even notice it anymore. But it takes a while. (Monica)

> ……yeah and on the fifth day probably four- fourth or fifth day... that's when my milk came in and that was….When I had the hardest time. And that that's when I understood, why some women might quit...What did I do? I tried..... then, the my breasts were, uh so full and hard...And sore. Really really really sore and then..…. Well the that really, t- hard part, during engorgement, probably took 'til she was 'bout two weeks maybe. (Barbara)

> Um... he, I offered him formula, he was getting dehydrated. Yeah. When he was three and a half weeks. Um his eyes were sinking, in, looking...Dark. ……Uh probably not having enough milk. Um, I offered it um just once during the night. And then um... for about, three days, four days, and then I switched him to, formula. (Francine)

Lotta Work

Lotta Work refers to women's perspectives of the difficult work involved in breastfeeding. It includes the early or beginning work of breastfeeding and the physical and emotional fatigue associated with breastfeeding. It also refers to women's lack of confidence and knowledge in regard to breastfeeding. It denotes women's stress and uncertainty in learning the skill of breastfeeding, and their concerns as to whether they are "doing it right" and whether breastfeeding is progressing well.

Early work.

Seven women spoke specifically of the early work involved in breastfeeding. Women spoke of the amount of work and the time involved in breastfeeding and learning to breastfeed. They also discussed the up and down nature of breastfeeding in terms of a lack of routine and demand feeding.

> …it is hard in the beginning, it is really really hard….'Cause, e- you know in the middle of the nights you know? Four five sometimes you know? Five times in the night …and you feed on demand like the, the breastfed babies are not like a routine. ….but in the beginning e- you're on demand so it's like...You know? Fed, cha- I mean changed you know? Cuddled, loved up but then feed feed feed feed right? (Candace)

Participants discussed figuring out what to do in the beginning, feeling emotionally overwhelmed and stressed in learning a new skill and coping with the demands of breastfeeding. They also shared how they "figured it out".

> … I think it just got very overwhelming for me by the time I got home because...He just needed that closeness all the time but, holding him wasn't enough

> he needed to be on the breast... So it just, it got very overwhelming for me... (Beatrice)

> But, as far as the breastfeeding went it was, trying to find a comfortable position to put him or to put me because.. …. yeah it was, a little bit of a challenge to figure things out at the beginning……yeah, I think it's just, the learning curve is the hardest part.....(Joan)

Women described how their breasts and their bodies needed to learn about breastfeeding. They also discussed the early work infants had to do in learning a new skill, "Your breasts don't really know yet and baby...Doesn't really know yet that happened... once we had, probably... gotten a little bit more into the swing of things so." (Barbara)

Women spoke of the length of time this early work lasted. Some described the early work as being most difficult in first few weeks or first month. Others described this early work as lasting for up to 3 months.

> …Then it, things calmed down. But that was the hard part. ……probably took 'til she was 'bout two weeks maybe. I just remember it being really hard ... During... when the milk was coming in….That was challenging right in the beginning. That first...Maybe month after where you're like...(Barbara)

> Yeah so I was just like... the first three months of breastfeeding...Was challenging. Super super challenging. Yeah. It was it's just like I say wo- uh struggling in the first three months, after that it was great. (Candace)

It's tiring.

Seven women emphasized the physically and emotionally fatiguing nature of breastfeeding that contributed to making it a lotta work. Women described how the nature of breastfeeding – the frequency of it -- impacted their fatigue.

> Um. It's pretty tired. (laugh) Um. And you get thirsty a lot. Physically um. It's just, if, well at the beginning it feels like you're doing it all the time. Like, I felt like I was, always sitting in that chair feeding... and then at night, getting up every, two hours, to feed him, was very exhausting….(Hunter)

> ….being tired. ‘Cause it’s demanding right? You don’t get any sleep. …Knowing that I had to get up. Especially when he’s going through a growth spurt and he cluster feeds for hours and hours and hours, and you’re sitting there going huh, I just wanna sleep. (Monica)

Lack of confidence and knowledge.

Nine women described being unsure or voiced a lack of confidence regarding breastfeeding and parenting in terms of not knowing what to do, in learning a new skill, and lacking confidence in their ability. “Hum. It was a little stressful at first just ‘cause... you’ve never had a baby before. You don’t know what you’re doing.” (Hunter) Women noted a lack of confidence and knowledge in regard to whether their infants were receiving enough breast milk and how this uncertainty affected them emotionally. During this period they also described not knowing what was normal as far as feeding frequency and expressed a lack of confidence in their ability to read their infant’s cues, particularly feeding cues.

> When, when you get a baby it’s... it’s really... nerve na- nerve racking, right? Because... is so tiny. He was so tiny that I didn’t... I felt... a little scared. Right? Because if he fell the wrong way or... if I wasn’t doing it right I wouldn’t know and... and I wasn’t too sure if he was, eating right and... was kinda sad ‘cause I Hmm. Emotionally. Hmm. There is some days I just wanna break down and cry. (Joan)

> Where I can tell like okay she’s hungry, she wants to nurse, she’s tired...She’s going to sleep she’s waking up she wants to play and everything’s straightforward. But um, it’s those tricky days where it’s not straightforward and I can’t figure out...What she wants ‘cause she’s acting like she’s hungry but she’s not...You know? Those are challenging. (Barbara)

This lack of confidence led some women to consider discontinuing breastfeeding. In some cases it influenced women’s breastfeeding behaviors, supplementation choices and interventions such as pumping.

> Yeah and then you know because I wa- I wasn't sure 'cause you can't see, what they're consuming so I'm like e- e- ha- it was challenging. Huh. 'Cause I didn't know, if he was getting anything and how much he was drinking. ….They're, don't get me wrong though like uh seriously there was times where I was like huh no- sno-, he's knocked up... he's not full he's not getting enough…. I wanted there was about three or four times when I wanted to switch him... Because I wasn't sure. I wasn't sure. (Candace)

> I tried it for awhile but then she was getting more and more, connected and latched on to the bottle. And because she was getting some from the bottle and I notice when I breastfed... it wasn't enough because she'd be getting frustrated with me... You could tell that she was wanting more...And I wasn't coming with that, with the milk. (Francis)

Time Consuming Labor

Nine participants shared the time consuming nature of breastfeeding and how this contributed to the tough work of their experience. Women noted the element of time involved in breastfeeding in terms of frequency and length of time at the breast.

> I guess all the... time consuming but...Well at the beginning that's all I do, eat and sleep...Wake up and eat and then, back to sleep..... ....Mm. I don't know. Some people say it can be... tough and like we said it is time-consuming ... (Anna)

Other mothers noted the sacrificing of their time and inability to get anything else done as part of the time consuming nature of breastfeeding. "Takes a lotta sacrifice. You know? Sacrifices your time and...." (Roberta).

Mindfulness of the Woman

Three women acknowledged how mindful they were of what they ate and did and how this could affect their breastfeeding and their child. They described avoiding smoking, drugs and certain foods or beverages as part of this mindfulness.

> I'd even ask questions like... this like uh how does smoking affect and you know like all I always got information right 'cause I was paranoid at e- I don't, take a pill or, you have to eat right and, you know what you eat baby eats so that was a big thing for me too is eating.

> …..So everything like I do, I have to, keep a conscience mind of what I'm giving him. So it's like, you know it's always thinking what I'm what I'm consuming too right? 'Cause I have to be mindful, what , what's going through my body 'cause it's going through his. That's a big thing too right? (Candace)

Each Breastfeeding Experience Different

Women discussed how each breastfeeding experience was different even if they had breastfed a child before. They noted the differences in how each of their infants fed, the variation in their breastfeeding success and the changes in their parental responsibilities with the arrival and breastfeeding of each child.

> It was all different with all of them. ….What was different? Um...Well because I only had a couple a kids back then... And you know I just...Down the line it got harder because I had to tend to everybody else and it's harder... For me now. You know? But it wasn't that hard before because I only had two a them. You know? Or, three a them. (Colleen)

> ..... I breastfed all my kids so it was just a thing that... I automatically want to try, right? Doesn't always work out but, I wanted to try right from, when I found out I was pregnant.
> My son it was only a month and a half. My daughter was three months. They both didn't take to it. Oh a lot different. Yes. Well he's almost six months and he's still breastfeeding so that's just amazing. (Monica)

Dependence

Seven women discussed the dependent relationship between mother and child during breastfeeding. They shared their varying interpretations of this dependence and how it impacted their lives. They described their partner's response to this dependency. Participants also noted the organization required to coordinate being away from their infant and how issues with pumping or bottle refusal could hamper their ability to have time apart from their child. The following quotations describe women's varying levels of acceptance of this dependency. Many women acknowledged the dependency of breastfeeding as meaning not having time to themselves and expressed a need for time

away from their infant. They also noted how breastfeeding differentiated their parenting role from that of their partner's role.

> I need time like sometimes I just wish I could... pop that soother in and...Go to sleep on your own kinda you know? But no he needs... so...Yeah well I mean it's nice to say there ain't, many babies out there that hasn't had a father or a bottle...Or a soother but now...I'm kinda stuck in the middle tryin' to wean him off but...It's hard because... That's the only kinda...He drinks from a cup but it ain't the same. (Anna)

> You know? Like, 'cause I don't get to go out because I'm breastfeeding, right? So- My life is him. So there's also that too ye- it kinda takes away from your being able to go out… And then who gets up in the morning with him after we've gone out drinking? The mommy. Not daddy. But the mommy and he gets to sleep in so it's kinda like well that, that's not fair." (Carol)

Other mothers acknowledged the dependent nature of breastfeeding but were more accepting of its part in breastfeeding. Some recognized the potential for this dependency in the prenatal period and others made this realization during breastfeeding. Some mothers even accepted the dependency of breastfeeding as a necessary part of the experience. Regardless of when this discovery occurred these women framed it differently than other participants.

> That's one a my favorite parts it's just to like giving her all the attention she deserves and... and also it means that I... can't go out as much as, as some moms would like to but ahuh I... don't mind it as much though because, then she doesn't, she doesn't have to sit there crying and wondering where mommy is she, she always has me. (Taylor)

> And see that's that's where I, that's how I felt is like I, I had nowhere to be but here and doing...What I needed to do. So I didn't feel like I was missing out on anything.....I didn't feel that... uh uh is some something else was more important. .....I didn't feel like I was, missing out on anything.. ... Exactly where I needed to be was, here. Yeah. With him. (Candace)

Some women described their partner's view of the dependence associated with breastfeeding. Mothers noted that in some cases their partners were anxious for life to return to pregnancy or pre breastfeeding way of life.

> Like I don't mind as much. The boyfriend does because we don't get to actually go out on dates because, we don't have babysitters. So he's a little more frustrated 'cause he wants life to go back to normal and to be able to go out and... (Carol)

Women described the type and amount of organization required to be away from their infant. They also noted how dependence concerns were exacerbated for some women due to issues with pumping, milks supply or refusal of an infant to take a bottle.

> Yeah. Just knowing that okay I need to leave... you know at this time in order for me to be back by this time so I can... you know? Be there to nurse the baby you know? But there's been there's been times where I've... just told my husband okay, just take out... you know, pack in the freezer. Just give that to her... and then I'll... pump when I get home. …. Yeah. So I think... you definitely have to be... somewhat organized …(Roberta)

> Well it was it was really the milk supply is kinda my reason for not going out but then also, it is hard for him to n- take the bottle..... his dad gets frustrated because he's not taking it easily and I ha- and I tell him like even when I'm giving him the bottle it's it's still hard and... (Joan)

Persevering

Persevering refers to what occurred as women were working through breastfeeding challenges and the tough work of breastfeeding. It is divided into two sub themes: Persevering Background and Persevering during Breastfeeding.

Persevering Background

Persevering Background consists of three subthemes: breastfeeding is something you do; culture supportive of breastfeeding; and beliefs about other women breastfeeding. It is these subthemes that comprise the backdrop from which these women faced the hard work of breastfeeding.

Breastfeeding is something you do.

Women spoke of breastfeeding as a natural act and a normal part of life or their daily living. This stance helped women to continue to breastfeed regardless of the difficulties they encountered in childcare or in their breastfeeding experiences. "Uh... just like an, normal life that I...feeling this over long time. Because to me it's just like...Living your life…" (Ethel)

Culture supportive of breastfeeding.

Two women discussed how their culture supported breastfeeding. Mothers described how it was expected that mothers would breastfeed their infants in their culture.

> So. It so-... it's really, interesting to know that... the woman's body is meant for that. Right? That's, that's what we were created for... and... I'm kind of a, big believer in our... in the, Aboriginal way so. I mean I think if that's the... that's the way that, our creator built us and that's what we're for then, we should at least try it so. (Joan)

Beliefs about other women breastfeeding.

Women discussed the beliefs they held entering into their own breastfeeding experience about breastfeeding itself and other women's experiences of breastfeeding. They expressed their beliefs about women's choices about breastfeeding when faced with its challenges.

> … I have a girlfriend that actually breastfed her kids up until they were almost three, and I remember looking back and saying oh my God that's just so nasty I don't know how she coulda did it that's practically... you know molestation and, you know and looking back it's like ha- wow, how rude was that. Because if anything... those children are so healthy. Uh, their closeness with their mother is, is the bond is just unbelievable. There's so much love... (Beatrice)

> …I did have friends that they had trouble. Like, and you know and they felt the same way too like they just they didn't have enough... But it also came down to if you didn't have them on you, every two hours you wouldn't have enough milk..... And for some women they just find that it's too much. Like you know? And and

> it's okay. I think that's part of it too like a lot of stress is put on... now 'cause they're trying to push the you know breastfeeding is really good... But for a lotta moms they feel like they have to come up with the excuses... (Carol)

Persevering During Breastfeeding

Persevering during breastfeeding includes the subthemes as outlined in Table 6 and discussed in the overview of the themes noted earlier in the findings section. These subthemes are: how I needed to think, be and do; reasons to breastfeed or continue breastfeeding; persevering as an evolving decision; breastfeeding in public and the things that helped with breastfeeding perseverance.

How I needed to think, be and do.

This refers to what women thought, how they felt they needed to be or were, and what they needed to do to cope with the tough work of breastfeeding and persevere in their breastfeeding efforts. Women spoke of needing space to figure it out. This refers to women needing to think and work on breastfeeding on their own. Women also spoke of not forcing it (the breastfeeding), giving it time, the role of patience in persevering with breastfeeding, and trusting their instincts.

> I was lucky that... my mom and my family ... gave me space to figure it out...Do my own thing with him. That you don't have other people telling you, how you should be doing it ...I would want to figure it out...the rest of the way ….I think the most important thing again is just to... allow yourself that space, to just figure it out...On your own between, you and your baby, you know you don't, really need a whole bunch of other people...Telling you all the time how it should g… (Fanny)

> I guess the important thing too is, not to force it, you know? You let, I found it, watching him and letting him, try to figure it out and learn... you know after a couple of weeks you know he became a pro at it.….and, what helps is just having patience and giving it time..... So. I mean the only thing you can do is just relax and trust your instincts. (Fanny)

Women also spoke of the notion of listening to their baby and the importance of this in her breastfeeding continuation.

> I think the most important thing is just to watch, the baby and...And, their cues to...how much they want, when they want it and... So you start to recognize... And, after being around you know your baby twenty-four seven. ..Listen to your baby. That's the most important. Listen to your baby, and, you'll have a happy baby. (Fanny)

> …He'll he'll he'll wake you up he'll wake you up and say hey I'm hungry or... need a burp. Yeah and you could tell which one it is too because, he puts his legs up and he, he catches his toes and he's like, that means I wants to get up. (laugh) Or it he just puts his mouth open he's hungry... now so. Yeah you can tell yeah. (Joan)

Participants discussed what they needed to think and do terms of coping with the stress and tough work of breastfeeding as part of breastfeeding continuance. They spoke of needing to be in the moment and putting everything else aside including their own concerns.

> …I think the, if you're under stress and anything that's going on the important thing to do is just focus on what you're doing at the moment which is feeding your baby. Everything else, can just...Be put to the side and then find it much easier to...You know be in that moment with your baby... To... breastfeed him, properly... So it might mean putting a lot of your own needs, to the side for the moment. So that's something you have to... just accept... That's probably the deal. (Fanny)

> Yeah like sometimes I'll be in the moment …you know in a stressful moment you know where, baby's crying I know she's hungry, you know so, someone got into something you know having to go deal with that... and then, you know, and then finally you get... get to the baby... or you just or you just pick up the baby and just forget about what happened. You know for the moment... and... just feed her …(Roberta)

Women spoke of how they needed to frame or think of their breastfeeding work and the demands in their lives, as a way to cope with stress and persevere with the tough work of breastfeeding. Some spoke of setting breastfeeding goals as part of the way they mentally framed their breastfeeding continuance.

> ….you're not sleeping because you gotta always got somebody attached to you it makes it difficult. Yeah.... it's a good stress though. Sometimes like the no sleep and everything but then you wake up in the morning and you see, your kids are happy and they're smiling ….you know you're tired but you just you you you do it. So it's it's s- good stress. It's not a bad stress. (Monica)

> ….my boyfriend also he just said just keep at it for a little bit longer. He said, you know just... go past two, three months... you know try to, try to give yourself a target point and just try to go past it and I said okay... I'll wait till Halloween... And then... from there we'll t- we'll take it from there and we'll see how it is. (Joan)

Other mothers shared more practical coping strategies in terms of what they thought and did to continue their breastfeeding efforts. These strategies varied from striving to be consistent with their breastfeeding, to employing relaxation techniques, to the use of formula.

> Continuing to do it, and being consistent and I think key thing is consistency. And don't give up…..the way I managed my, my stress and the way I coped with everything that was going around with me, is every time I would vent or, take a moment away from (child's name) …that stress e- was gone as soon as I came back to him because I knew everything I would feel or had a tensed emotions or, anything like that he would sense that, and I didn't want him to feel any of what I was feeling in that sense.….So. Like, I'd always manage to like calm e- myself down breathe, and just when I looked at him I was just happy. (Candace)

> ... Some people wouldn't agree with that but...Um, it was intervals of two hours and a...I really desperately needed rest so I thought... I'd introduce a formula to him. So it just, it got very overwhelming for me...Because I didn't have any support, um, there wasn't anybody to just take him from me for a couple of hours to allow me...So... but the only the reason why I gave it to him is because I really did want him to feel full and be off me give me some relief... right? But I was definitely not gonna cut him completely off. (Beverly)

Reasons to breastfeed and continue breastfeeding.

Women spoke passionately about the reason they chose to breastfeed and continue breastfeeding in the face of difficulties. They offered general statements about the benefits of breastfeeding as part of their motivation to initiate and continue

breastfeeding. "I, basically think it's incredibly important." (Barbara). The also offered the following specific reasons as to why they initiated and continued to persevere in their breastfeeding efforts: health benefits for the infant and mother; to comfort their infant; easier to breastfeed; its natural; savings and cost benefit; watching him/her grow; so baby not apprehended; bonding; and through breastfeeding their infants received everything they needed from their mother. They particularly emphasized the health benefits for their infant, it being the best for their baby and the bonding benefits as crucial reasons to persevere with their breastfeeding despite any challenges they faced.

Health benefit for infant and mother.

Women cited the health benefits as a reason they breastfeed and continued to breastfeed. Their belief in their responsibility to ensure their child is healthy and in the benefit of breast milk is evident in their statements.

> Yeah. I really wanted to breastfeed 'cause I knew how... how healthy, breast milk is for the baby and that was also definitely one of the... reasons why I kept going So yeah I guess it was knowing the benefits of breast, breastfeeding. …Yeah. I guess most importantly is the health of the baby. …Like... I'm, I feel responsible to make sure my family's healthy and, I knew for, I know for infants... breast milk... is... one of the best options. (Roberta)

Mothers noted allergy prevention (N = 2); seeing how healthy their infants were (N =2); the immunological properties breastfeeding conferred (N = 6); the belief that breast milk was the best for their child or children; the nutritional benefit of breastfeeding (N = 8); and the belief that their children would develop better and be more intelligent (N = 3), as influencers in their endurement of breastfeeding challenges and in persevering.

> Of course. The most important aspect of breastfeeding is for baby's health; it's, there's so many, good things that, that come from it. The antibodies, right? The... colostrum you know that first comes first and... there's, no wrong aspect I think of breastfeeding. (laugh) At all. (Francis)

> Well I was just like... I'm gonna do it because it's best for him. I don't care if I don't like it or not 'cause ….was like, ugh I really don't really, want to... but when now I like really like it. Umm. Just when I found out I was just I was pregnant I just decided that it was best for him so. I would just force myself to do it. ….I refused to let myself stop. ... I just feel like... it's best for him so ….. Like I really don't wanna let anything... stop me so. (Phoebe)

Women (N = 7) also shared their desire to breastfeed and continue breastfeeding was linked to the health benefits they saw for themselves.

> ..and emotional satisfaction, and you get some physical benefits too. Physical benefits what I have read is that... it helps to get back your uterus, a in it's position... pre-pregnancy position it's helps that... to get back the uterus, faster in the pre-pregnancy position and secondly it helps you... to shed off the extra pounds, which you put on during the, pregnancy and thirdly... that, it's good for the breast as well because the be- the women who do not breastfeed they gets they, they have chances to get the breast cancer. So. So these are-Yeah. Very important. (Constance)

Content and for comfort.

Participants described how breastfeeding made their children more content and how breastfeeding also served to comfort them. Four mothers expressed how these effects encouraged them to continue breastfeeding.

> I don't know I just it's so it's so good for him he's, he's so healthy he's, I find he's way more content, he's calm... um... he doesn't cry like, cra- he's barely cries. A huh. Only when he really is in need of something a, you know? (Candace)

Easier to breastfeed.

Seven women described the ease of breastfeeding as compared to bottle feeding as a reason to breastfeed and continue breastfeeding.

> It's easier. It's easier than making bottles. Yeah. Boiling water. Cleaning the nipples and ugh. Yeah. Well it's just harder. I find it harder yeah. I it's easier just to... put the baby there you know? Feed him and go. That's what I gotta do. Yeah.Like the milk is warm and ready, it's there... for the babies, it's their milk. You know what I mean? (Colleen)

It's natural.

Five women discussed breastfeeding, breast milk and the act of breastfeeding as natural and how this belief encouraged their choice to breastfeed and continue breastfeeding.

> And it give them... mm natural things on that...Food in their body. And... giving her the... what do you call... natural food... Instead of giving my baby an at... formula s- while I have milk for her no need. I decide to say uh, this is, better than her than giving her natural other one. (Ethel)

Savings and cost benefit.

Women (n=8) spoke of the financial saving associated with breastfeeding and how this helped encourage them to breastfeed and persevere through difficulties. They made the following comments: "In the back a your mind, you think of all that money that you're saving. Yeah and the money." (Anna)

Watching him/her grow.

Four women remarked that watching their children grow and thrive served as a motivator to continue breastfeeding.

> Just looking at him. Because seeing how strong he is, how, how much he's grown like, he's four or five months but he fits clothes that are like nine twelve months right? …and he's so smart and his neck is strong and just…. and he's, he's just, seems a lot healthier than a lot of other ones and, they were like... there are some ……some kids they're in their six seven months and my kid looks bigger. Right? (Joan)

So baby not apprehended.

One participant chose to breastfeed and continued breastfeeding as a measure to prevent her child from being apprehended by a child welfare agency.

> I chose to breastfeed because... um... just, just because, just because I, well, to prove to sear- to (Name of Child and Family Services Agency) they're trying to apprehend my baby and I said... No, you guys are, aren't apprehending my baby

> because, I'm gonna be breastfeeding my baby and um, the grandmothers and grandfathers, who have passed on are making sure you don't hurt my baby so. It was kind of like a little, challenging...It was a s-, straight up....Yeah. To show them yeah. (Francine)

Bonding.

All 18 women who participated in the study described bonding as a motivator to continue and persevere with breastfeeding. It also was its own important entity in the breastfeeding experience. Women spoke of it as both a reason to continue and a by-product or result of breastfeeding and as a critical and integral part of breastfeeding their child. Many identified it as the most important reason they chose to breastfeed. Many women also acknowledged they persevered through the tough work of breastfeeding for what they saw as the most important part of the experience, the bonding aspect of breastfeeding. "Mm. Like I say the bonding and I mean...Mm. It's tough but I mean it's a good bonding... with the baby." (Anna)

Women spoke of breastfeeding as being the ideal way to bond with their infant in terms of the constant close proximity inherent in breastfeeding. Mothers emphasized breastfeeding and the associated bonding as an opportunity for their infant to learn to trust and rely on them.

> Uh well it was also kinda nice, like bonding wise, because he's always close right? And he was like always right there so I spent a lotta time staring at his face. (laugh) Because he's like right there right? ….But yeah, you get to be as close to the baby as you can. And if you're breastfeeding every two hours, that that's a lotta time you're...Actually like holding your baby...And you get to, be that person that's there for them. Like it does help you bond more. (Carol)

> Just the... the fact that she is getting heal- healthy milk and she's... and she loves…. sometimes she loves being fed just, to get hugs from mommy. She just wants s- to comfort from mommy and... I love being able to, be there for her and give her my love and attention. Right. That's one a my favorite parts it's just to like giving her all the attention she deserves and... (Taylor)

Women shared their beliefs about the difference between breastfeeding and bottle feeding mothers and the dynamics between mother and infant. They also noted differences between their bonding with children they had breastfed and those they had not. Mothers even noted a difference in the bond they had with those children they breastfed for an extended period of time versus those who they only breastfeed a few months.

> I just found that... it was just good for him I just wanted to have that bond and attachment and make him have the best... The best in life from the beginning right?… I never had this experience and I find that, the attachment, the bond..... all the good stuff that comes with the breast milk is just wonderful for him..... I wasn't, I was at a point in my life where I was... just not feeling, n- feeling it at all. I think uh... I wasn't ready, to do that, to the breastfeeding and have that... I don't know I don't have like that, bond bond, as much as I do with him. And I think breastfeeding helped, with that. It really, strengthens a bond. (Candace)

> He's more familiar like... when I... my other kids when I took them off the breast they, they, they don't seem so close but him he's really close to me eh?" (Colleen)

As part of this bonding process, women spoke of their and their infant's enjoyment of breastfeeding and how this assisted in their enjoyment of the experience and helped them to persevere through difficulties. Four women shared their enjoyment of breastfeeding. Five women discussed how their infant's pleasure in breastfeeding encouraged them to persevere with their breastfeeding efforts. Other mothers noted their and their child's mutual love of breastfeeding, the resultant bonding experience and desire to continue breastfeeding. Key to these descriptions and the bonding experience was the dynamic interaction of breastfeeding.

> ….and... I wound up just liking it. I didn't think I was going to and I didn't think I was going to breastfeed this long but...and I, I really liked it like you know like, he enjoys my time with me and I enjoy that time with him and... sometimes we just lay down and cuddle (laugh). So I I spoil him a little bit like that … (Joan)

> Yeah. Like right now I'm just starting, I'm just talking to the baby eh? And... he's talking back to me... and I'm talking to him and he's eatin' there and, he'll start talkin' back to me. Baby talkin' eh? (Colleen)

Getting all they need from me.

Women also noted in their breastfeeding experiences, the idea that their infants were "getting all they needed from me" (their mother). This referred to women being able to provide for all the emotional and physical needs for their child through breastfeeding.

> And just I've just really, enjoyed it and it's, it's just so adorable and... nice to have him here. I like …. providing for him. Still through my body like I was when I was pregnant. How big he's getting and... it's just really... really neat. (Phoebe)

Persevering as an evolving decision.

Most participants did not specify a length of time they planned to breastfeed or persevere in their breastfeeding efforts. Some women spoke of persevering or continuing to breastfeeding as an evolving decision. This decision was based on factors such as difficulties they anticipated encountering (e.g., biting; public breastfeeding and return to school); if they were able to cope with those challenges; and if they felt they were successful in breastfeeding and achieving their goals.

> ….I told myself too I said if he gets teeth that's it. You're done. I'm not I'm not letting you bite me 'cause it's gonna hurt right so.... I also want to see, if it hurts too right 'cause if I can pull through it or if we, or if I can train him... teach him not to bite..... then I'll stick with it. But it all depends like it's kinda... gonna go... week by week day by day kinda thing see how it goes. (Joan)

> I kept saying oh yeah the first three months then I extended it to the six months now we're, past the nine month mark you know? So I think about a year….that would be my next goal...Will be about a year I'd like to cut him off but if it doesn't happen... and, you know he doesn't negotiate in front of people...And things go smoothly...I'll continue to breastfeed... but when it starts to feel that embarrassing….until it just gets to the point where I'm just gonna say absolutely not...That's it. We're done. (Beatrice)

Breastfeeding in public.

Many women discussed breastfeeding in public as a challenge in persevering with their breastfeeding efforts. Participants spoke of initially being uncomfortable or shy about breastfeeding in public.

> ... That part was very inconvenient 'cause....I was shy in the beginning... So if I had to breastfeed in public because...I couldn't, fully cover myself 'cause there was no blanket that he'd allow me to keep on there. (Carol)

Women noted that part of this public breastfeeding experiences was the negative response that occurred when they breastfed in public.

> Is... it's difficult when you're feeding in publics and stuff and people don't understand right and they'll make comments or whatever. That's when it's difficult and you're like uh, why do I do this you know? You get …..all this flack for it but then you realize wait no... they're wrong not you. ....I've actually had somebody come up to me in a food court and say can't you do that in the bathroom? (Monica)

Breastfeeding an older child created more disapproval than feeding a younger infant.

> No, I just find sometimes like 'cause he is, a big boy...For his age I find...But like that was said earlier he looks like he's eighteen months almost. I find like if I go out in public and he wants it I mean I'm not gonna deny him milk... But I feel like people look at me like ooh isn't he too old for that? (Anna)

Women described how they managed public breastfeeding. They shared their strategies and how they worked to achieve privacy in terms of covering themselves and finding private space to breastfeed.

> Like when I go out with him? That's fine. That's fine. I me- might take a blanket and, yeah … be. Yeah. I'm a little shy still. But I have a apron and, it's not as bad. I can always go to my car or something if I feel, shy. Yeah. Yeah I've, gone and hid in the backseat. (Joan)

Women described being comfortable breastfeeding in front of certain people and in certain situations and not in others. Some women noted a difference in breastfeeding

in front of their family and friends versus the general public. Others described being comfortable breastfeeding only in front of certain family members or only in the presence of women.

> ...Just certain people. Um I would never breastfeed out in public. … I myself actually kind of feel uncomfortable… if it was a room full of women, and, someone wanted to breastfeed I would feel absolutely, fine. As soon as a man's in the picture it's a very uncomfortable feeling for me. Um. My family, I'm one hundred percent okay, breastfeeding in front of them as a matter of fact they encourage it, they think it's kinda funny you know? Um. Friends, absolutely not. Not even with a blanket. No way. (Beatrice)

Many women noted that with time and experience and as their confidence grew they became more comfortable with breastfeeding in public. The length required for this comfort and confidence to develop was unique for each woman varying anywhere from a month to nine months to in some cases never breastfeeding in public.

> 'Cause you know breasts are so sexualized now and everything and it was just like... oh they're just popping out their boob but now I'm like... well they're feeding their baby…I don't care now. …Like after I had him it was like... the whole blanket thing was just getting so annoying and... so I was just like whatever I don't care huh if you have something to say then... screw off kinda deal. (laugh) So....Maybe like a month. (Phoebe)

Some women described part of this transition to becoming comfortable with public breastfeeding as receiving support or being exposed to a positive role model.

> A lot of it was being with my other friend who breastfeeds and her being able to just like pull it out in public and not care about what anybody thinks and I was like wait a second. (laugh) Was like I should be like that yeah. (Monica)

Things that helped.

Participants discussed things that helped them persevere with breastfeeding. Women outlined how the items; concepts; things they did; or the type of experiences that

helped them with the tough work of breastfeeding and to persevere through the challenges they encountered.

They noted the following things assisted in their breastfeeding efforts: breast pump use (N = 3); nipple shield use (N = 4); nipple creams (N=8); tea bag or warm water use (N = 2); books and reading (N = 6); co-bedding (N = 3); hot or cold showers (N = 1); baby wearing or swaddling (N = 2); previous breastfeeding experience (N = 2); and helpful general suggestions (N = 2). Women commented about why the items, strategies or experiences noted above were helpful.

> ….. read a lotta books … Books just gives you the basics but it did tell me, a lot about the positionings... and... about dry cracked nipples and stuff like that. Stuff that I didn't really know about that would happen or could happen.... they have some like Baby Cente, online ... like pinpointing what I was thinking about in that month. Like month three getting time to yourself and stuff like that so it was really... really helpful ….(Joan).

> I did my daughter (i.e., breastfed) so I mean it's...Well I guess doing it once before was...You know what to expect. I mean if I think back to the first...Pregnancy, then yeah but now with him like I knew, what to do, what to expect. (Anna)

The Flow Came

The Flow Came refers, as previously noted to women's experiences of breastfeeding becoming easier. This theme in the breastfeeding trajectory applied to those women who continued to breastfeed or pump beyond a certain point, were having success and were able to persevere to where breastfeeding became, for most women, easier. It consists of three subthemes: things got easier; infant learning breastfeeding; and pride and confidence.

Things Got Easier

For the majority of women who continued to breastfeed, there came a point in their breastfeeding journey where "things got easier" or women were not experiencing as much difficulty in their breastfeeding. This was the point at which women felt they had reached a place where things became physically easier for them and where they felt confident in their ability to breastfeed and read their infant's cues. Some women noted that their bodies and the flow of the milk was matching their infants' needs at this point. Other women found it was at this point that their infants went longer between feeds or that they were more efficient with their feeds and breastfed for a shorter period of time. Some women also noted the bond or emotional connection with their child had reached a different level at this stage. Women also spoke of their or their family's adjustment to the infant as having improved or occurred by this point, making life easier.

> Then it, it, one day just got easier. .....It just it, seemed it was just, yeah it was just easy all of a sudden, it was like it was just natural s'like okay plop it out here. And he would sleep a little tiny bit longer at that point. An hour at a time especially in the beginning now it doesn't...Take that long but….You know if you just stick with it it's really hard in the beginning. But at some point it does get easier which it did it just kinda like magically all of a sudden was a lot easier. (Carol)

> Like us I mean the flow as in... my breasts being balanced to her needs. Her being able to latch on properly...Feed well... That sort of thing. So it's consistently getting easier...The longer we do it...The more we do it. ….My breasts have returned almost to their normal size. …..So physically it's less painful and... Less uncomfortable. …. things got better physically and.....Like the, emotional bond got, became more and more...Yeah it just keeps getting easier ….. (Barbara)

Participants described how they started to feel they were getting the hang of it and noted an increase in confidence in a number of areas including reading their infants' cues and their ability to produce an adequate amount of milk.

> You're breast milk does not, it, it will not stop producing...It's there it's good to go you have a good foundation...It's there and it wi...It'll always be there for him. And then after just knowing that, after three months you're good it's good like it's some something in my brain just said okay I'm good like, milk's not going anywhere... you know he, he's knows he's got a preference he knows what he's doing... we, we, we got attached that way you know? So he, he knows right? (Candace)

Mothers also described a family adjustment and improvement as part of this stage in the breastfeeding process.

> Well I'm... I don't know. It's... i- it's e- it's getting easier... Anyways yeah. It is getting easier. Like... with my kids' help and that...And we're all... I don't know adjusting to the baby and... Yeah. (Colleen)

Women spoke of this point as occurring anywhere from one month to three months after the birth of their infant.

> Then, mm, it wasn't until, probably about, between... two to three months...That, the flow, came. ….Uh-hum. It's hard to say because every... with e- with every week that passes I think...Oh this is getting easier. (Barbara)

> Mm- when she was about a month... and sh-, she's c- we're bo- well I'm an old pro at it and she's an she's getting to be pro at it too like really good at it so. (Taylor)

Infant Learning Breastfeeding

This subtheme refers to the women's perspectives of how their infants' abilities and learning contributed to this improvement or progression in assisting to make the Flow Come. Women noted how their infants' abilities contributed to breastfeeding becoming easier for them and their child.

> I think it's more. Him……It's definitely easier. Like he kinda finds his... way on the nipple a lot easier and..... don't have to... support him like when holding him as much…I just could tell like... he just right away would find .. find the spot and... I could ... like now I can breastfeed, in different positions. Like laying down or...Or sitting or it's just a lot more comfortable. (Hunter)

Pride and confidence.

Women noted the pride (N = 2) and confidence (N=3) they developed as they had breastfeeding success and continued to breastfeed.

> It is a good feeling that when you... breastfeed your... child, you give your milk, you feel, you know? You feel proud that you are doing something for your, child. And, it's really you feel very good, it's a good feeling, that you are you know? (Constance)

> It really gives you a lot of confidence...As a mother. That you're able to do that. I would say it's very rewarding for yourself. Um, you know it gives you more confidence as a mother, 'cause you know you're doing the right thing. And, when... you need to, pay attention to your baby and you follow his needs then... it just reinforces that confidence...When you see that he's happy and satisfied. (Fanny)

Based on this pride and confidence participants felt the need to encourage other women to breastfeed and offer advice to other mothers based on their personal experiences.

> I very much encourage it. I really... think that ... women should breastfeed…... to allow, not only the closeness, but the, the proper nutrients, the anti- ahi- antibodies. …..I think it's really important, for the baby and for the mom. …. I just really encourage moms to do it. No matter what...Don't listen to your friends. Don't listen to silly people. It's about you and your baby. It's not about everybody else. (Beatrice)

Breastfeeding Variability and Change

For those women who continued to breastfeed or pump, they noted that even after breastfeeding became easier or The Flow Came, there was still change and variability in their breastfeeding that posed challenges and made it difficult at times. Mothers noted the ongoing frequent feeding, variability, non-routine and time consuming nature of breastfeeding even for their older infants.

> …….as soon as I'd think that I would get it, and I was starting to understand it, he'd throw me for a loop and be s- crying non-stop and we sick in a r- or

> something that a, it was just like oh my God I don't know what I'm doing. (laugh) You know like as soon as I thought I would get it and I, I got this down pat he would just, throw a curve ball at me. (laugh) Oh yeah he you think you're getting it. (Joan)

> But when he was sick a couple of weeks ago so I let him feed during the night...Because he wasn't eating much... So it was to compensate that. So now...He got used to that again...Because he was doing that for a week so now he thinks it`s okay... To feed at two four and six in the morning and it`s like no. No, we can`t! It`s too much for me! (Carol)

Even though breastfeeding had become easier overall at this point, the variability and changes these women experienced still caused them to consider discontinuing breastfeeding.

> So if he needs to feed for twenty minutes he needs to feed for twenty minutes I can't time it sometimes it's five sometimes it's two, sometimes it's an hour I'm sitting on the couch. Yeah and that's just the way it goes. ..Yeah. Some days you wanna quit 'cause you're just like oh this is too much right? But, other days you're like oh this is great. (Monica)

Participants described how they coped with this breastfeeding variability in terms of their thoughts and framing of the situation.

> …it's still challenging..... I've, lear- learned to remind myself is some days are good and some days aren't. And I.. will say to myself in my head like today is a good nursing day...Or, today is not a good nursing day.....If I were to think that that would be the rest of our nursing life that would be very frustrating. But then I, remember that we do have really good nursing days...And just knowing that like, if I get past this time period there will be a time period shortly, where things... will be smooth again. (Barbara)

Not Continuing

This theme refers to the differences noted between women who did not continue breastfeeding or pumping versus those who continued breastfeeding. The two participants who ended their breastfeeding journey shared parts of their experience or thinking that was different than other women who participated in the study. They shared

thoughts of not originally planning to breastfeed, the idea that breastfeeding went its own path and how breastfeeding did not work with their lifestyle.

Not Originally Planning to Breastfeed

This theme refers to women not originally planning to breastfeed and at the time of delivery changing their mind.

> It wasn't originally planned. But, when I first started... um was in the hospital. So. It, it was, kind of encouraged by the nurses...So. It wasn't originally planned...But, uh it, did come, to us as, we were in the hospital and it was more encouraged there at the women's hospital. ….. They really encouraged it. It was just really... what everyone did... And so, I did start breastfeeding at the hospital… (Francis)

It also denotes the prominence of doubt women had about their ability to juggle or manage breastfeeding and the contradictory thoughts and feelings they described regarding breastfeeding continuance. This contradiction for women was also apparent in their breastfeeding actions and choices, and even in the way they spoke about their breastfeeding. They engaged in actions that were not supportive of their breastfeeding.

> …there were some doubts, that, the beginning and that, those were the differences I guess. ... I felt that, you know? This time around, you know with, not only having... one child I have two this time and so I needs to pay some attention to (name of 1st child)..and so I thought okay, yeah we'll bottle feed this time. …I was thinking, great. You know? She's on the breast. That's great. That's what, you're s'posed to do. Or supposed to do right? But um... in the back of my mind I kind of wanted her... on to, one kinda wanted her to... go on the bottle….I was at home here for the first two months with her breastfeeding. Introduced her to the bottle because... (Francis)

Breastfeeding Went Its Own Path

Breastfeeding was also described as going its own path. This refers to women's interpretation and beliefs about how their infant's perceived breastfeeding; the lack of control these women believed they had over their breastfeeding path; and how they interpreted breastfeeding problems. Women discussed this concept by noting that their

infants went naturally toward the bottle or perceiving that their children were choosing or preferring the bottle-feeding versus breastfeeding..

> Started her off on the breast and went towards the bottle.... it just went on it's own, path after... I'm introduced the bottle. Yeah..... I just, embraced whatever she wanted, right? ..... it was just it, it naturally went towards the bottle. She, actually I think liked the bottle more... in the end.…. (Francis)

Women also described what happened in terms of their breastfeeding trajectory as being meant to be and something that they or others did not control. In essence they, contrary to women who continued to breastfeed, described not having control over their breastfeeding course and did not feel they or anyone else could have done anything to alter the course of their experience.

> I don't think it's anything anyone could've done. Mm like I said um once (name of 2nd child), got introduced, to the bottle and leaned more towards it...That's what she wanted... then we gave her that, that she wanted…. It's, it's how things went for our family.... it just went on it's own, path after... I introduced the bottle…. It's just it that's the way things happened.....When we let things go with the flow so to speak. (Francis)

This belief of breastfeeding going its own path resulted in women interpreting breastfeeding problems differently than mothers who continued to breastfeed. Women either did not recognize or acknowledge breastfeeding problems and therefore did not independently intervene themselves nor did they seek assistance from others to rectify the concern.

> ..And because she was getting some from the bottle and I notice when I breastfed... it wasn't enough because she'd be getting frustrated with me... You could tell that she was wanting more...And I wasn't coming with that, with the milk.... And so that's how I, cam-, kinda dried out so they say. …. I never uh thought of it as a problem. No. Like...I'd never really asked for help...When it stopped. We just... went on to the bottle. (Francis)

Breastfeeding Did Not Work With Our Lifestyle

The two women who discontinued breastfeeding described breastfeeding as not fitting with their lifestyle. These mothers acknowledged that early in their breastfeeding experience (i.e., in the first 1 to 2 months of breastfeeding) that breastfeeding did initially fit with their and their family's lifestyle.

> And... it fit right in with of course with our schedule here at home. …And I stayed home for the first two months with her and so..... Staying at home and being with baby. It everything fit in perfect.…. It was just me and baby and (name of 1st child)...(Francis)

> Was... I don't know 'cause it was... 'cause I wanted to s- just, stay in my room. I didn't wanna go out nowhere. Uh that just, n- 'cause um I had no, I had, I disconnected all my phones. (laugh) I want to be left alone. (Francine)

Over time however, these women described how breastfeeding eventually did not fit with their and/or their family's lifestyle. They described breastfeeding as restricting their life in terms of their freedom to do other things and limited other people's willingness to care for their child and therefore their opportunity for respite or time alone or without their child.

> 'Cause nobody would babysit, for your, your kid or you can't go out though. Yeah. 'Cause they're on a time limit. …. so I could never do anything. I could never go anywhere... well you have to make sure like, time limit if um... if you know when he's gonna, wake up, and you just finished feeding him ….. So it's like a time limit thing. (Francine)

Mothers described conflicted feelings regarding breastfeeding and in some cases noted regret regarding cessation but ultimately noted breastfeeding did not work with their or their family's lifestyle.

> ….I know for a fact I could probably get her back on...If I stayed at home for a whole week straight. ....Just gave her nothing but breast milk. I knew it would come back.... I know for a fact I could probably get her back on... it's something

> that... I don't want to do...Personally. But in her best interest it would be best I know. I know that… But it's not in, in the, our lifestyle right now.....I like going out a lot and doing...Things and it's just really easier for me to, to give her the bottle. (Francis)

Chapter Summary

This chapter presented the demographic data collected to provide a picture of the participating women and their families. The essence of the breastfeeding experience of low-income women in the city of Winnipeg was breastfeeding is "amazing and tough". The following major themes further described the experience of all participants: life context; tough work; and persevering. Women discussed their breastfeeding experience in terms of life stressors, new starts or changes, juggling work and school and the supports in their lives that helped or hindered their breastfeeding experience. They shared what made breastfeeding tough work and what helped them persevere. Those women who continued to breastfeed also described the themes of the flow came and breastfeeding variability and change. These participants noted how with time breastfeeding became easier and how their infant's learning contributed to this ease. They also described their confidence and pride in their ability to breastfeed and persevere. Participants discussed how even as breastfeeding became easier there were still changes and variation in the experience. Those participants who discontinued breastfeeding noted the theme of not continuing and described breastfeeding as not being the original choice for feeding or provided rationale for breastfeeding not in keeping with those who continued to breastfeed. These women, who discontinued breastfeeding, also described breastfeeding as going its own path and as not working with their lifestyle.

CHAPTER 5: DISCUSSION

In this chapter, the varying demographic face of low-income women is discussed. The significant role of stress in the lives of these women and its effect on their breastfeeding is also reviewed. The differences in the breastfeeding experience of those low-income women who continued breastfeeding and those who discontinued breastfeeding as well as outlier study topics are outlined. The results of the study in relation to previous breastfeeding research are reviewed. Other points for dialogue are: the application of Fishbein's (2009) Integrative Model of Behavioral Prediction to study results and study limitations and strengths. An overview of the implications this study has for practice, policy, education and research is also provided.

The Varying Face of Low-Income

The results of this study, in particular the demographic data, underscore the varying face of what it means to be living as low-income women. Not only was there variability in the age of women who participated in the study, but there was marked difference in the education level of the participants. Low-income women in this study were in their early and late 20's as well as in their mid to late 30's. Increasing age during the child bearing period did not protect a woman from poverty.

Women participants were diverse in terms of their education level. Not only had some women not completed grade 12, some did not have junior high, or in some cases had not finished elementary school. Women, with this education and associated literacy level, would find working and functioning fully in Canadian society very difficult (Human Resources and Skills Development Canada (HRSDC, 2013). The majority of women had completed Grade 12, a factor, one would hope would offer some protection

from low-income status. Unfortunately it did not provide this for these participants. The other surprising finding is the prevalence of women with post-secondary and graduate education being part of a low-income group. The advanced education these women had attained did not shield them from financial insecurity.

It is unclear, as this was not asked of participants, the length of time women had been living in their current income circumstance. It is probable, as all women were receiving the Manitoba Healthy Child Prenatal benefit during their pregnancy that their income was at this level for at least the duration of their most recent pregnancy. If some women's low-income status was more temporary in nature this was not captured in the study or part of the scope of the study. This information may have provided insight into the lives and circumstances of participants in a unique and insightful way, including if this influenced breastfeeding behavior.

As noted in the literature review, although family income influences breastfeeding behavior, other variables such as age and education have been found to better explain breastfeeding initiation and duration outcomes (Al-Sahab et al., 2010; Millar & Maclean, 2005; Sheenan et al., 2001). The variability in the demographics of low-income women in terms of the stressors and life circumstances shared by participants, may also account for the discrepancy seen in the literature as to why other variables in breastfeeding research are often found to better explain the differences in breastfeeding initiation and duration, as opposed to income. If stressors and other variables, more difficult to capture, are not accounted for then it may seem that age, education and these other variables more strongly influence breastfeeding behaviors. It would be important to capture and quantify stressors, level of stress and life circumstances in future research to determine if there is

an effect and the extent of the effect these variables have on breastfeeding outcomes.

The Role of Stress in the Lives of Low-Income Women

One of the prominent findings of this research study is the role of stressors in the lives of participants. All participants except for one made reference to the stressors in their lives. Most participants noted multiple stressors and often of a severe nature (e.g., housing issues; homelessness; spousal abuse/recent separation). Many of these women continued to exclusively breastfeed or breastfeed at some level despite the stress occurring in their lives. For some women, the stress of being a single parent and lacking assistance resulted in supplementation and the discontinuation of exclusive breastfeeding. For other women, homelessness, severe financial issues, addiction history and other stressors contributed to breastfeeding cessation.

Current breastfeeding literature neither explores nor notes the impact of life stressors these low–income women described as being part of their breastfeeding experience. It would be important to determine the impact of stressors on breastfeeding initiation, level of breastfeeding and breastfeeding duration and to determine if there is a certain level or threshold of stress that influences breastfeeding outcomes. It is also imperative to determine if certain types of stress (e.g., homelessness) or how a woman experiences or interprets this stress affects her breastfeeding status. Additionally, the role of supports and the problem solving assistance she has in her life, to assist her not only in her breastfeeding efforts but in all areas of her life that are causing stress or are challenging, would be important to explore via research. For example, participants, who had left an abusive relationship, were living in supportive housing and receiving counseling and support, may have been able to continue to exclusively breastfeed due to

these changes and the types of support they received. In contrast, women who noted no supports or limited supports in their lives in general and did not appear to receive the appropriate breastfeeding support or other assistance with housing or other life challenges, discontinued breastfeeding. The type of stressor, the differences between the levels of their stress and how they interpreted these challenges, as well as the kind and quality of the support they received may have resulted in the differing breastfeeding outcomes.

The participants' comments regarding housing concerns, depression, financial issues, work stress, spousal abuse and other stressors brings into focus the unique needs these women have and their quality of life. If these needs are representative of the needs of low-income women as a whole, this points to the importance of addressing not only their breastfeeding issues and providing appropriate breastfeeding support but also doing so for their other life challenges. This type of action may be required if we truly wish to support them in their breastfeeding efforts and in their lives as a whole.

Continuing and Discontinuing Breastfeeding

There were differences noted between the participants who discontinued breastfeeding and those who continued. Participants who discontinued breastfeeding noted breastfeeding as not fitting with their lifestyle; either: (a) made the choice to breastfeed late in their pregnancy or (b) had originally planned to formula feed; described unique reasons for choosing to breastfeed; and noted either a lack of support from others regarding breastfeeding or a neutral response. In this category, women were often experiencing high levels of stress and/or interpreted breastfeeding difficulties differently than other women. These women described breastfeeding as not fitting with their

lifestyle. This was in marked contrast to the other women in the study who described the tough and challenging work of breastfeeding but who did not refer to this concern (i.e., breastfeeding not fitting with their lifestyle) as these participants did. The women who discontinued breastfeeding depicted breastfeeding as not fitting with their lifestyle due to the other demands or priorities in their lives such as finding housing; juggling the care of other children; volunteering at school; and not being able to go out and be away from their infant unrestricted by breastfeeding times and frequency. This difficulty in integrating breastfeeding into life was noted in the research for other women who ceased breastfeeding or decreased their level of breastfeeding (Raisler, 2000). Raisler (2000) noted women commented about "getting on with my life" and the difficulty of resuming activities at home, work or school. The author also described women's experiences of the downside of the physical bond of breastfeeding as feeling restricted by breastfeeding or tied down as the reason to switch from full to partial breastfeeding or ceasing in their feeding efforts (Raisler, 2000).

Timing of these women's breastfeeding decision-making was also a unique factor for these participants as compared to other participants who continued to breastfeed. These participants either noted planning to formula feed and only due to the encouragement of hospital staff deciding to initiate breastfeeding, or decided to breastfeed late in their pregnancy. They also described an ongoing struggle and doubts about breastfeeding even after initiating it. A late decision to breastfeed, either later in the pregnancy or at the time of delivery, or an original decision to bottle feed, are noted in the literature as key factors in breastfeeding cessation, shorter breastfeeding duration and are also linked to a low level of breastfeeding (Bonuck et al., 2005; Dennis, 2002;

Donath & Amir, 2003; Digiorlamo et al., 2005; Mistry et al., 2008).

An additional explanation and unique finding for some of the participants who discontinued breastfeeding was their descriptions of motivators to make this feeding choice. Although these participants noted, as did women who continued to breastfeed, reasons to breastfeed such as bonding with their child or knowing that breastfeeding was best, a unique reason to initiate breastfeeding was also noted in some circumstances. A participant described choosing to breastfeed as a method to prevent apprehension of her child. It is unclear when the involvement with the child welfare system in pregnancy began and whether this involvement may have coincided with the decision to breastfeed. It is possible if there had not been this added pressure on the feeding decision the participant may have made her choice at a later time and/or made a different choice. The participant noted that once she had announced her feeding decision to the child welfare agency she was involved with and linked this choice as grounds for the organization not to apprehend her child, she knew she would have to deliver on this statement. This motivation to breastfeed and continue to persevere is therefore markedly different from other women in the study. This may have contributed to her discontinuing breastfeeding, particularly if she felt the threat of apprehension for her child was decreasing at the point she ceased breastfeeding.

Participants who discontinued breastfeeding were experiencing multiple stressors and often of a severe degree, including homelessness, no personal or professional support, severe financial issues, child welfare involvement and a history of spousal and addiction issues. The amount and type of stress women in this category were experiencing was in some cases different than what other women in the group were

experiencing. Lack of support or encouragement regarding breastfeeding or neutral response regarding feeding choice and continuation was also experienced by participants who discontinued breastfeeding. The stress these women were experiencing coupled with lack of support regarding breastfeeding and other areas of their lives could be contributing factors to their early breastfeeding cessation. Lack of support or neutral or ambivalent responses (Scott et al., 2001) regarding breastfeeding initiation or duration are noted in the literature as negatively influencing breastfeeding outcomes (Bai et al., 2009; Hurst, 2007; Locklin, 1995; Olayemi et al., 2007) This held true for the women who discontinued breastfeeding in this study. Although other participants in the study noted negative, unhelpful experiences or described unsupportive people in their lives, they also noted either some positive, helpful experiences and/or positive support people who encouraged them to initiate breastfeeding and continue breastfeeding. This positive support and encouragement appeared to counteract the negative. Research confirms the importance of supportive partners (Bai et al., 2009; Hurst, 2007; Olayemi et al., 2007), friends (Barona-Vilar et al., 2009; Greathouse, 2008; Heineg et al. 2009), family (Greathouse, 2008; Olayemi et al., 2007) and professional support (Bailey et al., 2004; Greathouse, 2008; Raisler, 2000) in encouraging the initiation and continuation of breastfeeding.

Participants who discontinued breastfeeding did not experience markedly different breastfeeding challenges than other participants. What was different was the type of support received and their perception of the problem. These participants either received inappropriate professional support when experiencing breastfeeding challenges, support not tailored to their individual needs or they did not realize they were experiencing a

breastfeeding challenge that could be addressed. In some cases they did not view their breastfeeding issue (e.g., milk supply) as a challenge that could be or needed to be resolved. The literature notes the need for support to be individualized to a mother's needs due to the variation in breastfeeding experiences and differences among women (Greathouse, 2008). It also describes the importance of a support person who will strategize; lay out an intentional plan to handle problems; help the woman come up with an order of steps and determine if they will help; take specific action and follow-up; and find a plan for continued breastfeeding (Johnsen, 2002).

Outlier Study Topics

There was a comment noted by one woman that was not described by other participants. She made comments about finding breastfeeding initially as sexually arousing. She stated the following:

> when I started um... I guess it was uh... you know you don't know what to expect nn and stuff and, uh... actually uh... it is a little bit sexually arousing...With the breastfeeding. But as time went on that actually started to diminish. Like that sensation would uh...Diminish so. Before like... um... I guess playing with my nipples was always sexually arousing but...Now it's not anymore. So that was...Yeah that changed. (Fanny)

It is unclear if these comments are truly unique to this participant, or if other women were not comfortable to discuss breastfeeding and their sexuality and the pleasurable sensation that may be associated with it. The literature does not discuss breastfeeding, sexuality and an association between the two. It may be that such effort has been made to de-sexualize breasts in order to make breastfeeding more palatable for women and the public that the sensations and pleasure associated with the experience have been discouraged from being expressed.

Links to Previous Research

As noted earlier in the discussion section, previous research findings regarding the integration of breastfeeding into a woman's lifestyle, timing of the decision to breastfeed, and lack of breastfeeding support were confirmed to similarly influence breastfeeding outcomes in this study. There were also other areas where the results of this study concurred with previous research. This congruence occurred in the following areas: breastfeeding level and exclusivity; previous breastfeeding exposure; maternal smoking; lack of maternal preparation; breastfeeding difficulties; early breastfeeding learning; breastfeeding confidence; the theme of persevering; reason to continue; bonding and attachment; dependency and loss of freedom; support; breastfeeding in public; return to work or school; and continuing to breastfeeding as an evolving decision. Differences between the results of this study and other breastfeeding research are also discussed.

Breastfeeding Level and Exclusivity

The majority of women (11) in this study were not exclusively breastfeeding. The offering of formula occurred anywhere from their postpartum stay in hospital to during the early weeks or months in the postpartum period. The reasons for supplementation varied. Women noted the rationale for supplementation as being related to the some of the following issues: milk supply concerns; infants failing to latch; and feeling overwhelmed with the demands of breastfeeding. The low frequency of exclusive breastfeeding in this study fits with the research noted for low-income women that suggests a negative association between these two variables – low-income and exclusive breastfeeding (Coulibaly et al., 2006; Dubois & Girard, 2003; Millar & Maclean, 2005).

A sound comparison between participants regarding the duration of breastfeeding

is not possible. Women were at different stages in their breastfeeding experience in terms of the age of their infant, as ages ranged from 2 ½ months to greater than 1 year of age. The majority of women were continuing to breastfeed so their actual duration is not known. It is therefore not possible to come to conclusions about the breastfeeding duration of these participants or discuss breastfeeding duration in terms of previous literature in this area.

Previous Breastfeeding Exposure

Previous breastfeeding exposure was described by the majority of women in this study. Women spoke of family members and friends who they knew had breastfed or who they witnessed breastfeeding. Those who did not have this exposure noted the benefit of finding a friend or receiving positive exposure to breastfeeding. The literature confirms that women who have been exposed to breastfeeding are more likely to initiate breastfeeding, have a higher level of breastfeeding and longer duration (Hoddinott & Pill, 1999; MacGregor & Hughes, 2010).

Maternal Smoking

Research suggests that low-income women are more likely to smoke (Greaves et al., 2003; Greaves et al, 2006; Women's Health Data Directory, 2011) and this was true for 10 of the participants in this study. There did not seem to be a relationship between breastfeeding level or exclusivity and smoking as 3 of the 7 women who were exclusively breastfeeding were smokers. Smoking did not appear to affect the level of breastfeeding (i.e., high, medium or low) of those women who were partially breastfeeding. It also did not appear to affect breastfeeding duration, as of the 2 participants who discontinued breastfeeding, one woman was a smoker and the other was a non-smoker. These findings

do not reflect the findings from previous research regarding smokers being less likely to breastfeed exclusively (Kristiansen et al., 2010; Li et al., 2008; McLeod et al., 2002; Scott et al., 2006) or breastfeed for a shorter period of time (Amir & Donath; 2002; Forster et al., 2006; Gilgia et al., 2006; Kristiansen et al., 2010; Li et al., 2008; Scott et al., 2006; Thulier & Mercer, 2009). This difference could be reflective of the small sample size of the study. It may also be possible that smokers who discontinued or had a low level of breastfeeding chose not to participate in the study. Another possibility is as, noted by Donath and Amir (2004), that the independent effect of breastfeeding intention on duration was stronger than the effect of cigarette smoking for the women who participated in this study.

Participants in this study did recognize the negative effects of smoking on their infant, discussed in the mindfulness section of the findings of this paper. This concern fits with that noted in the research where women perceived a strong risk of harming their child when smoking while breastfeeding (Goldade et al., 2008). Participants however recognized the importance of breastfeeding and regardless of their smoking habits continued to breastfeed, despite in many cases, an inability to stop smoking. Only one mother noted specific assistance or support to discontinue smoking from a health care professional.

Lack of Maternal Preparation

Participants in this study described breastfeeding as demanding, tough and time consuming and experienced it as more difficult than they anticipated. They also admitted to struggling to continue breastfeeding. Other researchers also noted the anticipated versus the reality of breastfeeding in terms of difficulties and women struggling to

exclusively breastfeed or continue any level of breastfeeding (Burns et al., 2010; Scott & Mostyn, 2003). Studies have also described this similar maternal lack of preparation for the tough and difficult work of breastfeeding (DaMota et al., 2012). One of the participants, specifically noted utilizing supplementation as a way to cope with the demands of breastfeeding, an outcome also described by DaMota et al. (2012). Reasons for supplementation noted in the literature were related to inadequate preparation for the experience of caring for their newborns; lack of knowledge about the process or physiology of breastfeeding; and the belief that formula is the solution if breastfeeding was perceived as not effective (DaMota et al., 2012), all of which apply to many of the 11 participants who supplemented their infants. Participants who supplemented spoke of breastfeeding difficulties and did not seem to be prepared for the frequent feeding, amount of time breastfeeding consumed and other challenges of breastfeeding.

Breastfeeding Difficulties

The majority of participants discussed breastfeeding challenges they experienced and their struggle to overcome them. Obstacles or problems encountered with breastfeeding is also a theme noted in breastfeeding literature applicable to low-income women (Greathouse, 2008; Johnsen, 2002). Both this research study and past research described the physical demands of breastfeeding and problems associated with it in terms of sore nipples, difficulty latching, milk supply issues and other related concerns (Greathouse, 2008; Johnsen, 2002; Marshall et al., 2007).

Early Breastfeeding Learning and Confidence

In addition to the challenges of breastfeeding and its physical and emotional demands, participants remarked about the early breastfeeding learning and uncertainty or

lack of confidence in knowing if their infant was getting enough, how to breastfeed and how to manage breastfeeding concerns. These experiences are also noted in the literature. Burns et al. (2009) noted the physical and emotional aspects of breastfeeding experienced by women. Greathouse (2008) identified the "learning curve" regarding the mechanics of early feeding. Locklin (1995) noted women "making the discovery" or the process whereby women, after initially experiencing a time of stress and uncertainty when breastfeeding for the first time or after experiencing unsuccessful previous attempts, discovered their own bodies' capabilities and their newborn's competencies. Part of this transition was the realization by women that once learned, breastfeeding is easy (Locklin, 1995). This progression noted in the literature is similar to that described by participants in this study and termed "the flow came". Participants noted navigating through this period and the increase in their knowledge, self-confidence and personal satisfaction with breastfeeding (Locklin, 1995). This learning curve was described by current participants and in past literature as being related to both maternal and infant learning (Greathouse, 2008). The timing of this learning curve is depicted in other research as ranging from a few feedings to 6 weeks (Greathouse, 2008), which differs from the one month to 3 month range described by participants in this study. Women in this research project noted, as was found in past research, that this increase in confidence and the learning and discoveries, acted as encouragement, or as per Locklin's (1995) description, served as "hooks" in the breastfeeding process to foster continued breastfeeding.

The increase in confidence and participants' pride in their success discussed in this study was also noted in other breastfeeding research. Locklin (1995) and Locklin and

Naber (1993) found women who were successful and persevered in their breastfeeding discussed their confidence in their breastfeeding ability and noted the theme "telling the world" whereby they wanted to share their success with others.

Persevering

Persistence was identified as an important theme by women in this study. Other researchers have also noted this as an important part of the breastfeeding experience (Avery et al., 2009; Burns et al., 2010; Hoddinott & Pill, 1999; Locklin & Naber, 1993). Greathouse (2008) noted this theme in her description of how low-income women exhibited a strong sense of determination and commitment to breastfeed successfully. Locklin and Naber (1993) described this persistence in terms of personal motivation exhibited in mothers' seeking of information and guidance to deal with problems, and perseverance in the face of limited encouragement, medical issues, and family constraints. The women who participated in this study and who continued to breastfeed described similar experiences of difficulties, expressed personal motivation to continue in their efforts, sought assistance with problems and overcame stressors and social obstacles.

Reason to Continue, Bonding and Dependency

Women in this study discussed the reasons they persevered and continued to breastfeed despite difficulties. Their rationale included knowing that breastfeeding was best for their infant, the health benefits for their infants and the importance of breastfeeding in terms of bonding and attachment. Participants placed particular emphasis on what breastfeeding conferred in terms of health and well-being for their child. They also emphasized the bonding opportunity breastfeeding provided and its role

in creating a foundation for the attachment to their child and its part in fostering this ongoing relationship. All participants shared the important role bonding played in their choice to breastfeed and their rationale to persevere despite the many challenges and stressors they faced. Previous research also noted links between a woman's breastfeeding behavior and the role of bonding and infant health and a woman's beliefs about these concepts. Scharfe (2012) noted that women with attachment approach orientations were more likely to breastfeed, breastfeed longer and continue breastfeeding when they experienced initial difficulties. Johnsen (2002) identified "a reason to continue" as a major theme in her research. This referred to the mother breastfeeding for the infant's health (Johnsen, 2002). Nelson (2012) also noted women's identification of breastfeeding as being best for their child and as a reason to persevere. The physical bond of breastfeeding or attachment is identified in the research as an important characteristic of women's breastfeeding experiences (Locklin & Naber, 1993; Raisler, 2000). Women in this study and in previous work discussed their deep satisfaction and emotional investment in their infants and the special closeness they felt was part of the breastfeeding process (Locklin & Naber, 1993, Raisler, 2000). The downside of this physical closeness, attachment and the breastfeeding experience expressed in this study and shown in previous research, was the dependency or feeling of being restricted or tied down by breastfeeding (Raisler, 2000) and a lack of personal freedom (Alexander, Dowling & Furman, 2010). In both this study and other research, women regardless of whether they continued to breastfeed or not commented about the dichotomy of breastfeeding in terms of their enjoyment of it but also that it held them back from doing other things and getting on with their lives (Raisler, 2000).

Support

As noted previously in the discussion section, this study concurs with previous research as to the importance of supportive partners and family and friends in assisting women to initiate and continue breastfeeding. Women in this study also shared the professional support they received and how this helped them to choose to breastfeed or continue breastfeeding. They shared how physicians, nurses, lactation consultants and paraprofessionals spoke of the benefits of breastfeeding; provided in person practical tips and hands on support of what to anticipate; and how to solve breastfeeding challenges specific to their needs. They also noted how these individuals were engaging and developed a supportive relationship with them; provided ongoing support; encouraged their continued efforts; and were readily available, all of which helped them to continue breastfeeding. The current literature confirms the success of in-person support (Renfrew et al., 2012) by professionals and paraprofessionals (Britton et al., 2007; Chapman et al., 2010; Greathouse, 2008; Raisler, 2000; Renfrew et al., 2012); by practitioners who were generally accessible (Johnsen, 2002) with whom women had developed a positive relationship (Johnsen, 2002); who had a positive attitude toward breastfeeding and were encouraging of mothers and maternal efforts (Johnsen, 2002); practitioners who answered questions clearly and in a friendly, welcoming manner (Raisler, 2000); and provided individualized care and ongoing follow-up (Johnsen, 2002), as being linked to women initiating and persevering in their breastfeeding efforts. Those participants who noted negative or unhelpful support in this study described not being informed of the reality of potential problems in the prenatal period; unhelpful advice about breastfeeding problems such as latching issues and milk supply concerns; or inappropriate follow-up or

referrals, all of which are noted in the literature, as negatively affecting breastfeeding outcomes.

Participants in this study also noted the positive support of the Healthy Baby program on their breastfeeding efforts. All women in the study were receiving the financial prenatal benefit and in some cases were also attending community support programs affiliated with this program. Brownell, Chartier, Au and Schultz (2010) in their evaluation of the Healthy Baby program found women who were receiving the Prenatal Benefit were more likely to breastfeed their babies than those who did not. They also found that for those women who were receiving the Prenatal Benefit, attendance at one of the Community Support programs was associated with an increase in breastfeeding initiation and status of breastfeeding at hospital discharge (Brownell et al., 2010).

Breastfeeding in Public

Women's concerns regarding breastfeeding in public and modesty are themes identified in this study and by other researchers (Guttman & Zimmerman, 2000; MacGregor & Hughes, 2010). The literature noted women's difficulty with public breastfeeding, embarrassment and lack of confidence in feeding in front of others, even family members and friends (Greathouse, 2008; Johnsen, 2002; MacGregor & Hughes, 2010). Participants in this study shared their avoidance of breastfeeding in public and restriction of their movements to achieve this, so too did women in other breastfeeding studies (Raisler, 2000; Scott & Mostyn, 2003). Women in this and past studies also noted arbitrary and very individual distinctions between private and public breastfeeding, in terms of in front of whom and where they felt comfortable breastfeeding (Hoddinott & Pill, 1999; Raisler, 2000). Many participants in this study, echoed the experience of

women in past research, as finding breastfeeding in public an issue that could be overcome (Greathouse, 2008).

Return to Work or School

Although only two of the participants in this study were returning to work or school, many participants discussed the potential impact of and their concerns about juggling breastfeeding and employment or educational endeavors. This concern and the negative impact of this change to a woman's schedule, on her breastfeeding, are noted by other researchers (Greathouse, 2008; Johnsen, 2002; Raisler, 2000). The greater the amount of time away from her infant, lack of access to her child, and workplaces or schools that allowed no time for and contained no breastfeeding amenities to permit the expression of breast milk, all contributed to difficulty in continuing to breastfeed (Greathouse, 2008; Raisler, 2000). This type of situation was experienced by a participant who returned to school and subsequently began to supplement at an increasing level and was considering weaning.

Continuing to Breastfeed as an Evolving Decision

In this study, a woman's plan to continue to breastfeed was noted to be an evolving decision dependent on many factors such as: the resolution of breastfeeding difficulties; pain or difficulties with teething; and negotiating breastfeeding in public. It was not a predetermined or fixed decision. This attitude or belief about continuing to breastfeed is similar to the theme of "give it a go culture" noted by Bailey et al. (2004). Bailey et al. (2004) found that if an aspect of breastfeeding "went wrong" (e.g., milk supply, exhaustion), the underlying pessimism regarding breastfeeding and expectation of difficulty and/or failure was born out. Women then developed an alibi for breastfeeding

difficulties, their lack of success and for the introduction of supplementation or for breastfeeding cessation (Bailey et al., 2004). This description matches those comments made by participants in this study of the difficulties they experienced, supplementation and their rationale for its utilization, and reasons why they chose not to continue breastfeeding.

Differences

There are differences in the findings of this study and those noted in previous research in the following areas: the diagram depiction and process of breastfeeding; the "amazing" part of breastfeeding; and the stressors noted by women. The findings and breastfeeding process for low-income women, in terms of their depiction in Diagram 3, has not been noted previously in the literature. Although other research notes the difficult and engrossing personal journey of breastfeeding (Nelson, 2006), it does not discuss the amazing part of the experience that women in this study shared. Other research noted the positive part of breastfeeding as pertaining only to the bonding experience of breastfeeding (Locklin & Naber, 1993; Raisler, 2000). This could be a reflection of the type of participants who shared their experiences in this study. The majority of these women were still breastfeeding, a factor that may characterize a difference between them and women who discontinued breastfeeding earlier and did not participate in the study. It may also be that women who felt more positive about their experience and what they had accomplished were more likely to have participated in this project, as opposed to those who participated in other low-income breastfeeding studies. Also, other breastfeeding studies do not discuss or note the type, degree and prevalence of other stressors in the lives of low-income women. The possible reasons for this have

been discussed earlier in the discussion section titled the role of stress in the lives of breastfeeding women.

Fishbein's Model and Results of this Study

The results of this study are discussed in terms of Fishbein's (2009) Integrative Model of Behavioral Prediction. Diagram 4 shows the application of Fishbein's (2009) model to the findings of this study. The major theme and subtheme findings are noted in the diagram under its applicable model heading.

Diagram 4: Application of the Integrative Model of Behavioral Prediction (Fishbein, 2009) to the Findings of the Breastfeeding Experiences of Low-Income Women

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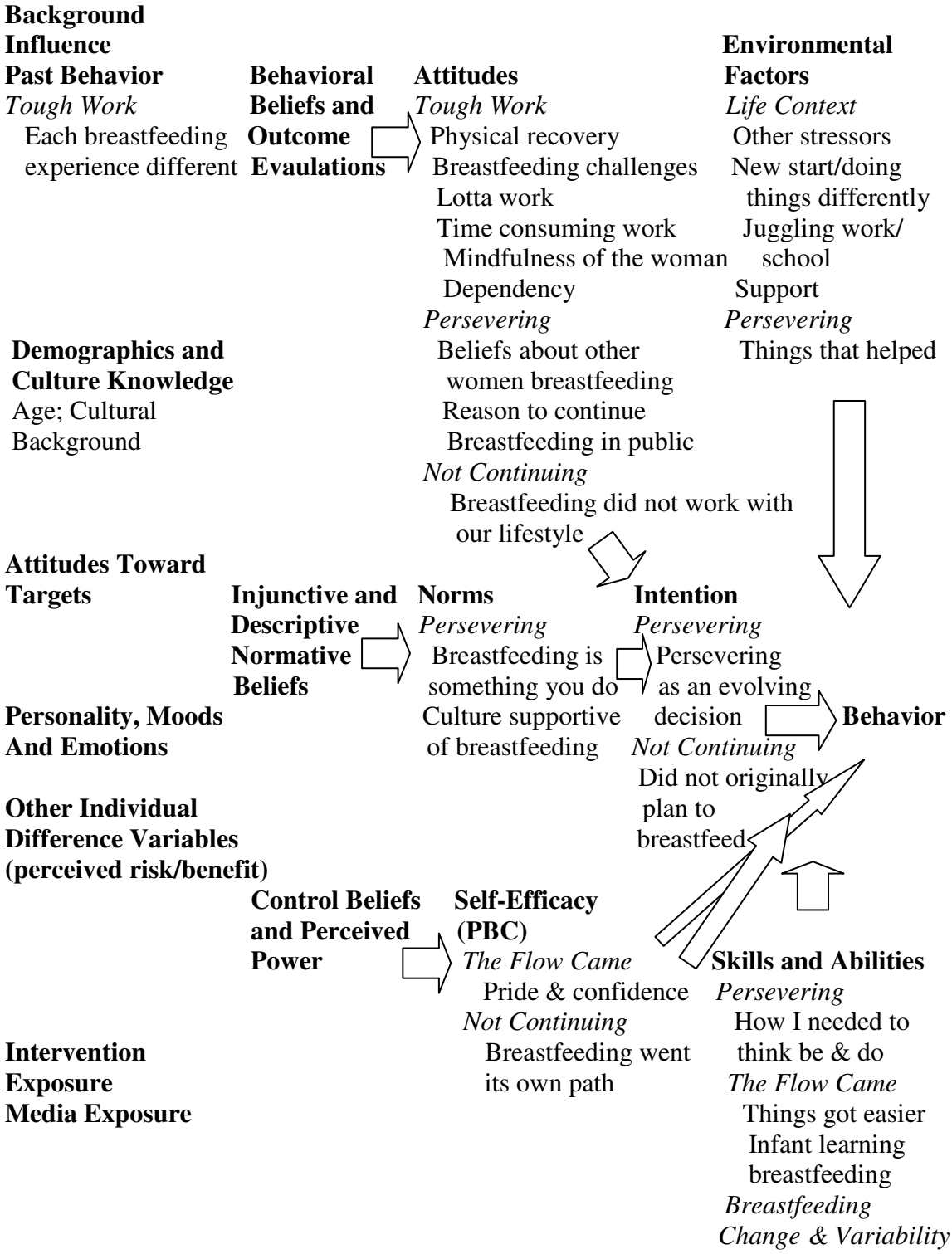

The following discussion of the application of Fishbein's model (2009) to the results of this study assesses the presence of Fishbein's (2009) model constructs in terms of breastfeeding initiation and continuance or in effect provides the results of the qualitative testing of the model. In relating Fishbein's (2009) model to the breastfeeding decision-making and behaviors of participants, many constructs noted in the model were noted by participants of this study as influencing their breastfeeding initiation and duration behaviors. Other portions of it were not representative of the experiences of the low-income women who participated in this study. Fishbein's (2009) model in diagram 4 notes the presence of background influences such as an individual's past behavior; demographics and culture; attitudes toward a situation (breastfeeding); emotions, personality and mood and other individual characteristics; and exposure to media or other intervention exposures, that can influence beliefs (behavioral, injunctive and control). Findings of the study noted some of the background influences described in the model as being factors that influenced a woman's breastfeeding choices. The background influences noted in the findings are: past breastfeeding behavior; demographics; culture; and moods and emotions. Women spoke of their past breastfeeding behavior as influencing their current breastfeeding choices and duration. The model notes the importance of past behavior in predicting future breastfeeding behavior. The participants who discontinued breastfeeding all described successful past breastfeeding experiences (i.e. from 4 to 12 months). The participants who continued to breastfeed described both successful and unsuccessful previous breastfeeding experiences.

Demographics, cultural knowledge, and mood and emotions were important influencers of participants' breastfeeding behaviors. Some women noted ethnic culture

and knowledge as factors that influenced their decision to breastfeed and to persevere. Age may have played a role in breastfeeding decision-making for some women, as although both younger and older participants chose to breastfeed and continue breastfeeding, the majority of breastfeeding participants were older. Many participants described their emotions and mood, in terms of stress and mental health issues as characteristics that influenced their breastfeeding beliefs and actual behaviors.

Individual difference variables, and intervention and media exposure, as noted in the model, were not described by participants. Participants did not describe any individual difference variables that were commonly shared, in terms of perceived risks or benefits. Women did not describe any exposure to a specific or uniform intervention as influencing their breastfeeding behavior. They also made no comments about the role of the media in affecting their breastfeeding behavior.

Fishbein (2009) determined that a person's intentions are the best predictors of whether a person will or will not perform a given behavior. As the majority of the women in this study intended to breastfeed and did breastfeed, this portion of the model is corroborated. Where there is some disagreement is that the model does not take into account the timing of decision-making. When a woman choses to breastfeed (i.e., when intention commences) is a critical determinant as to whether she will actually proceed with this behavior. Women who choose to breastfeed late in pregnancy or at the time of delivery are less likely to breastfeed (Bonuck et al., 2005; Dennis, 2002; Donath & Amir, 2003; Digiorlamo et al., 2005; Mistry et al, 2008). This is not accounted for in Fishbein's (2009) model. Participants in this study also described their intention to or decision to continue breastfeeding as an evolving decision and not static in nature. Fishbein (2009)

describes the interplay of factors that influence breastfeeding intention but does not specifically confirm that breastfeeding intention is an ongoing feature throughout the course of a woman's breastfeeding journey.

The three primary determinants of intention in the model are attitude toward performing the behavior; the normative influence or the amount of social pressure one feels vis-a vis performing the behavior; and one's sense of self confidence with respect to the performance of the behavior (Fishbein, 2009). The findings of this study confirm the importance of breastfeeding attitudes, noted in Fishbein's (2009) model, in determining breastfeeding behavior and continuance. All women spoke of their perceptions and attitudes regarding performing the act of breastfeeding in terms of its tough work and persevering through the difficulties associated with this act. They described in detail their beliefs and attitudes about the impact their physical recovery had on breastfeeding, the milieu of challenges they faced in terms of sore nipples and other specific breastfeeding related challenges, in addition to their beliefs about the amount of work and time consuming nature of breastfeeding. They noted the need to be mindful of their lifestyle and their attitudes toward breastfeeding in public. They shared their attitudes as to whether the act of breastfeeding and its continued place in their and their families' lives fit with their lifestyle. Participants also shared their beliefs and attitudes regarding other women's breastfeeding and breastfeeding choices.

The majority of participants expressed a positive attitude toward breastfeeding and the act of breastfeeding that strengthened their breastfeeding intentions, and their breastfeeding initiation and continuance efforts. However they also described their beliefs and attitudes toward breastfeeding in both positive and negative ways. All

participants noted positive beliefs or attitudes regarding bonding and the health benefits and other advantages of breastfeeding as strong influencers of their breastfeeding initiation and continuation. Some participants described negative beliefs and attitudes toward breastfeeding in terms of dependency and the loss of freedom. For some women this dependency did not negatively affect their breastfeeding continuance and was viewed as a natural part of breastfeeding or as an inconvenience. For other participants this dependency led to breastfeeding cessation or supplementation.

In terms of the normative influence of social support or perceived normative pressure the women felt to breastfeed, most described knowing that is was best for their child and that others (friends, family and/or health care professionals) told them this. This reinforcement of the benefits and encouragement by others close to them or in a position of authority, in many cases served to reinforce their breastfeeding intentions, and positively influenced their breastfeeding initiation and breastfeeding duration. Participants also alluded to societal and cultural norms that encouraged or discouraged them from breastfeeding in terms of breastfeeding duration norms in their family, circle of friends and ethnic community. Thus based on this information, the involvement of social pressure and support was confirmed by the findings of this study to be involved in decision-making regarding breastfeeding intention and breastfeeding initiation and continuance behavior.

Although Fishbein's (2009) model notes that breastfeeding self-efficacy influences both breastfeeding intention and behavior, the findings of this study suggest its relevance to breastfeeding behavior more than breastfeeding intention. It is unclear if prior to breastfeeding the participants were confident in their ability to breastfeed. This was not

asked during the interview with participants. It would have been advantageous to ascertain the answer to this question during the prenatal period and prior to feeding initiation. Certainly, once they initiated breastfeeding many participants described doubts, and a lack of confidence in their knowledge and ability to navigate the difficulties of breastfeeding. Many women, who noted confidence in their ability while breastfeeding or described overcoming insecurity and uncertainty about this practice, continued to breastfeed despite misgiving and lack of confidence. Women who discontinued breastfeeding noted how breastfeeding went its own path, a reference to their lack of control over their breastfeeding course and in effect a lack of breastfeeding self-efficacy.

The model acknowledges that intention does not always predict behavior and that a lack of necessary skills or abilities or unanticipated barriers or environmental factors or constraints may prevent people from carrying out their intention (Fishbein, 2009). Participants spoke of initially lacking the necessary skills to know how to breastfeed. They described how they needed to think and be and what they needed to do in order to learn and persevere with breastfeeding. Participants noted that as they and their infant acquired breastfeeding skills and knowledge, the flow came or breastfeeding became easier and they were able to continue. They also discussed how even as breastfeeding became easier it continued to vary and they were required to learn and develop new skills on an ongoing basis.

Participants, as noted in the model, discussed the importance of and impact that unanticipated barriers as well as environmental constraints such as spousal abuse, financial concerns, homelessness, return to school and single parent status, had on their

ability to continue breastfeeding. They noted the unanticipated barriers of the tough work of breastfeeding in terms of breastfeeding challenges, frequency of feeding, and the time consuming and fatiguing nature of the behavior. They spoke of other environmental factors in terms of the family, friends, professionals and paraprofessionals and other supports who assisted or hindered their breastfeeding efforts and influenced their choice to breastfeed and continue breastfeeding. Participants also shared the physical aids and ideas from their environment that encouraged their breastfeeding behavior.

For the purpose of this study, Fishbein's (2009) model was to guide the development of the study. It successfully served to influence the development of the interview questions based on the literature and framed the findings and discussion sections of this thesis. The majority of the constructs noted in Fishbein's (2009) model were also noted by participants in this study to be involved in determining breastfeeding behavior.

Study Limitations and Strengths

The main limitation of this study is the difficulty in recruiting and hearing the experiences of women who discontinued breastfeeding. Only 2 of the 18 participants had discontinued breastfeeding. It is interesting to note that these 2 women, were at the time of the original phone contact with the researcher, still breastfeeding. Over the weeks before the interviews occurred they discontinued breastfeeding. If the phone contact had not occurred when it did, prior to their termination of breastfeeding, it is possible these women may not have participated. They may have chosen, as other potential interviewees who had already ceased breastfeeding, not to contact the researcher.

Participation from a larger number of women who were no longer breastfeeding would have provided more weight to those themes and conclusions attributed to this portion of the findings – Not continuing. It may also have provided more insight into the experiences of women who ceased breastfeeding and offered a clearer understanding of how to better support these women.

Some of the potential reasons why recruitment of this portion of the low-income breastfeeding population may have been more difficult may be related to the way they see themselves. If women who persevere and continue to breastfeed become more confident and see themselves in a positive light, as noted in this study, then women who discontinue breastfeeding may feel less positive about the experience, feel less successful and be less willing to share their experiences. If they are less interested or invested in breastfeeding they may also not see the importance of sharing their story. Women who discontinued breastfeeding may also have had more stressors and been too overwhelmed to make contact with the researcher. Different recruitment techniques for future studies with this population may need to be employed to ensure participation of short-term breast feeders.

On of the strengths of this study is the participation of a cross-section of women of varying ages, ethnicities, parities, and marital and family status living arrangements. There was also representation from the majority of community areas across Winnipeg, including those areas with the greatest number of low-income households. Overall there were an adequate number of participants who agreed to participate in the study. The design of the study is another of its strengths. Intercoder reliability of the study occurred by the researcher and advisor simultaneously coding the first 2 interviews and verifying

coded themes for the overall data analysis. An additional strength of this study relates to the validity and verification of the trustworthiness of the data. Nine of the participants, or half those women interviewed for the study, confirmed the essence of the experience and major themes developed.

Implications for Practice, Policy and Education

Results of this study and previous breastfeeding research confirm the need for alterations to breastfeeding practice, policies and education. The following should be considered in breastfeeding clinical practice with low-income women: maternal breastfeeding preparation; consistency in information delivered by healthcare professionals; early and ongoing breastfeeding support; extra support and follow-up requirements; alterations to the Family First program; smoking cessation interventions; and coordinated follow-up and care between health care professionals and other agencies (e.g., public health; subsidized housing; income assistance; child welfare agencies).

In light of the research regarding inadequate maternal preparation for the reality of breastfeeding and its effect on breastfeeding duration and exclusivity, provision of information and education regarding this is important. This education should include not only a maternal, but a family centered approach to planning and preparation for the frequency of and time consuming nature of breastfeeding and potential problems that may arise.

Based on the concerns noted by some participants there is a need for consistency regarding the information and care provided by nurses, lactation consultants, physicians and other health care professionals. Participants' comments also highlight the lost

opportunities to provide evidence-based, appropriate breastfeeding and health care to low-income women. Low-income women, in every contact with nurses, physicians, and other health care team members, at every prenatal, intrapartum and post-partum contact (and beyond) should hear about the benefits of breastfeeding and receive enthusiastic, positive encouragement, support and/or hands-on support in their breastfeeding efforts. The approach practictioners utilize in discussing breastfeeding and feeding choices with low-income women during the prenatal (Hartley & O'Connor, 1996), intrapartum and postpartum period (Johnsen, 2002; Raisler, 2000) requires care and the utilization of evidence informed methods, as research notes its effect on breastfeeding initiation and duration. The support provided should also be individualized to women's needs and circumstances. Referrals to other professionals such as physicians, counsellors and social workers, should occur in a timely manner.

The type of care delivered to this population requires the consideration of their elevated stress levels and its effect on their coping (Heinig, 2009). When breastfeeding low-income women are faced with stressful circumstances, such as childbirth and breastfeeding difficulties, and are already experiencing elevated stress levels, they are more likely to use emotional regulation coping skills (Heinig, 2009). This type of coping occurs when individuals are faced with a stressful circumstance and the problem is not perceived as solvable (Heinig, 2009). With this method of coping, individuals focus on changing their feelings about the situation, and denial, disengagement and anger occur (Heinig, 2009). In addition, negative behaviors are reinforced and the justification of poor health choices ensues (Heinig, 2009). Due to the stress levels of this population and this emotional regulation coping response, supportive encouragement and problem-

solving in childbirth and during their breastfeeding experience is even more important for low-income women. This type of supportive approach, coupled with breastfeeding benefit reinforcement as opposed to risk-based messages and interventions, is more likely to allow women to act in a problem management coping method (Heinig, 2009). A problem management coping response is utilized by individuals when a situation (i.e., breastfeeding challenges) is perceived as solvable and results in individuals focusing on changing the situation and engaging in seeking information, and planning and implementing solutions (Heinig, 2009). Low-income women would be more likely to initiate and continue breastfeeding: if advised of breastfeeding benefit reinforcement information; and if they received care from a practitioner in an environment that is supportive and encouraging and where problem management type coping skills are employed by the practitioner and therefore adopted by the breastfeeding woman (Heinig, 2009).

This and other studies (Bailey et al., 2004; Raisler, 2000) note the importance of early support in the breastfeeding experience. There is also a need for ongoing support during the breastfeeding experience to assist with normalizing, planning and problem-solving regarding transitions such as teething, return to work or school and the overall integration of breastfeeding into the lives of low-income women. This type of follow-up needs to be integrated into the timing and type of health care being provided.

Low-income women may require more support in managing breastfeeding challenges and in addressing other health and social needs than other women. MacGregor and Hughes (2010) noted that mothers from disadvantaged groups such as low-income women or adolescent mothers may require extra input and support to

overcome problems associated with breastfeeding. Women who participated in this study, due to their breastfeeding difficulties and social stresses and concerns certainly exhibited a need for more breastfeeding support and guidance, in addition to support for their financial, housing and other health and wellbeing concerns. Altering direct service practice and health care policies that guide these practices to ensure low-income women receive early and ongoing breastfeeding support and support for their other health, familial and social concerns is imperative. The Manitoba Provincial Breastfeeding Strategy unveiled in September 2013 notes the importance of targeting interventions to increase breastfeeding among women affected by poverty, low-income/unstable housing, nutrition and food security issues and the need to link and support other health strategies including primary care, early childhood development, and poverty reduction strategies (Government of Manitoba, 2013).

One of the provincial programs for which many low-income families may be eligible is the Family First program. This program, as noted previously provides ongoing public health nursing and Family First home visitor paraprofessional support for a 3 year period. The research is clear regarding the benefit of healthcare professional and particularly paraprofessional involvement on breastfeeding duration and exclusivity in low-income women. Thus in addition to ensuring all public health nurses have further breastfeeding education and certification, implementing hiring and training practices similar to that employed by La Leche League in their recruitment of peer counselors should be considered in the employment of Family First home visitors. A home visitor and public health nurse with this training working in concert in the prenatal and extended period after the birth of the child could greatly improve breastfeeding initiation, duration

and exclusivity rates.

The high rate of smoking by participants and in the population of low-income women in general, brings into focus the need for smoking intervention programming and support for these women. The absence of smoking cessation support noted by low-income women that participated in the study highlights the missed opportunities by health care professionals to address this health issue. The importance of linking and supporting tobacco reduction strategies for women and other health strategies is highlighted in the most recent provincial breastfeeding strategy (Government of Manitoba, 2013). This type of care should be part of the agenda and interventions of Family First programming support and that of other health care professionals' involved with low-income families. However, care should be taken in the manner in which smoking cessation is addressed with low-income women. Smoking should not be conveyed by health care professionals as a barrier to or reason not to breastfeed, particularly in light of the research that notes breastfeeding's overall protective effect against respiratory and other illnesses (Duijts et al., 2009; Ip et al., 2007), its protective effect even in children exposed to environmental tobacco smoke (Chatzimichael, et al., 2007) and the bonding and other health benefits breastfeeding confers.

Due to the breastfeeding needs, the number of health care issues (e.g., smoking) and stressors noted by women in this study there is a need to simultaneously address these issues. Owing to the multitude of stressors experienced by this population, it is also important to ensure that appropriate resources for the women and their families are in place and that there is coordinated health care, social service and family/community input.

The findings of this study and the above noted clinical practice recommendations require accompanying policy and education changes to occur. Policies and funding that support multisectorial care of low-income women in terms of housing, access to counselling service and child care support would benefit the health of these women and their families and their breastfeeding potential. These policy and funding opportunities could take the form of enhanced case management via nursing, social work, mental health services and financial and other counselling services. Breastfeeding specific policies such as the requirement of all provincial hospitals and community health service agencies to become Baby Friendly by a specified time (i.e., 2016) would enhance the quality of breastfeeding services and outcomes in Winnipeg and across the province of Manitoba. The 2013 Manitoba Provincial Breastfeeding Strategy as noted previously, targets 2018 as the goal for achievement of Baby Friendly Initiative accreditation in 75% of all Manitoba birthing hospital/centres that have more than 100 births/year and 75% of all provincial community public health offices (Government of Manitoba, 2013). Requiring all provincially funded health care and government facilities (i.e., shelters, transitional housing) to become Baby Friendly would also benefit breastfeeding outcomes. In addition, the adoption of provincial breastfeeding policies that require regional health authorities to provide ongoing and enhanced professional and paraprofessional support and visitation with low-income women at specified, minimum intervals prenatally and throughout the first two years of life (e.g. weekly prenatal visits via Family First Home visitors and monthly Public Health Nursing visits) would improve initiation and duration rates. This ongoing contact would address breastfeeding issues and anticipate breastfeeding challenges and transition periods such as the transition to

work or school.

The assessment of the effectiveness of existing breastfeeding policies and funding and their impact on breastfeeding outcomes is also required. Determining if current WRHA and provincial breastfeeding services such as breastfeeding clinic and support groups are addressing the breastfeeding needs of low-income women is necessary. This assessment would determine if current services are being accessed by this income group and if not, are additional supports such as on-site child care services required to encourage attendance or are alternative services such as enhanced home visiting a more effective option to implement.

Policies to address the quality of services delivered to low-income families are also required. To ensure that appropriate breastfeeding support is being provided to these women and their families by health care professionals, regular, interval audits of medicine, nursing and allied professional care services by regional health authorities are required. Quality of care issues can then be addressed on a regional, departmental and individual level and opportunities for further policy changes can be identified and implemented.

The results of this study and other breastfeeding research confirm the need for breastfeeding and communication training for health care professionals, paraprofessionals and allied health care professionals. The unsupportive interactions with the healthcare system women shared and the incorrect breastfeeding information noted in the interviews, speaks to the need for a minimum standard of breastfeeding education and the importance of ongoing training and certification for professionals and paraprofessionals. Interprofessional education regarding breastfeeding and the support these women require

would improve the knowledge base of physicians, nurses, allied health professionals and paraprofessionals and allow these groups the opportunity to better understand the overlapping and complementary roles each plays. This could lead to better collaboration and communication between the above noted groups and result in better breastfeeding outcomes.

Implications for Research

Based on the finding of this study the following are recommendations regarding breastfeeding research with this population. Due to the limitation of this study related to the difficulty in recruiting short term breast feeders it would be beneficial to complete further qualitative research regarding the breastfeeding experiences of low-income women who have breastfed for less than 1 or 2 months. This would confirm and further expand our knowledge of the experiences of women who initiate but are not able to continue breastfeeding and the challenges they face. It may also be advisable to complete further mixed method research comparing short (a few weeks to a month), mid-term (2 to 6 months) and long term (6 months or more) and extended (1 year or more) low-income breast feeders to see if there are more specific differences between their experiences.

Recruitment methods for this and any studies involving low-income women would need to specifically consider how to best encourage study participation. There would need to be financial incentives offered to encourage participation as well as the potential need for the provision of childcare. Utilizing health care or other trusted personnel in the lives of these women, as those who would share information about potential studies, is also an important research design and recruitment consideration in ensuring successful participation.

Breastfeeding literature does not explore the role of stressors in the lives of women including low-income women and its effect on breastfeeding initiation, exclusivity and duration. Based on the finding of this study, further research needs to include this as a variable that may influence breastfeeding outcomes and the experience of these women and their families. There is also opportunity for further provincial research regarding the Family First program and its effect on breastfeeding outcomes now and the potential for alterations to the program to further enhance breastfeeding initiation and duration (as suggested under the implications for practice section).

Conclusion

Low-income women are less likely to initiate breastfeeding and breastfeed exclusively compared to other women (Amir & Donath, 2008; Dennis, 2002). They are more likely to breastfeed for a shorter duration than their higher income counterparts. They and their infants, in light of the poor overall health outcomes for this population, would benefit greatly from the health, economic and other advantages breastfeeding confers. Although breastfeeding research has been conducted with this population, only limited studies consider the lived experience of low-income women. None of these studies have been conducted in Canada or consider the experience of this economic group receiving Manitoba provincial health care services in an urban setting.

The purpose of this qualitative phenomenological study was to determine the lived experience of breastfeeding for low-income women living in Winnipeg, Manitoba. The essence of the breastfeeding experience for these women is *breastfeeding is amazing and tough.* Participants described the life context of their experience in terms of stressors in

their lives; a new start or doing things differently in their life; juggling the demands of work and school with breastfeeding; and the support or lack of support they received from family, friends and professionals and paraprofessionals. Low-income women's experiences of breastfeeding are particularly influenced by stressful life events including financial, housing, and childcare stressors.

Women discussed the tough work of breastfeeding in terms of their physical recovery; the breastfeeding challenges they encountered; and the "lotta work" or the early work, time consuming and fatiguing nature of breastfeeding. They also described the tough work of breastfeeding in terms of their mindfulness; the getting used to it; the acknowledgement of each breastfeeding experience as being unique or different; and the feeling of dependency that breastfeeding engendered. Women shared how they persevered during breastfeeding and what beliefs and ideas they brought with them to be able to persevere. In particular women spoke of their breastfeeding as an important bonding experience with their child and as the best for their infant. They shared how continuing to breastfeed was an evolving decision; their struggles with breastfeeding in public; and the things that helped them continue breastfeeding. Participants also described how professional, paraprofessional, family, friends and others assisted or discouraged their persevering efforts.

Women who continued to breastfeed shared how breastfeeding became easier, how breastfeeding challenges resolved and how "the flow came". They noted an increase in confidence and pride in their ability to breastfeed as they continued to breastfeed and experienced success. They also noted how even after it became easier there was still ongoing variability and change in their breastfeeding experience. Those participants who

discontinued breastfeeding described it as not fitting with their lifestyle, and noted their initial decision to formula feed or unique reasons for breastfeeding. Women who did not continue breastfeeding also described breastfeeding as "going its own way".

Fishbein's Integrative Model of Behavioral Prediction (2009) was utilized as an organizing model for this study. The study results suggest that many of the constructs in the model are linked to breastfeeding behavior. The model does not explicitly state how these factors interact and which factors are more predictive of breastfeeding decision making and outcomes. Quantative testing of this model with a variety of low-income populations would help clarify this interaction and improve its use in research and practice.

The study findings have important implications for health researchers and also for health professionals who provide prenatal, intrapartum, postpartum and ongoing breastfeeding support and other health care services to low-income women. Health care researchers are encouraged to work with low-income women to develop further research inquiries that determine the challenges and solutions to their breastfeeding and other health and social needs. Health care personnel and policy makers are encouraged to work in concert to develop breastfeeding, health and social policies that support breastfeeding and the well-being of low-income women. Health care personnel and paraprofessionals are encouraged to utilize this and other research involving low-income women to provide individualized, supportive interventions that encourage breastfeeding initiation, and assist these women to exclusively breastfeed for an extended duration.

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APPENDIX A

Breastfeeding Committee for Canada Integrated Ten Steps & WHO Code Practice Outcome Indicators for Hospitals and Community Health Services: Summary

The WHO 10 Steps to Successful Breastfeeding (1989) and the Interpretation for Canadian Practice (2011)

Step 1 WHO Have a written breastfeeding policy that is routinely communicated to all health care staff.

Canada Have a written breastfeeding policy that is routinely communicated to all health care providers and volunteers.

Step 2 WHO Train all health care staff in the skills necessary to implement the policy. Canada Ensure all health care providers have the knowledge and skills necessary to implement the breastfeeding policy.

Step 3 WHO Inform pregnant women and their families about the benefits and management of breastfeeding.

Canada Inform pregnant women and their families about the importance and process of breastfeeding.

Step 4 WHO Help mothers initiate breastfeeding within a half-hour of birth. WHO 2009: Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour. Encourage mothers to recognize when their babies are ready to breastfeed and offer help if needed.

Canada Place babies in uninterrupted skin-to-skin1 contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes: encourage mothers to recognize when their babies are ready to feed, offering help as needed.

Step 5 WHO Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.

Canada Assist mothers to breastfeed and maintain lactation should they face challenges including separation from their infants.

The phrase « skin-to-skin care » is used for term infants while the phrase « kangaroo care » is preferred when addressing skin-to-skin care with premature babies.

Step 6 WHO Give newborns no food or drink other than breastmilk, unless medically indicated.

	Canada	Support mothers to exclusively breastfeed for the first 6 months, unless supplements are medically indicated.
Step 7	WHO	Practice rooming-in - allow mothers and infants to remain together - 24 hours a day.
	Canada	Facilitate 24 hour rooming-in for all mother-infant dyads: mothers and infants remain together.
Step 8	WHO	Encourage breastfeeding on demand.
	Canada	Encourage baby-led or cue-based breastfeeding. Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.
Step 9	WHO	Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
	Canada	Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).
Step 10	WHO	Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
	Canada	Provide a seamless transition between the services provided by the hospital, community health services and peer support programs. Apply principles of Primary Health Care and Population Health to support the continuum of care and implement strategies that affect the broad determinants that will improve breastfeeding outcomes. The Code WHO Compliance with the International Code of Marketing of Breastmilk Substitutes. Canada Compliance with the International Code of Marketing of Breastmilk Substitutes.

The full version of the Breastfeeding Committee for Canada Integrated Ten Steps and WHO Code Practice Outcome Indicators for Hospitals and Community Health Services is available at:

http://breastfeedingcanada.ca/documents/BCC_BFI_20110704_Final_BCC_BFI_Integrated_Indicators_English.pdf

APPENDIX B

Baby Friendly Manitoba Committee Update

Manitoba

The Baby Friendly Manitoba Committee is the provincial authority for implementing the Baby Friendly Initiative (BFI) through the Breastfeeding Committee for Canada (BCC). Manitoba Health has developed a Baby Friendly Hospital Working Group; and a Baby Friendly Community Health Working Group to assist RHAs and birthing facility staff to implement the Baby Friendly designation standards (included in the background section). Participation on these working groups is at the discretion of the RHA. The working groups have been very effective in sharing best practice approaches, maximizing training opportunities, co-developing teaching materials, problem solving issues and providing staff encouragement and support.

- The province is working with the BCC to provide an accreditation function for the Baby Friendly Initiative in Manitoba. Manitoba currently has four assessors in training.

- **In 2002, MHHL initiated a performance deliverable initiative**. The purpose of the deliverable was to set measurable expectations for Regional Health Authorities (RHAs) and other funded health care organizations to focus improvements on key health issues and improve reporting on those issues to increase accountability. Breastfeeding was identified as a key deliverable. The breastfeeding deliverable specified that RHAs develop frameworks and activities to improve breastfeeding rates. Additionally, RHAs were asked to target percentage improvements in breastfeeding initiation, duration and exclusive breastfeeding to six months as recommended by Health Canada. RHAs developed and submitted regional frameworks to Healthy Living in 2005. Detailed reports outlined activities conducted to date as RHAs implemented their coordinated approach to breastfeeding promotion and support within each region. As well, RHAs provided a Regional Breastfeeding Framework that reflected the target increases approved in their region. The framework included a Population Health Approach which was supportive of the Baby Friendly Initiative, an international program to improve breastfeeding outcomes for mothers and babies by improving the quality of their care.

- **In 2002 MHHL developed a Provincial Breastfeeding Strategy** that is operationalized by Regional Breastfeeding Frameworks. The Provincial Breastfeeding Strategy set targets to improve provincial breastfeeding initiation, duration and exclusive breastfeeding rates. RHAs also set individual targets for breastfeeding improvement (2006-20011). The full Provincial Breastfeeding Strategy and RHA Frameworks may be found online at http://www.gov.mb.ca/health/nutrition/bfi2.html

- **In 2002, MHHL developed a breastfeeding policy template** and made that available on the MHHL website (currently in revision). Several regions now have a breastfeeding policy: Burntwood RHA, Churchill RHA, and South Eastman RHA. Brandon Hospital (Brandon RHA), Boundary Trails (Central RHA), Selkirk Hospital (Interlake RHA), and The Pas Hospital (Nor-man RHA) each have baby friendly breastfeeding policies. Many Community health sites have developed baby friendly policies (Brandon, Flin Flon, Winnipeg RHA has a baby friendly policy (2005, rev 2008, 2012) contained in their breastfeeding guidelines and as of 2009 most of the RHAs have adapted these guidelines. Assiniboine RHA, North Eastman RHA, and Parkland RHA are working towards regional / community / hospital baby friendly policies.
- **The CPPHO: Report on the Health Status of Manitobans emphasizes prevention** as one of the most promising ways to improve the health of Manitobans, to reduce inequalities of health among Manitobans and to sustain the publicly funded health system and other public programs and services that directly or indirectly prevent disease and injury (ex: Education, Family Services). This report recommends exclusive breastfeeding for six months and continued breastfeeding, links the development of asthma with exclusive breastfeeding for less than four months, calls for better data collection and increased support for breastfeeding initiation in institutional and other settings. It includes the recommendation of the Baby Friendly Manitoba Hospital working group for a human milk bank to support maternity units in the province. http://www.gov.mb.ca/health/cppho/

- **The Manitoba Women's Health Strategy (2011)** recognizes the distinct health needs of women in the planning, implementation and delivery of health care services. It seeks to address the broad range of women's health issues, and ensure awareness and responsiveness to gender differences in all aspects of health care delivery in Manitoba. One of the strategic actions called for in this document is to "Enhance breastfeeding support, services and education by continuing to develop the Baby friendly Manitoba breastfeeding initiative." http://www.gov.mb.ca/health/women/

- In January 2012, a **Workplace Breastfeeding policy** was created to outline the support and accommodations that shall be provided to breastfeeding mothers who are clients of Manitoba Health and to employees upon their return from maternity leave. A private room at 300 Carlton is available for staff who need to pump.

- Starting in June 2011, RHAs including birthing centres or hospitals with +/= 100 births and community health sites were required to submit a **Baby Friendly Initiative Status Update** around Accreditation. Each site offers available data, activities, progress on last year's priorities as well as priorities for the coming year. Sites fit into one of the following categories: A. Beginning: formed a multi-disciplinary committee B. Had a mock assessment or in progress C. Applied for Baby Friendly Contract D. Pre-Assessment Document Review E. Pre-assessment site visit F. External site visit G. Working towards re-assessment

- In 2012, Manitoba Health (MH) convened a working group involving multi-departmental stakeholders and RHAs to renew the **Breastfeeding Strategy**. A Breastfeeding Strategy has been developed and approved at the ministerial level based on the goals and targets established by the 2002 Breastfeeding Strategy. A committee of provincial and regional breastfeeding experts including the Baby Friendly Manitoba Hospital and Community working groups developed a draft Strategy document which was then circulated to additional stakeholders including Public Health, Primary Health Care, Maternal and Child Health, Health Equity, First Nations, Metis & Inuit Health, Healthy Child Manitoba, Manitoba Centre for Health Policy, and the Public Health Managers Network.Stakeholders have provided input and revisions to the Strategy document have been made to include this input. Key points include:

  Goals:
  - Increase breastfeeding initiation and exclusivity rates at discharge from hospital, birth centre, or following home birth
  - Increase the rates of exclusive breastfeeding to 6 months and continued breastfeeding to 2 years and beyond
  - Narrow the gap between breastfeeding initiation, exclusivity and duration between northern and southern Manitoba, urban, rural and isolated communities as well as between different socio-economic groups
  - Achieve Baby Friendly Initiative accreditation in Manitoba birthing hospitals, birth centres and community public health offices

  Targets:
  - Increase BF initiation rates to 85%
  - Increase exclusive BF rates (including those infants who require medically indicated supplementation) at birth hospital/centre discharge to 75%
  - Achieve improved BF rates in the community including:
    - Exclusive BF on entry to community service to 75%
    - Duration of BF at 6 months to 55% (25% exclusive)
    - Continued BF at 18 months to 25%
  - Achieve Baby Friendly accreditation in 75% of all Manitoba birthing hospitals/centres that have more than 100 births/year and 75% of all community public health offices by 2018

- Strategic Priorities and Actions have been developed to improve services, build on existing programs and community relationships, decrease inequity and address social determinants, support policy and program development, improve data, education and knowledge and achieve Baby Friendly Accreditation in Manitoba hospitals and community health offices.

P/T Breastfeeding Education Opportunities

- In addition to the Baby Friendly Manitoba annual conference, twelve Breastfeeding Clinical and Research Rounds through Manitoba's Tele-health network have been held to increase prenatal and postpartum education. Annually 12 CERPs are available for Lactation Consultants.
- In 2009 and 2010 the committee organized "Train the Trainer" days (one-day, two-days), which were attended by facility educators and breastfeeding champions from almost every RHA in the province.
- Winnipeg, NorMan, Assiniboine, Central, Brandon, South Eastman and Burntwood RHAs have nursing staff that provide breastfeeding clinical training on an ongoing basis. Specialized training through the Douglas College advanced breastfeeding course is held annually for staff from Winnipeg, Brandon, and Central, and is accessed by other RHAs,
- Breastfeeding is an important component of Healthy Baby Community Support Programs that offer social support and informal learning opportunities to families before and after baby is born. The Manitoba Prenatal Benefit (MPB) assists women in meeting their nutritional needs in pregnancy.
- Through Women's Hospital and the University of Manitoba, a 3 hour on-line multi-disciplinary interactive BF education program has been developed for health providers (2011). http://www.umanitoba.ca/faculties/medicine/units/obstetrics_gynecology/breastfeeding.html

P/T BFI Survey - Monitoring of BF(I) Implementation

- At the monthly Manitoba BFI Hospital Implementation and Community Implementation working group meetings, birthing facilities and regions offer an update about their progress towards BFI implementation.

P/T BFI Survey / Data Collection

- Manitoba Centre for Health Policy (MCPH) provides breastfeeding data to the province (Manitoba Child Health Atlas Update 2008; What Works? A First Look at Evaluating Manitoba's Regional Health Programs and Policies at the Population Level 2008) http://mchp-appserv.cpe.umanitoba.ca/deliverablesList.html

Baby-Friendly Designated Facilities

- BFI pre-assessment site visit at St. Anthony's Hospital in Nor-man RHA in October 2011.
- BFI pre-assessment site visit at Bethesda Hospital in Southern RHA in May 2013. A BFI External site visit (and subsequent designation) is planned for September 2013.
- Capacity building (mock assessment) site visits by BCC lead assessors to: Neepawa Hospital (2008), Thompson Hospital, St. Anthony's Hospital, Women's Hospital (2009), Brandon Hospital, Bethesda Hospital, St. Boniface Hospital and Youville Community Centre (2010), Flin Flon Primary Health Care Centre, The Pas Primary Health Care Centre (2010).

- Capacity building site visits by the government lead and the Baby Friendly Manitoba consultant to Central RHA and North Eastman RHA (2011/12), Thompson Hospital/ Community Health, St. Anthony's Hospital, The Pas Primary Health Care Centre (2012/2013).
- The new WHC Birth Centre (September 2011) intends to become Baby Friendly (built into the terms of reference).
- As of May 2013, 4 Hospital facilities have contracts to pursue Baby Friendly designation. All birthing facilities are working on the ten steps to successful breastfeeding and the WHO Code.
- 5 regional community health sites have contracts to pursue Baby Friendly designation. Most community health sites are working on the ten steps to successful breastfeeding and the WHO Code
- The provincial Healthy Baby program has created Baby Friendly guidelines and policies that align with those community health sites who are beginning the journey to Baby Friendly designation.

Human Milk Bank

- Two Winnipeg hospitals using purchasing pasteurized donor breast milk (DM) (from Ohio Milk Bank) for use in NICU (2011).
- Women's Hospital (Winnipeg) has put forth a proposal to have a milk bank in the new hospital.
- Approval has been given to extend the purchasing of pasteurized donor breastmilk for use in other hospitals in Manitoba.

P/T Government Financial Support

- To date the cost for informal site assessments has been offset by proceeds from the annual Baby Friendly Conference. It is our plan to continue defraying costs for assessment travel with provincial educational events.
- All telehealth presentations are offered free to health care providers and peer support.
- Conference costs are kept to a minimum to make it affordable for participants to attend.
- In 2004, MHHL developed a number of breastfeeding resources to support BFI Hospital Accreditation and to replace resources provided for free by Formula Companies. A Manitoba Baby Friendly breastfeeding poster, crib cards with breastfeeding information for mothers, Baby Friendly measuring tapes for staff to measure newborns in hospital, a magnet and info sheet with breastfeeding information to support mothers in the first weeks postpartum were developed and provided at no cost to hospitals and community sites.
- In 2006 MHHL provided the "Babies Best Chance" book to RHAs. "Babies Best Chance" provides pregnancy, breastfeeding and infant care information. The book is available in French (2013) and English at no cost to RHAs.
- In 2010 in collaboration with Nova Scotia, 5 posters provide Baby Friendly and breastfeeding messaging (Family Friendly Pledge) to contribute to consistent approach to communicating the Baby Friendly Initiative to families and staff across

the province.
http://www.gov.mb.ca/healthyliving/hlp/nutrition/bfm.html#.TiyAjr_wHDE

P/T BFI Coordinator and/or Government Lead

- A Baby Friendly government lead has been working with regions and facilities since 2001.
- In 2008 a consultant was contracted to provide support to the Baby Friendly lead for on-going Baby Friendly initiatives.

APPENDIX C

WRHA Letter of Support to ENREB for the Study --

Breastfeeding Experiences of Low-Income Women in the City of Winnipeg:

A Qualitative Study

Winnipeg Regional Health Authority
Caring for Health

Office régional de la santé de Winnipeg
À l'écoute de notre santé

490 Hargrave Street
Winnipeg, Manitoba
R3A 0X7 CANADA

490, rue Hargrave
Winnipeg, Manitoba
R3A 0X7 CANADA

January 19, 2012

Attention: Chair and Committee Members of ENREB

The Experiences of Breastfeeding in Low-Income Women in the City of Winnipeg: A Qualitative Study

This letter is to offer support in principle for the above noted qualitative research study by Lorelei Pierce, graduate student, University of Manitoba and Winnipeg Regional Health Authority (WRHA) Public Health Nurse, with Dr. Beverley Temple supervising. The WRHA believes that this research is a valid and necessary project that fits with regional values and goals to improve maternal and child health. This project will also provide valuable information to support our attempts to improve breastfeeding initiation and duration rates for low income women in our region.

As outlined in Ms. Pierce's submission, pending WRHA and U of M ethics approvals, the WRHA public health program has agreed to assist in the recruitment of participants via the following methods: a. the distribution of the study invitation letter by WRHA Public Health Nurses to all women who reside within the WRHA and have delivered a live infant; b. the inclusion of the study invitation letter in the Infant Feeding class mail out sent to parents of infants 3 to 4 months of age who reside within the WRHA.

The WRHA recognizes the risk of double agency for Ms. Pierce, in her role as a regional Public Health Nurse and principal investigator of this project. The health authority is satisfied that this ethical concern is addressed by Ms. Pierce's recommendation that the women that she provides direct service nursing care to in her role as a Public Health Nurse will not be included as study participants.

We look forward to supporting Ms. Pierce in the completion of this important breastfeeding research. We anticipate this research will benefit the WRHA in our health promotion and protection efforts.

Sincerely,

[redacted]

Lynda Tjaden
Director, Population and Public Health Program
Winnipeg Regional Health Authority

APPENDIX D

Study Invitation

This is your Invitation to participate in a Breastfeeding Research Study

What's it all about?

It's a study to help

better understand the experience of breastfeeding

for women living in Winnipeg (within the area where the Winnipeg Regional Health Authority provides health care to women)

What's it like? What were the challenges? Who or what helped you? What didn't help?

A woman (hopefully you!) would met with the research nurse for about an hour to share your breastfeeding experience and your story. All women who choose to participate in the study will receive a small honorarium of $25.00 in recognition of their contribution to this research.

We are interested in hearing from women who are **currently breastfeeding or were breastfeeding and stopped breastfeeding** and **were also eligible for the Manitoba Healthy Baby Prenatal Benefit Program**. Please call if you are interested in participating in or learning more about this study.

Contact Person: ***Lorelei Pierce***

Graduate Nursing Student

University of Manitoba

XXX-XXXX

APPENDIX E

Semi-Structured Interview and Demographics Forms

Semi-Structured Interview Form

The Breastfeeding Experience for Low Income Women in Winnipeg: A Qualitative Study

Participant Code: 0___

1. Could you describe your breastfeeding experience or Tell me about what your breastfeeding experience was like (Porter Lewallen & Street, 2010) (Additional Cues: What did the experience feel like – physically, emotionally, what did or do you think about your breastfeeding experience)
2. What was the most important part of the experience/ the least important?
3. What or who helped or improved the experience? Additional cues: Some women talk about the people that helped, the things that helped them breastfeed ……
4. What or who did not help or improve the experience?
5. What kind of help or advice did you get with breastfeeding that was useful (Porter Lewallen & Street, 2010)?
6. What kind of help or advice would have been useful, but that you didn't get (Porter Lewallen & Street, 2010)?
7. When you stopped breastfeeding, what reasons did you have for stopping (Porter Lewallen & Street, 2010)? Ask only if have stopped breastfeeding.
8. Was there anything anyone could have done to help you breastfeed longer (Porter Lewallen & Street, 2010)? Or Breastfeed exclusively?

9. Are there any problems you ran into while breastfeeding? (Additional Cue: Ask them to describe the problem and how it impacted/affected them and their breastfeeding. What helped or hindered in resolving this problem? Was it resolved?)
10. Of all the things we have discussed today, which would you think is the most important (Porter Lewallen & Street, 2010)?
11. Is there anything today that you have shared with me that you would like further assistance/help with? Or that I can connect you with someone (name the type of professional or support) to help you?

Demographics Form

Breastfeeding Experience of Low Income Women in Winnipeg: A Qualitative Study

Date:

Participant Code: 0___

Mother's Age:

Gender of infant:

Date of Birth of infant:

Current age of infant:

When did you decide to breastfeed (in pregnancy/gestational age of infant/number of months into pregnancy; prior to pregnancy; after deliver)?

How soon after birth did you breastfeed your baby?

Did you offer only breastmilk or pumped breastmilk to your infant?

How often did you breastfeed?

If you supplemented your infant – when did this happen (age of infant) ?_____

What did you supplement with? _____ and how often (average frequency per day and amount each time)?_____

Have you introduced solids?

If yes, when and the type of solids?

_____

Are you currently breastfeeding?

If no, when did you stop breastfeeding?

Height:

Weight:

Education Level Achieved:

Number of Pregnancies:

Number of Living Children:

Marital Status: (common law; married; divorced; widowed; single)

Born in Canada? Yes or No

If no, what is birth place? _____

How long in Canada? _____

Ethnicity?

_____

Living Arrangement: (who lives in home)

_____

_____

_____

Previously breastfeed Other Children: Yes or No

If yes, Number of children ____ and for how long was each child breastfed for?

_____

_____

_____

Other family or friends that have breastfeed? Yes or No

If so, who are they? (List all)

_____

_____

Employment or School Status: (in pregnancy, now and plan to return to work or school; also include if casual, part-time or full-time work or school attendance and number of hours per week; type of work)

_____

_____

_____

_____

_____

Smokes: Yes or No

If yes, for how long?

In pregnancy? In Postpartum Period?

Number of cigarettes a day currently smoking and how long you have been smoking this amount:

_____

_____

_____

APPENDIX F

Guide for Verification of Findings and Trustworthiness with Participants

At the time of the interview and your participation in the study, Breastfeeding Experiences of Low-Income Women in the City of Winnipeg: A Qualitative Study, you consented to a follow up contact after all of the interviews were completed. The purpose of this contact is too ensure the "trustworthiness" (that it is accurate and valid) of qualitative research. People who have provided information or shared their stories are often contacted by the researcher to review the themes or ideas that are commonly shared by the people who have participated in a study. This means I, as a researcher, want to be sure overall what women shared with me. No identifying information will be shared only the overall themes developed by the researcher based on the experiences of the women who participated in this study.

The purpose of this contact is to review the themes developed by me the researcher, from the 18 interviews with women that participated in this study. Do you still wish to participate or hear about the themes that were developed?

If the participant confirms **YES** continue and provide the following information. (If the participant declines or states **NO** then thank them for their time and participation in the original interview and end the phone call).

- Share the Essence of the Breastfeeding Experience: Amazing and Tough. Women described their breastfeeding experience as both amazing and tough. Women such as you spoke of how amazing and beneficial it was for them and their baby. They also spoke of how difficult and hard it was.

Eg. Well I think breastfeeding like, is amazing...It's awesome. Like it is... it's hard...But it's also... great on the other side of it. Like it's a lotta work- But....It's so beneficial for them, and for you.

Eg. So I think the breastfeeding like the experience it was pretty awesome....Once you got past all the little... little kinks in it. But it is definitely something you have to work at, it's not like it just comes easy. Yeah. Like i- it's a roller coaster it is stressful....But it's worth it.

Share the diagram from the findings section and Table 6 and briefly describe the themes and their meanings.

- Share quotes specific to the participant being contacted and how this quote fits in with the theme
- Ask them if they recognize their story and breastfeeding experience in the themes developed.
- Document their confirmation or comments regarding the themes.

APPENDIX G

ENREB Ethics Approval

UNIVERSITY OF MANITOBA | Office of the Vice-President (Research and International)
Research Ethics and Compliance

Human Ethics
208 - 194 Dafoe Road
Winnipeg, MB
Canada R3T 2N2
Fax 204-269-7173

APPROVAL CERTIFICATE

June 19, 2012

Prairie Women's Center of Excellence

TO: **Lorelei Pierce** (Advisor B. Temple)
Principal Investigator

FROM: **Stan Straw, Chair** [redacted]
Education/Nursing Research Ethics Board (ENREB)

Re: **Protocol #E2012:057**
"Breastfeeding Experiences of Low-Income Women in the City of Winnipeg: A Qualitative Study"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). **This approval is valid for one year only**.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- **If you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to the Office of Research Services, fax 261-0325 - please include the name of the funding agency and your UM Project number. This must be faxed before your account can be accessed.**

- **if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.**

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans.*

The Research Ethics Board requests a final report for your study (available at: http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html) **in order to be in compliance with Tri-Council Guidelines.**

APPENDIX H

Study Consent Form

UNIVERSITY OF MANITOBA

Faculty of Nursing

Helen Glass Centre for Nursing
89 Curry Place
Telephone (204) 474-7452
Fax (204) 474-7682
nursing_info@umanitoba.ca
umanitoba.ca/nursing
Canada, R3T 2N2
Winnipeg, Manitoba

Consent Form for Research Project Title: Breastfeeding Experiences of Low-Income Women in the City of Winnipeg: A Qualitative Study

Principal Investigator: Lorelei Pierce, Graduate Student Nurse, University of Manitoba
Phone Number: XXX-XXXX

Research Supervisor: Dr. Beverley Temple, Assistant Professor, University of Manitoba
Phone Number: XXX-XXXX

Informed Consent: This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

Purpose of the Study: The purpose of this study is to better understand the breastfeeding experience of women living within certain economic situations (those women receiving the Manitoba Healthy Child Prenatal Benefit) and who live within Winnipeg (women that live within the area where the Winnipeg Regional Health Authority provides health care to). Talking with women in these situations about what their breastfeeding experience is or was like will help others understand it better. The results of the study will be shared with nurses and other people who work in health care to help them better support breastfeeding women.

What will you be asked to do if you participate in this study? If you agree to participate in this study you will be asked question about yourself (e.g., your age, lifestyle, number of children you have) and about your breastfeeding experiences. The interview will take approximately 1 hour of your time and will be recorded on tape and then transcribed. The researcher will also take notes during the interview. The interview will occur in your home or in a place that you feel comfortable and at a time that is convenient for you.

Participation in the Study: Participation in this study is voluntary. If you change your mind and decide you do not want to participate at any time in the interview you are free to do so. If you choose not to answer any question(s) in the study you are free to do so.

Risks for participating in the study: There are no known risks to participating in the study.

How will the information you share today be used? The information about your breastfeeding experience that you share today will be used as part of a qualitative research study. This means that the taped conversation will be transcribed (written down) and analyzed by the principal research and/or other members of the research team. All the interviews conducted for this research project are analyzed and pooled together to determine things that are common or different in the breastfeeding experience of all of the women who participated in the study. You may be contacted again (if you agree to be contacted) once this part of the research is completed to help ensure the accuracy of the information. If you would like a summary of the results of the research study, as noted below, this can be sent to you. The results will also be shared with nurses and other health care professionals and supervisors that work for the Winnipeg Regional Health Authority and other health agencies. The results will also be shared with the funders of the research project (e.g., Prairie Women's Center for Excellence) or other professional audiences. No person will be identifiable in the results that are shared.

Sharing of Results with Participants: It is anticipated that the study will take at least 6 months to complete (May 2013). A brief summary of results can be made available to you by mail or email at this time.

Thank you: All women who choose to participate in the study will receive a small honorarium of $25.00 in recognition of your contribution to this research.

Confidentiality: What you share in the interview and with the interviewer is confidential. The information you share will be used as part of all the information pooled together from breastfeeding women who are interviewed as part of this study. Neither your name nor any identifying information will be used in the written results of the study. Either a pseudo name or no name will be used in the quotes and discussion of the results of the study.

The only time confidentiality cannot be maintained is if during the interview you share information regarding a child in need of protection/in danger or another person including yourself who is in danger (as per the Child and Family Services Act; Mental Health Act or other relevant provincial Act).

The tapes and written transcriptions will be kept in a locked cabinet for 7 years and then destroyed by confidential shredding as per University of Manitoba guidelines. Only the principal researcher and the Thesis advisor noted at the top of the consent form will have access to your confidential information.

Debriefing: If after participating in the interview, you have concerns about yourself, your infant or your family, Lorelei Pierce, the principal investigator is available to talk with you or refer you to resources in the community.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time and/or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The care you receive through the WRHA will not be affected by participation in this study. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Education and Nursing Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 474-7122. A copy of this consent form has been given to you to keep for your records and reference.

Participant's Signature_____ Printed Name _____ Date _____

Researcher or Delegate's Signature_____Printed Name _____Date _____

To ensure the "trustworthiness" (that it is accurate and valid) of qualitative research, people who have provided information or shared their stories are often contacted by the researcher to review the themes or ideas that are commonly shared by the people who have participated in a study. No identifying information will be shared only the overall themes developed by the researcher based on the experiences of women in this study. Would you be prepared for me (L. Pierce, Graduate Student Nurse) to contact you sometime in the next 4 to 6 months or more for this feedback?

Yes _____ No _____

If Yes, What number should you be contacted at?

_____

If you would like to receive a summary of the results of the study please fill out the information listed below.

Name:

_____

Address or email address of where the results should be sent to:

_____

APPENDIX I

Referral Resources for Study Participants

Referral Resources

Breastfeeding Hotline: 788-8667

Health Links: 788-8200

Public Health Services (by Community Area):

Assiniboine South	940-1950	River Heights	938-5500
Downtown (East)	940-8689	Seven Oaks/W.K.	938-5600
Downtown (West)	940-2236	St. Boniface	940-2035
Fort Garry	940-2015	St. James-Assiniboia	940-2040
Inkster/Tyndall Park	940-2020	St. Vital	255-4840
Point Douglas	940-2025	Transcona	938-5555
River East	938-5300	Youville Centre	255-4840

Child and Family Services – Child and Family All Nations Coordinated Response Network (ANCR): 944-4200

City of Winnipeg Police Services (Non Urgent): 986-6222 (Urgent): 911

Manitoba Suicide Line: 1-877-435-7170

Mobile Crisis: 940-1781

Klinic Crisis Line: 786-8686

Klinic Sexual Assault Crisis Line: 786-7565

Winnipeg Harvest: 986-3663

Osborne House Crisis Line: 942-3052