Breastfeeding experiences of immigrant mothers of low-birth weight babies living in Montreal, Quebec

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ABSTRACT

Context and Purpose: The present study explores the breastfeeding experiences of non-Canadian-born mothers who come from countries where breastfeeding is the usual way to feed new-born babies, and who have given birth to low birth weight babies. It more particularly examines the challenges faced by these women with respect to breastfeeding and to getting support for breastfeeding from doctors and nurses in hospitals and primary health care units in Montreal.

Methodology: The methodological framework of the current study was based ona qualitative ethnographic approach. According to a purposeful sampling strategy, participants where non-Canadian mothers from countries where breastfeeding was the usual practice to feed babies (n=9), and who had given birth in three Montreal hospitals (Quebec, Canada) over the period of six months prior fieldwork. Data source was face-to-face, semi-structured interviews with participants, and thematic analysis of transcribed verbatim from interviews was performed to address the research question.

Results: The results suggested that immigrant mothers who come from traditional breastfeeding cultures and give birth to low-birth-weight babies have difficulties accessing proper prenatal care and

support for breastfeeding in Montreal. Their healthcare and breastfeeding challenges may be attributed to:(i) language barriers; (ii) the low education level and socio-economic status of the immigrant mothers; and (iii) a lack of understanding on the part of Canadian health professionals and community workers of the healthcare and breastfeeding support needs of immigrant mothers.

Conclusion: This research suggests that there is a need for health services to develop strategies aiming at educating health professionals to better enable them to address the breastfeeding support needs of immigrant mothers of low-birth-weight babies. It also supports the need to provide these women with sources of information and support on breastfeeding in a Canadian cultural context.

RÉSUMÉ

Contexte: la présente étude explore l'expérience de l'allaitement maternel d'immigrantes ayant donné naissance un bébé de poids insuffisant (< 2500gr.). En particulier, l'étude examine les défis auxquels font face ces femmes qui viennent de pays où l'allaitement est traditionnel et tente de cerner leur expérience du soutien reçu des médecins et des infirmières tant lors de leur hospitalisation que lors de leurs contacts avec les unités de soins de santé primaires à Montréal.

Objectifs: le but de cette étude este comprendre l'expérience de l'allaitement maternel d'immigrantes provenant de pays où l'allaitement est traditionnel et qui ont donné naissance à un bébé de petit poids (< 2500 gr.).

Méthodologie : Le cadre méthodologique de cette étude est fondé sur une approche ethnographique par laquelle les données qualitatives ont été recueillies au moyen d'entretiens individuel semi-structurés avec neuf mères qui ont donné naissance à un bébé de petit poids dans trois hôpitaux de Montréalais (Québec, Canada). Toutes les mères venaient d'un pays où l'allaitement est la méthode d'alimentation traditionnelle du nouveau-nés. Une analyse thématique des données de l'entrevue a été réalisée afin de répondre à l'objectif de recherche.

Résultats : Les résultats suggèrent que les mères immigrantes de notre échantillon sous-utilisent les soins prénatals et les services de soutien à l'allaitement. Les défis qu'elles ont expérimentés peuvent être attribuée à (i)la barrière de la langue ; (ii) le niveau d'éducation et la situation socioéconomique faible; et (iii) la difficulté des professionnels de la santé et travailleurs communautaires comprendre les besoins relatifs au soutien de ce groupe de mères..

Conclusion : Cette recherche a mis en lumière l'expérience d'allaitement des mères immigrantes d'UN bébé de petit poids (< 2500gr.) et la nécessité pour les services de santé d'élaborer des stratégies visant à améliorer l'accessibilité aux services de soutien l'allaitement maternel qui répondent aux besoins spécifiques des mères immigrantes.

CHAPTER ONE

INTRODUCTION

The purpose of the present investigation is to explore and better understand the experiences of breastfeeding immigrant mothers who have given birth to low-birth-weight (henceforth LBW) babies, either preterm or at term, and who come from countries where breastfeeding is the usual way to feed new-born babies. World Health Organization (WHO, 1993) has defined low birth weight as a birth weight of less than 2.5 kg, the measurement being taken preferably within the first hour of life, before significant postnatal weight loss has occurred. Breastfeeding tradition is as old as humanity itself and is a biological, cultural, and social practice underpinned by different cultural values, beliefs and social support networks. The issues related to breastfeeding have therefore been widely investigated during various eras throughout history (Groleau et al., 2006; da Silva, de Souza et al., 2013).

Breastfeeding exclusively is the optimal method for feeding babies during the first six months of life according to the World Health Organisation (WHO, 2008) due to numerous nutritional and immunological advantages associated with it (Goldman, 1993; Kramer et al., 2001; Lee et al., 2009). According to the United Nations International Children's Emergency Fund (UNICEF, 2008), breastfeeding holds great importance for babies and mothers alike because of the related health benefits; it is therefore important that mothers breastfeeds soon as the baby is born (da Saúde, 2007).

The nursing mother/newborn dyad is likely to be subjected to various influences. First and foremost, it is important to consider that the myths and beliefs associated with breastfeeding have been a part of everyday life for many centuries. Various cultures still place great importance and value on the practice of breastfeeding and consider it a socio-cultural practice which must be followed as a matter of heritage and passed on to coming generations (Groleau et al., 2006; Marques et al., 2011). A woman's decision to breastfeed is linked to her way of life and the meaning it gives to this practice. Breastfeeding is therefore influenced by the personal, cultural, social and economic

context a woman evolves in (Teixeira et al., 2006). Each culture has traditions which have been built and perpetuated over time, forming the basis of the teachings, beliefs and values passed on through generations. As a result, each culture has numerous and diverse beliefs regarding the practice of breastfeeding and/or feeding and rearing children in general, and these beliefs and practices are culture specific (Poli & Zagonel, 1999).

Healthy babies with an adequate weight have fully developed their ability to coordinate sucking, swallowing and breathing, which means that they can start feeding by mouth immediately after birth (King, 2005). However, LBW babies have difficulties in sucking and swallowing and are at high risk for feeding difficulties (Lang, 2002). Due to being fragile, LBW babies are more often kept under special care in the hospitals NICU which in turn delays the development of oral feeding. LBW infants therefore represent a vulnerable population which is at great risk of neo-natal and neuro-developmental impairments which affect their likelihood of being successfully breastfed. Whereas it has been noted that LBW infants need the health benefits of breast milk even more than healthy weight babies (Yip et al., 1996; Ryan, 1997), it appears however that once the LWB baby is discharged from the special care unit in the hospital, it is quite difficult to switch from alternative feeding methods to breastfeeding. Due to cultural pressures, this situation may be particularly challenging for mothers akin traditional breast feeding cultures (Ryan, 1997).

Despite current trends that call for a better consideration of cultural issues when delivering care, little is still known about processes whereby healthcare professionals become more culturally-sensitive to better sustain new immigrant mothers when breastfeeding their LBW babies. In order to provide culturally appropriate breastfeeding support to immigrant mothers of LBW babies who come from a cultural background that has favored this practice for long time (whereas in Canada, the institutional support for breastfeeding stems from the 1990s), there is a need to explore and better understand how immigrant mothers negotiate the barriers to breastfeeding their LBW. Accordingly, an investigation based on the experience of such mothers will help identify and understand the nature

and type of breastfeeding problems faced by these mothers during the first few weeks after the birth of their LBW baby. The information thus gained would help healthcare providers to better support this desirable practice in vulnerable populations, particularly primary healthcare professionals since they will take care of and provide support to the mother and child after their discharge from the hospital.

CHAPTER TWO

LITERATURE REVIEW

In order to gain insight and appreciate the relevant literature relating to the challenges faced by breastfeeding immigrant mothers of LBW babies who are now living in Montreal, I performed a search of relevant published works in MEDLINE, PubMed, Web of Science, CINAHL Plus, Health Source, CINAHL Complete and Academic Search Premier search engines using the following key words: ("breastfeeding" OR "breast feeding practice" OR "breast feeding experience" OR "breast feeding problems") AND 'breast "feeding cultures" OR "traditional breast feeding cultures" OR "exclusive breast feeding cultures") AND ("low birth weight babies" OR "unhealthy weight babies") AND ("Canada"' OR "Quebec") AND ("perinatal care" OR "prenatal care" OR "postnatal care"). The period initially considered covered from 1987 to 2014. A total of 216 articles were found. After a careful reading of their abstracts, 56 were found to be relevant to the current research topic.

2.1 Epidemiological and Clinical Portrait of Low Birth Weight Babies

According to WHO (1993, 2004) and UNICEF (2004), LBW is defined as weight at birth less than 2500 g, the measurement being taken preferably within the first hour of life, before significant postnatal weight loss has occurred (WHO, 1993). The two major causes of LBW are prematurity (born before 37 weeks of gestation) and intrauterine growth retardation, a condition in which foetal

growth has been constrained (Kelley & Pojda, 2000). Each year, over 20 million infants are born with LBW worldwide, resulting in a LBW rate of 15.5% (UNICEF and WHO, 2004). The risk of neonatal death for LBW infants weighing 2000–2499 g at birth is estimated to be four times higher than infants weighing 2500–2999 g, and ten times higher than for infants weighing 3000–3499 g because of associated health problems (Ashworth, 1998).

It is estimated that LBW babies account for 20 million of the 139 million live births worldwide each year, with more than 95% of them being born in developing countries, mainly South Asia and sub-Saharan Africa (Sachdev, 2001). In India, 30-40% of live births result in LBW babies, 60-70% of which consist in intrauterine growth retarded infants, with the rest being due to a preterm delivery (WHO, 1992). In addition to the risk of death, LBW can have deleterious effects on growth and cognitive development (Simhan&Caritis, 2007).

LBW infants are at high risk of early growth retardation, infectious disease, developmental delay and death (McCormick, 1985; Ashworth, 1998). In addition to having a high risk of mortality and morbidity, these infants exhibit growth patterns that differ from that of normal term babies (Babson, 1970). It should be noted that infant growth, especially head growth, has a bearing on neurodevelopmental outcome. LBW babies therefore have an increased risk of cognitive and language deficits (Ericson & Kallen, 1998). Further LBW is a potential indicator of the mother's nutritional and health status (Sachdev, 1997).

2.2 The Practice of Breastfeeding Newborn Babies

Breastfeeding is an important component of child feeding, one that can single-handedly nourish children adequately during the first six months of life and which can be later be supplemented with adequate food to avoid malnutrition and to prevent childhood morbidity and mortality (Oliveira et al., 2012). Breastfeeding plays an important role in the infant's growth (Demirtas et al., 2011) and has been a hot topic for debate since the turn of the twentieth century (Oliveria et al., 2012).

The WHO and UNICEF recommended exclusive breastfeeding during the first six months of life which can later be supplemented with solid and semisolid foods for at least two years (WHO/UNICEF 1990; 2003). Moreover, WHO and UNICEF launched the "Baby-Friendly Hospital Initiative" in 1991 as a means of addressing the fact that those mothers and other caregivers require support to establish and sustain appropriate breastfeeding practices, given that breastfeeding is a learned behaviour as well as a natural act. "Ten Steps to Successful Breastfeeding" is the basis of the "Baby Friendly Hospital Initiative", which further stipulates that every facility providing maternity services and care for newborn infants should take these steps (WHO/UNICEF 1990, 2009; Demirtas et al., 2011).

2.3 Health Benefits of Breastfeeding for both the Newborn and the Mother

The health benefits of breastfeeding for both infant and mother are multiple and widely recognized in the medical and public-health literature. Breastfeeding is known to contribute to the physical, neurological and cognitive development of children (Paine et al., 1999) and there are numerous physical, psychological and physiological benefits to infant breastfeeding. Breast milk provides excellent nutrition to infants by providing many necessary vitamins (Wolf, 2003). Additionally, the colostrum in breast milk provides immunological protection from illness through IgG, an immunoglobulin that helps the immature immune system of the infant fight off pathogens (Wolf, 2003). The resulting benefits include fewer respiratory tract infections and instances of necrotizing enterocolitis, and less otitis media and diarrhea in both full-term and healthy-weight, and premature and LBW infants (Center for Disease Control, 2006), which in young infants can be very serious and even lethal. Decreasing the risk of these diseases therefore drastically reduced the infant mortality rate. Additionally, there is some evidence that Type 1 and Type 2 diabetes mellitus (T1DM and T2DM, respectively) are less prevalent among breast fed children (Grummer-Strawn & Mei, 2004; Michaelsen & Schack-Nielsen, 2007).

Furthermore, there are psychosocial benefits to breast feeding infants. An interesting finding is a strong inverse relationship between breastfeeding and overweight children. Kersey et al. (2005) conducted a study on Latino children and found that increased duration of breastfeeding in Latino children is correlated with decreased rates of overweight in preschoolers (Kersey et al., 2005). This is an important consideration, given the increasing rates of obesity and resultant risk for T2DM in Hispanic and North American children. Breastfeeding also provides protection against allergies, ear infections, gastroenteritis (ADA Report, 1997) and respiratory infections (Wilson et al., 1998). Some studies have suggested that breastfeeding may protect at-risk children from certain cancers (Smulevich et al., 1999), Type 1 diabetes (McKinney et al., 1999), and Crohn's disease (Koletzko et al., 1989).

The benefits of breastfeeding extend to the mother as well. Women who breastfeed have decreased rates for ovarian cancer and premenopausal breast cancer (CDC, 2006), and are more likely to shed pregnancy weight with longer duration breastfeeding (Faraz, 2009). It is now widely recognized that the health benefits of breastfeeding increase with its duration and with the exclusion of other feeding methods (Vestergaard et al., 1999). Based on this evidence, the WHO and UNICEF declared in 1989 that all countries should adopt a health policy that promotes and protects EBF in infancy (WHO/UNICEF, 1989).

2.4 Social, Cultural and Institutional Determinants of Breastfeeding Practices

The social, cultural and institutional determinants of breastfeeding practice contribute to the construction of the meaning attributed by women to the act of breastfeeding. These determinants are shaped by the socio-cultural heritage gained by living in a society, by the transmission of cultural values from others, or simply by observing women in the same situation (Groleau et al., 2006; Silva et al. 2013). While breastfeeding is one of the oldest infant-feeding practices, it can be influenced by a complex interplay of social, cultural, economic, medical and institutional factors. It is therefore important to understand the role of all the aforesaid factors in deciphering the breastfeeding

decisions and patterns of immigrant mothers from breastfeeding cultural backgrounds (Riordan, 2005).

Breastfeeding makes a unique, foundational contribution to women's health and to the nutrition of infants. Women choose to breastfeed for a variety of reasons. Many women, regardless of their race or cultural background, must balance the perceived benefits of and obstacles to breastfeeding (Schlickau & Wilson, 2005). Convenience is also a major factor, as bottle feeding is much easier than breastfeeding for the working mother. This takes on particular importance as more women are working outside the home in addition to being the primary caregivers for their children (Wolf, 2003). Another influence on a woman's decision to breastfeed is whether her own mother, other close relatives, and friends breastfed (Libbus, 2000). Additionally, an often overlooked contributor is women's partners, specifically their attitudes toward and support of breastfeeding (Libbus, 2000; Faraz, 2009).

Several studies show that that family support, especially that of the father and maternal and paternal grandmothers, are important factors in choosing whether or not to breastfeed (Silva et al., 2012). Grandmothers are significant caregivers in the family, especially towards their daughters during their postpartum phase. They transmit their practices and their culture, and are often respected and valued for their expertise and experience, especially in caring for newborns (Teixeira et al., 2006). Even after deciding to breastfeed, many mothers fail to reach their own breastfeeding goals because of hindering factors (Thomson, 1990). Forster and McLachlan (2010) found that many women had both positive and negative feelings about breastfeeding. Furthermore, the factors which influence breastfeeding are both numerous and complex, for example factors like work and family constraints (Patel, 2008). More specifically, mother-related factors such as employment and perceived breast milk insufficiency, infant-related factors such as newborns being kept away from its mother in the hospital due to health problems or prematurity (McCarter-Spaulding & Kearney, 2001; Moffat, 2002), and husband-related factors (Earle, 2000; Kong & Lee, 2004) have all been reported.

Duong et al. (2005) found that the mother's educational level and comfort with breastfeeding in public places, the father's occupation and feeding preference, and the availability of sufficient food for the family all significantly influence the practice of breastfeeding. Meedya et al. (2010) found breastfeeding intention, breastfeeding self-efficacy, and social support to be modifiable factors that influence women's breastfeeding decisions. In addition, breastfeeding is influenced by health providers (DiGirolamo et al., 2003) and the marketing of artificial milk for infants too (Adair et al., 1993). It has also been reported that hyper-sexualisation of breasts also acts as a major deterrent to breastfeeding in a Western context, especially for women living in a context of poverty. However, it is not known how immigrant mothers negotiate this Western barrier to breastfeeding (Groleau& Rodríguez, 2009; Groleau, Zelkowitz, & Cabral, 2009; Groleau et al., 2013).

Barber et al. (1997) proposed that research on the health practices of immigrant populations must build on an understanding of the interests and beliefs of targeted groups within the socio-political context of structural changes affecting them. Health professionals often neglect the ways that patients' experience is shaped by cultural beliefs, and therefore may provide inappropriate information to new mothers about breastfeeding (Callister 2001). Breastfeeding strategies must therefore be adapted to the population's cultural background, habits, beliefs and socio-economic level (Bernaix, 2000).

The meanings attached to breastfeeding as a universally available means of feeding infants vary across cultures. Among the Bambara, a peri-urban patrilineal and patrilocal culture in Mali, children are thought to be of the same blood as the mother not through birth, but through nursing (Dettwyler, 1988). Thus, two children who have been nursed by the same woman cannot marry, even if they are biologically unrelated. Similarly, Fijians believe that when a woman breastfeeds a child who is not her own, a special bond and a concomitant sense of responsibility develop (Morse, 1985). However, breast milk and breastfeeding are not universally regarded as symbols of nurturance and love. In an impoverished area of north-east Brazil, breast milk is distrusted, seen as "worthless,"

dirty, sour, or curdled, an image that Scheper-Hughes (1984, p.544) interprets as a metaphor related to the scarcity and bitterness of life for women there. Haitian women consider thin, watery milk worthless (Farmer, 1988), and they worry that it may be turned to poison as a result of some malignant emotion. Women in industrialized societies voice similar negative perceptions (Jones &Belsey, 1977). While concerns about the quantity and quality of breast milk are common (Hull & Simpson, 1985; Groleau et al., 2006), exaggerated views such as these seem to reflect larger conflicts about maternal responsibilities. Groleau et al. (2013) conducted a study with poor French Canadian women exposed to breastfeeding promotion. The study's findings suggested that "the 'good mother' imperative in context of poverty and the Western hyper-sexualisation of breasts acted as major deterrents to breastfeeding" (p. 250). Clearly, interpretations regarding breastfeeding vary across cultures depending on social and economic factors (Wright, Bauer, Clark, Morgan &Begishe, 1993).

In agricultural societies, there are many benefits to having large families. Children are a resource in terms of their ability to contribute to food production and caring for elders (Biglan, 1992). Within this context, a woman may breastfeed for many years during her adult life, and children within this family structure – both male and female – accept breastfeeding as a social norm. Thus, breastfeeding is a common daily experience. Likewise, socialization processes influence attitudes toward breastfeeding considerably (Dykes & Griffiths, 1998). In the United Kingdom, breastfeeding is perceived as an activity that society requires to be hidden away. A similar mentality prevails in many Western countries with the exception of Scandinavian countries where breastfeeding is common and normative. On the other hand, in West Africa as well as in many developing countries, it is acceptable to breastfeed publicly when the need arises (Higginbottom, 1998).

The UNICEF UK Baby Friendly Initiative (BFI) was introduced in 1994 with the aim to act as a foundation to implement evidence-based care to support more women to breastfeed their infants. To achieve this, it was recognized that there was a need to update education for health care staff and

to implement an evidence-based service policy to underpin minimum standards that would support breastfeeding. The BFI program used a focused approach to implement significant changes to health care practice and to raise the bar on requirements for improving care. The BFI has succeeded in gaining national recognition for the importance of breastfeeding. It has also created a new "common knowledge" related to breastfeeding practice within the health service and among policy makers. Once hotly debated topics such as skin-to-skin contact, rooming-in, teaching mothers how to breastfeed and avoiding supplementation are now accepted as good practice (UNICEF, 2013). The Baby Friendly Hospital Initiative (BFHI) is a global UNICEF/WHO-sponsored initiative for promoting breastfeeding (World Health Organization [WHO], 2003). This initiative proposes that all mothers should be provided with sound information about infant feeding choices. Similarly, Purdy (2010) contends that mothers from all cultures who elect to breastfeed should be given evidence-based advice and skilled prenatal and perinatal assistance so that they can successfully breastfeed their infants.

2.5 The Challenges of Breastfeeding LBW Babies

As soon as healthy newborn babies leave their mother's womb, they have the physiological capacity to start to feed by mouth. Unlike healthy-weight babies who can be placed at the mother's breast immediately after birth, a LBW baby is usually separated from the mother and cannot feed efficiently. Because of their fragile body systems, the LBW babies are prone to necrotizing enterocolitis, apnea and sepsis (Merenstein& Gardner, 2006), which can prolong hospital stay and further delay the development of oral feeding.

Even in very low doses, using breast milk for enteral feeding to prime the gastrointestinal tract of the LBW baby can improve glucose tolerance and increase gastrointestinal function (Landers, 2003). In addition, breast milk can promote brain growth and cognition, enhance intellectual and visual development and protect a preterm baby against infection (King & Jones, 2005; Morales & Schanler, 2007). Therefore, once a LBW baby is stabilized, it is recommended that

breastfeeding be started within the first few days of life (King 2005; Tzu-Ying Lee, Ting-Ting Lee & Su-Chen Kuo, 2009).The use of maternal milk in LBW infants affords many early benefits such as providing the recommended source of enteral nutrition, lowering rates of infection, and of necrotizing enterocolitis and having a positive long-term impact on intellectual and neuro-psychomotor development (McGuire & Anthony, 2003; Vohr, Poindexter &Dusick, 2007). These advantages, along with others, support its use in the nutritional management of LBW infants both as inpatients and after discharge (Griffin &Cooke, 2007). However, mothers of LBW newborns have difficulty maintaining breastfeeding for the recommended period (Lee & Gould, 2009). These difficulties arise from fragility (requiring intensive care), longer hospitalization, and delayed onset of oral feeding, all contributing factors to mother-child separation, and, in turn, higher weaning rates (Kirchner et al., 2009). Breastfeeding, however, may be prolonged when the mother intends to nurse and has received instructions for the management of lactation, such as prenatal orientation, early visits to the neonatal intensive care unit to strengthen the mother-child bond as well as early and systematic breast milk pumping (Pinelli at al., 2001). As a result, low breastfeeding rates are found in LBW infants, even when inpatient incentive policies are applied (Bicalho-Mancini &Vela´squez-Mele´ndez, 2004; Maia et al., 2011).

Mothers who deliver LBW babies often face additional barriers to breastfeeding such as establishing human milk supply and getting the baby to nurse. For sick or premature infants, parents experience a roller coaster of complex issues related to infant survival. Despite the many benefits of breastfeeding for LBW infants, mothers often do not breastfeed after hospital discharge or stop breastfeeding shortly thereafter (Anderson et al, 1999). New mothers of medically unstable infants may not receive information from health care providers about pumping even when the baby is too sick to drink breast milk. They may also be confused by controversies such as whether pacifiers or bottle feeding create breastfeeding barriers. Excessive focus on calorie counting and infant weight gain may be stressful to breast milk production (Purdy, 2010). However, researchers and clinicians

increasingly recognize that nutrition during critical periods early in life may permanently affect the structure and function of organs and tissues. Enzymes in breast milk help LBW infants absorb and utilize nutrients more efficiently, which could translate into less time on intravenous feedings and a shorter hospital stay (Hamosh, 1994). Furthermore, LBW infants who are breastfed tend to have higher intelligent quotient scores (Anderson at al., 1999). Thus breast milk holds great benefits for LBW babies.

2.6 Breastfeeding Support for Mothers of LBW Babies

As breastfeeding support needs to start early (Purdy et al., 2007), health care professionals need to develop ethnically sensitive breastfeeding interventions and overcome their own cultural and professional biases about breastfeeding to support mothers through the process (Purdy, 2010). There is the need for the national health systems to realize the benefits of providing an educational intervention for health care and feeding of LBW infants. These benefits include increases in health professionals' knowledge as well as increase in the rate of breastfeeding at time of discharge and up to six months beyond discharge (Cattaneo & Buzzetti, 2003). Nurses also need to discuss maternal goals and potential cultural barriers that mothers could face after hospital discharge. Based on the perceived breastfeeding barriers that mothers identify, supportive interventions can be developed. These barriers may include a lack of staff awareness that their own opinions of breastfeeding may differ from maternal perceptions of benefits and barriers. Nurses also need to learn what the mother's long-term breastfeeding goal is. Nurses can become role models for all members of the health care team and for parents by enthusiastically supporting breastfeeding in the LBW newborn nursery (Maia et al, 2011). Hence, during hospitalization, it is essential to help mothers establish a plan that recognizes potential breastfeeding barriers (Purdy, 2010).

Despite evidence supporting that breastfeeding is in the mother's and baby's best interest, and despite the availability of free lactation support in many communities, a mother will always encounter cultural, societal, or family pressures that will influence her choice. Regardless of rigorous

scientific studies and what health professionals might say about the benefits of extended breastfeeding, evidence suggests that many mothers abandon their goals in order to comply with cultural and societal demands. In this regard, support targeted toward helping families develop a plan that overcomes stressful social, cultural, medical, and bio-physiologic barriers may increase the duration of breastfeeding of LBW babies (King, 2005).

2.7 Role of In-hospital Formula Milk Supplementation

The current high rates of in-hospital formula supplementation are of concern as multiple studies document that formula supplements during the hospital stay lead to shortened durations of both exclusive (Howard, Howard, Lanphear, Eberly, deBlieck & Oakes, 2003; Semenic, Loiselle& Gottlieb, 2008) and "any'" breastfeeding (Agboado, Michel, Jackson &Verma, 2010). For example, amongst 1,907 mothers surveyed in the Infant Feeding Practices Study II who intended to breastfeed for longer than two months, EBF during the hospital stay was associated with an OR of 0.47 (0.34-0.64) for breastfeeding cessation before 6 weeks (DiGirolamo, Grummer-Strawn & Fein, 2008). The study was limited, however, by measuring in-hospital breastfeeding exclusivity by maternal recall at one month postpartum. It is unclear whether early formula supplementation is causally related to shortened breastfeeding duration. None of the aforementioned studies adjusted for strength of breastfeeding intentions, and some did not measure intention at all (Agboado, Michel, Jackson &Verma, 2010), despite the fact that feeding intention has been demonstrated in previous studies to relate positively to breastfeeding duration (Blyth, Creedy, Dennis, Moyle, Pratt & De Vries, 2004; Ahluwalia, Morrow, D'Angelo& Li, 2012).

2.8 The Phenomenon of Immigration and Perinatal Care in Canada

Canada accepts approximately 250,000 immigrants annually, with the majority settling in the large metropolitan cities of Toronto, Montreal, and Vancouver (Citizenship and Immigration in Canada, 2008). Individuals emigrate from countries in Central & South America, Africa, the Middle East and Asia, countries where English and French are not the predominant languages (Citizenship

and Immigration Canada 2008). The "Healthy Immigrant Effect" (HIE) characterizes the changes in health experienced by immigrants, whereby immigrants are often healthier than non-immigrants when they first arrive but experience a deterioration in health as they become more established (Beiser 2005; Urquia, Frank & Glazier, 2007). Furthermore, the HIE appears more predominant in females (Dunn and Dyck 2000; Newbold and Danforth 2003; Newbold 2005, 2009), with women typically experiencing worse health outcomes than men (Ng &Newbold, 2011).

In part, observed declines in health amongst new arrivals in Canada are associated with barriers to health care, including language, location, transportation access, cost, knowledge of services and cultural sensitivity (Asanin& Wilson, 2008). While barriers to health care are well researched and understood, there are a limited number of studies that have analyzed the effects of immigration on birth outcomes and related reproductive health issues (exceptions include Urquia et al, 2007; McMichael & Gifford, 2010). For example, immigrant women experience poorer birth outcomes than non-immigrants, including LBW, premature births, intrauterine growth retardation, and higher rates of infant mortality (Hyman &Dussault 2000; Urquia etal., 2007).

For low-risk pregnancies, women can choose from different health care providers to monitor their pregnancies. Typically, at the 20th week of pregnancy, women are followed by an obstetrician gynecologist. If the pregnancy is low-risk, women have the option of a midwife, nurse practitioner, general practitioner, or obstetrician gynecologists to oversee their prenatal care. If the pregnancy is high-risk, the patient must be under the care of an obstetrician gynecologist. Prior to the 20th week check-up, immigrants can use private health insurance, although this is often a costly option, despite falling under the health insurance of each province that covers not only delivery, but pre-and postnatal care as well. Although immigrants tend to have more negative birth outcomes (1 out of 5 deliveries) than non-immigrants in Canada, the literature does not fully explain why these differences exist (Lin, Shieh & Wang 2008). Negative birth outcomes include LBW and higher rates of perinatal mortality, which research has found to be an indicator of poor prenatal care (Essen,

Bodker, Sjoberg, Langhoff-Roos, Greisen, Gudmundsson & Ostergren, 2002).These negative birth outcomes are correlated with cultural pressures, language barriers and lack of adequate prenatal care (Hyman &Dussault 2000; Essen et al., 2002). All of these trends are more prevalent in immigrants than non-immigrants in Canada (Essen et al., 2000). Barriers, and ultimately birth outcomes, may also reflect conflicting expectations of care that both provider and client have of each other. For patients, expectation of care, cultural practices surrounding pregnancy and delivery and/or type of care during pregnancy, may all influence utilization of care. Additionally, if expectations of care are not met because physicians have failed to recognize the cultural needs of their patients (i.e. issues of cultural competency) (Brach & Fraser, 2000), patients will be less inclined to continue care, or may be forced to seek care elsewhere (Ng & Newbold, 2011).

Health professionals have struggled in their attempts to address the health care needs of diverse cultural populations and provide culturally safe health care (Brach & Fraser, 2000). Over the years, nursing scholars particularly have focused on developing cultural assessment guides and "cultural profiles" for various groups (Anderson, 1990; Lipson et al., 1996). For example, Choudhry (1998) developed an overview of traditional perinatal beliefs and practices of women from India. Although such profiles have been helpful in providing some general understanding of the health beliefs and practices of specific cultural groups, these summaries have the danger of being simplistic and may fail to acknowledge the diversity that exists in communities as well as the impact of immigration on traditional beliefs and practices. Research is needed to allow the experience of new immigrant women who have recently given birth to be described in rich detail which acknowledges the individual differences among women as well as the cultural knowledge and traditions that they share (Grewal et al., 2008).

In recent years, there has been a shift toward developing care that is sensitive to the needs of diverse ethno-cultural groups (Whanau Kawa Whakaruruhau, 1991). This requires health professionals to be aware of the need for the provision of safe, competent care that acknowledges

patients' broader cultural experiences (Dyck& Kearns, 1995; Fulcher, 2002). This includes recognition of the impact of their own culture on their interaction with patients. Another important element is their knowledge, understanding, and recognition of the social, historic, economic, and political position of certain groups within society and the need for ongoing examination of unequal power relations (Polaschek, 1998). As a result, providing culturally safe care includes actions that recognize, respect, and nurture the unique cultural identity of those the health professionals engage with to safely meet their expectations and rights (Kearns &Dyck, 1996).

Within a Canadian context, Lynam et al. (2000) conducted diverse focus groups with key informants within the South Asian community. Participants described many of the traditional practices surrounding the perinatal period, the challenges and facilitators that South Asian women experienced in accessing timely health care, and the importance of the family and community in informing and supporting women. Although this research offered important insights into some of the issues that South Asian women face during pregnancy, further study is needed to lend a voice to new immigrant women. In response to the difficulties experienced by immigrant South Asian women during the perinatal period, prenatal classes have been recommended as one strategy that would improve women's pregnancy and childbearing experiences (Bowes &Domokos, 1996; Bowler, 1993). As a consequence, prenatal classes for new immigrants have been developed for the South Asian community and piloted within a Canadian context (Dhari et al., 1997). According to the authors, South Asian women who participated in prenatal classes reported feeling less anxiety, more prepared for childbirth, and greater comfort with the Canadian health care system (Dhari et al., 1997).

Research has suggested that formal health care and other community services may be underutilized by select groups of women, including new immigrant women (Lewis &Drife, 2004; Fung & Wong, 2007). Factors that may influence how new immigrant women access health care include settlement issues, language barriers, acculturating to a new community, experiences of

discrimination, and conflicting belief systems (Choudhry, 2001; Reitman ova & Gustafson, 2007). Underutilization of health care can have significant impact on new immigrant women' s health and well-being, particularly during vulnerable life phases such as the perinatal period (Grewal et al., 2008).

2.9 Breastfeeding Trends amongst Immigrant Women in Canada

Since the early 1990s, provincial surveys in Quebec have shown a steady increase in breastfeeding rates from 47% (Levill et al., 1995) to 54% (Levill et al., 1995), 72% (Dubois, 2000), and more recently 86% (Neill, 2006). The provincial policy on breastfeeding was revised in 2001, with the goal that by 2007, 85% of new mothers will adopt exclusive breastfeeding and that this practice will continue at rates of 70%, 60%, 50% and 20% at 2, 4, 6 and 12 months postpartum respectively (MSSS, 2001). A Canadian survey conducted in 1999 suggested that overall, immigrants to Canada are more likely than their Canadian-born counterparts to breastfeed their babies (82% vs. 69%) (Santé-Canada, 1999). This survey did not distinguish between specific ethno-cultural groups, country of origin, income, education level, or immigration status (Santé-Canada, 1999).

Summary of the Literature Review and Knowledge Gap

Current evidence clearly highlights the importance and benefits of mother's milk and breastfeeding in newborn babies. Importantly, breastfeeding is a traditional practice in many countries around the world. That said, a woman's decision to breastfeed her newborn is influenced by a great variety of personal, cultural, social and economic factors, this practice becoming rather challenging in particular circumstances. In this regard, specialized literature points out the difficulties to breastfeed encountered by mothers of LBW babies. Evidence also suggests that breastfeeding seems to be a more difficult practice among immigrant mothers. However, little is known about the practice of breastfeeding LBW babies for immigrant mothers coming from countries in which this practice is

sustained and legitimated. There is therefore a need to explore the breastfeeding experiences of these mothers to help them in continuing their traditional and cultural practice away from their native countries. In order to fulfil this knowledge gap, my aim in this study was to answer the following research question: "What are the breastfeeding experiences of immigrant mothers of low birth weight babies living in Montreal who come from a cultural background where breastfeeding is traditional?"

CHAPTER THREE

METHODOLOGY

3.1 The Selection of a Qualitative Research Design

While planning for this study, I selected a qualitative research design because it was the most suitable choice for answering the stated research question. The choice was based on the notion that qualitative studies have the key characteristics of:(i) accessing the complexities of meaning and experience in context; (ii) emphasizing on representing real voices; (iii) taking insights to another level through interpretation; and (iv) accessing the complexities of meaning and experience in context.

3.2 The Ethnographic Approach

I chose an ethnographic approach for my study because it closely fits within a qualitative interpretive tradition through its aim to explore the cultural influences on the ways a group of people, i.e., non-Canadian mothers, behave regarding breastfeeding. Taking an ethnographic approach involves building understanding of interaction from an insider's point of view (Barcelos, 2003), and uncovering beliefs and values that underlie in actions within social groups (Wragg, 1994). As Wolcott (1988) states: "ethnographic significance is derived socially, not statistically, from

discerning how ordinary people in a particular setting make sense of their everyday lives" (p. 191). This study was not confined to just looking at the breastfeeding practice of each mother, but also investigated the social, cultural and traditional influences on each mother's underlying beliefs and perceptions. Thus, in this study, I explored the mothers' breastfeeding practices with the ethnographer's desire to seek naturalistic, holistic and culturally situated interpretations along with an emphasis on understanding multi-layered complexity and the inter-relatedness of the interactions within (Wolcott, 1990; Barcelos, 2003).

In an ethnographic approach, understanding is progressively refined over a period of time (Nunan, 1992), and a sense of process is sought rather than a static picture (Woods, 1996). An ethnographic approach, therefore, has specific value in investigating breastfeeding practices and has rich potential for providing effective insights into how cultural traditions and values impact the breastfeeding practices of mothers from cultures where breastfeeding is traditional. Nonetheless, the present study does not claim to be traditional ethnography. Two key differences are pertinent. Firstly, while this study seeks to capture and understand the dynamic complexity of breastfeeding experiences, an ethnographic approach may allow for the examination of a more manageable slice of reality than would be possible in traditional ethnography. In addition, applied collaborative aspects integral to the design of the current study, may be more easily accommodated within a less restrictive ethnographic approach.

Pure ethnography has been traditionally regarded as requiring intensive participant-observation of a setting over an extremely long period of time (McDonough & McDonough, 1997). In reality, however, most researchers do not have unlimited time to spend in the research setting. In the present study, I therefore needed to find a methodological approach that would be manageable for me as well as the key informants (the mothers). In this regard, the choice of a qualitative ethnographic approach for the current study was deliberate, in that I saw its interpretative process as the best way to gain an understanding of the breastfeeding experiences of the mothers. Accordingly,

the data collected through ethnographic interviews was interpreted to specifically address the research question.

3.3 Participants and Context

The key informants of this study comprised nine mothers from a variety of countries from Asia, West Africa, and the Americas who gave birth in three hospitals in the city of Montreal, Quebec, Canada. The three hospitals included in the study were three acute-care hospitals with an academic affiliation. Following a purposive sampling strategy, the first criterion for inclusion was that participants had to be non-Canadian born mothers and have given birth to LBW (<2500 gm.) babies. Taking into account practical considerations, only mothers fluent in English or French were included in the study. Likewise, mothers suffering from any addiction of substance abuse problem were not considered eligible. This was a sub sample and a purposive sample created from a larger about LBW babies.

Taking into account a maximum variation sampling approach, nine immigrant mothers from a variety of countries where breastfeeding is traditional (i.e., from Pakistan, Sri Lanka, China, Philippines, Lebanon, Côte d'Ivoire, Guatemala, El Salvador, and the Dominican Republic) who had given birth to LBW babies were selected as key informants. The focus here was not on a particular cultural context, but rather on the fact that, in the new mother's country of origin, breastfeeding was the taken-for-granted practice to feed newborns.

3.4 Research Timeframe

In order to investigate and understand the research problem, i.e., the breastfeeding experiences of non-Canadian born mothers who gave birth to LBW babies and who come from the cultures where breastfeeding is traditional, I collected data through the research technique of semi-structured, face-

to-face interviews within a given timeframe. The study informants were interviewed during a period of a year from 2009 to 2010.

3.5Semi-structured face-to-face interviews

The technique use for data gathering was individual semi-structured interviews (Kvale, 1996) with participants. All the interviews were conducted face-to-face. The rationale behind conducting face-to-face interviews was to connect with the informants informally with the aim to gain insight into the research problem. I conducted two interview rounds of interview, two per participant (i.e. 18 interviews):

(1) Between 2 and 4 weeks postpartum.

(2) At 6 months postnatal, using the semi-structured interview schedule McGill Illness Narrative Interview Schedule (MINI) (Groleau et al., 2006). The MINI is a semi-structured interview schedule tool designed to elicit narratives about health problems, discomfort or symptoms relating to health behaviours. The MINI was divided into four parts that achieve:

1) A narrative describing the events related to the onset of health problems (having a LBW (<2500 g) baby and breastfeeding difficulties);

2) Prototypes of self and other health problems related to experiences;

3) Explanatory models of health problem; and

4) Mothers' expectations of care. For example, to discuss the explanatory models of mothers in relation to their reported symptoms, the interviewees were asked: "What do you think was the reason that your baby is born <2500 g? Why have you stopped breastfeeding?" Another aim was to reveal a prototype of mothers relating to breastfeeding a LBW infant, and interviewees were asked questions such as: "Do you know of a mother of a LBW baby who decided to stop breastfeeding before the time? What distinguishes your experience from that of the mother?"

The interviews were digitally recorded with the interview participants' prior permission. The researcher tried to make the conversation as informal as possible and make the interviewees share

information in a relaxed manner. Interview duration in the first round was 60 to 90 minutes because the ethnographic questions were designed to update representations organized in causal reasoning (explanatory model), analogical reasoning (prototypes), metonymical reasoning (chain of events of the illness narrative), and metonymy (story events). Interview duration in the second round was a little shorter, i.e., between 30 and 60 minutes, because it focused on the barriers to breastfeeding duration encountered since the first interview. Ethnographic questions in the second interview were also designed to update representations organized in causal reasoning (explanatory model), analogue (prototypes) and metonymy (story events). These categories of reasoning will be analyzed as separate semantic units to understand them as semantic entities and to appreciate any areas of complementary and contradictory representations.

3.7 Data analysis

The data analysis followed a systematic procedure in which the interview recordings were first listened to carefully, after which all the recorded data was transcribed and coded for each informant, e.g., informant #1 was coded as M1, informant #2 as M2, and so on. After that, the French interview transcripts were translated into English. As a next step, all the interview transcripts were read and initial coding was done manually. After that, a thematic analysis of the coded data was done and the emerging pieces of useful information were divided into the six emerging themes, and the findings were finally interpreted to answer the research question (Bailey, 2007).

3.8 Ethical Procedures and Considerations

Research ethics refer to the various research steps, involving: how the researcher:(i) formulates and clarifies research topic, designs research and gains access to the participants; (ii) collects, processes, stores and analyses data; and (iii) writes up findings in a moral and responsible way (Saunders et al, 2009, p.184). Research ethical procedures and considerations were adhered to at every stage of this

research. In this regard, ethics approval was obtained from the McGill Ethics Review Board prior to commencing the data collection. The key informants were asked to read and sign interview consent forms before commencing the interview; they were informed of their rights for participation in the study, that the participation was completely voluntary, that they were not bound to participate in the study, and they had the right to decline answering any questions during the interview. They were assured that their identity would not be disclosed at any stage of the study and that the data collected would strictly be used for this study only. The participants were also informed of the purpose of the interview. Once the participants understood their ethical rights, no problem was faced by both the interviewees and the researcher and the interviews were conducted in a friendly environment. Ethics certificate were obtained by appropriate institutional review boards prior fieldwork, i.e. McGill Faculty of Medicine Ethics Review Board) (reference: A08-B10-09B).

CHAPTER FOUR

FINDINGS

This chapter presents the findings of the current study. Central to this chapter is the data collected through the nine interviews conducted with mothers. The findings are interpreted under the themes that emerged during data analysis. Six key themes emerged, which are: 1) experiences of pregnancy and delivery; 2) the feeding decisions and experiences; 3) views on importance and benefits of breastfeeding; 4) the support or information received or available for feeding LBW babies; 5)

perceptions on how to raise awareness of breastfeeding and its benefits; and 6) perceptions on barriers to breastfeeding. The present chapter firstly presents a brief information on the socio-demographic profile of the nine mothers interviewed in table 4.1 followed by the sections comprising the six themes with evidence from the interview data. The quotations from the interviews are presented in italics.

Four mothers (M2, M6, M7 and M8) reported that this was their first baby, three mothers (M1, M3 and M5) that this was their second, and one mother (M4) that this was her third. One mother (M9) indicated that she already had two children, and that this time she had twins. All the mothers worked during pregnancy except for M3 who was a student and M7 who was a stay-at-home mother. All mothers expect for M3 and M7 also reported that they were living with their husbands/partners. M3 reported that her partner did not live with her, stating that he lived in the apartment next door and that she looked after her children alone. M7 reported that her husband was still in their home country and had not been with her during or after delivery (however; she indicated that she had her mother with her the whole time). Only M2 and M8 had other family members also living in Canada.

Table 4.1 Socio-demographic profile of the mothers

No.	**Mother code**	**Country of origin**	**Delivery hospital**	**Baby's birth weight in grams**	**Children**	**Feeding**	**Desired duration to breastfeed**
1.	M1	Philippines	H1	1735	2	Mixed feeding	Not decided

2.	M2	Pakistan	H1	1650	1	Mixed feeding	As long as the baby wants it
3.	M3	Côte-d'Ivoire	H1	2325	2	Breastfeeding	Not decided
4.	M4	Sri Lanka	H2	2452	3	Mixed feeding	As long as the baby wants it
5.	M5	Guatemala	H1	2200	2	Mixed feeding	Not decided
6.	M6	Lebanon	H3	2320	1	Formula milk	
7.	M7	China	H1	2135	1	Formula milk	
8.	M8	Dominican Republic	H2	2478	1	Breastfeeding	Not decided
9.	M9	El Salvador	H2	2600	4	Breastfeeding	18 months

4.1 Experiences of pregnancy and delivery

All the mothers experienced different complications during pregnancy and delivery which according to them, caused the LBW of their babies or the prematurity of delivery. The reasons put forth by the mothers included: (i) stress (M1, M2 and M7); (ii) high blood pressure (M2); (iii) high blood sugar

(M3); (iv) working for long hours, standing at work place for 7- 8 hours per day, and lifting heavy objects at work (M4); (v) their age (M9, who was 35 years old); (vi) a long gap between pregnancies (M9, who had a 9-year gap between last baby and her current twins), (vii) bleeding and spotting during pregnancy (M1 and M5); and (viii) anemia (M1). In this regard, M1 further stated:

> *Everything was normal up to seventh month…then bleeding started in seventh month and went on till eighth month when contractions also started…which stopped with medicine…I had first ultrasound at 28 weeks when contractions started…and scan showed that placenta was very low. I was also anemic and was given Materna vitamins…Bleeding and contraction again started in week 31…and couldn't be controlled with medicine…so the baby delivered through C-section.*

M2 said: *"*The cause of premature birth was stress". M7 further explained:

> *I had stress during pregnancy because of some issues with the baby's father and because of some family problems…and I had been eating less during pregnancy because of stress…I lost appetite…and there was also too much heat in my apartment…and I had more nausea and vomiting compared to the first pregnancy.*

When talking about their babies' premature birth, the mothers reported that their babies were born between 31 37 weeks. M9, who had twins said: *"The babies were born in week 37 through C-Section"*. M2 said: *"The baby was born in week 31…and it was a quick, easy and normal delivery*".

When asked to compare their present pregnancy and delivery to the previous ones, four mothers (M3, M4, M5 and M9) reported that they their first babies were healthy and full term. For instance, M9 said: *"My daughter who is 12 now, and my son who is 9…my pregnancy was good…no problems and I could work but this time…and I had to stop working in the seventh month."*

Sharing her pregnancy experience, M4 indicated: *"I had to work for long hours and keep standing for seven hours or so…my feet used to get swollen…my legs hurt, I found it even hard to walk… I decided to go on an early maternity leave."*

M1 revealed that she was anemic during her first pregnancy as well, but at that time the baby was healthy and full term: "*I was anemic during my first pregnancy too and I had to take supplements….but that time the baby was ok and full term and healthy…no problems like this time."*

While most mothers reported having only one ultrasound at around 28 weeks, one mother (M8) mentioned having a second ultrasound because her baby's heart had problems: *"I had my ultrasound at week 28…but in week 37 the baby's heart had some problem for which they did another ultrasound…and then decided to do a C-Section immediately."* These findings reveal that the mothers had only one ultrasound during pregnancy despite the slow growth and low weight of the babies, which suggests that immigrant mothers might not be receiving proper prenatal care.

All the mothers who had had a second or third delivery expressed dissatisfaction with hospital staff's attitude after delivery, particularly with regard to receiving information on their baby's health status and on how to take care of their premature baby after discharge. Another issue pointed out by mothers pertained to the attitude of nurses and the level of knowledge they had on the care of pre-mature babies and infant feeding. For example, M2, who had given birth in H1 and was unhappy with the attitude of the nurses in NICU, reported: *"You know like different nurses have different moods and attitudes… I hear like from some parents also… Like they… One parent said like she has a complaint about one nurse so… Those kind of stuff. Some nurses are severe."*

M7, who also gave birth at H1, shared the following experience regarding being discharged from the hospital: *"I was not provided with any information to look after the baby after coming home, I simply didn't know what to do…I was panicked…I started crying…the baby cried and I also cried."*

The mothers also complained that they were not consulted or provided with sufficient information regarding infant feeding choices during their hospital stay. The mothers revealed that when they asked the nurses questions regarding these issues, they were either discouraged from asking questions or provided with different and contradictory information from each nurse. M9, who gave birth at H2, also reported a similar situation:

> *I had twins….but no one from the hospital…followed me to ask for the babies' well-being…and see how the things were going…even the CLSC nurse did not visit me…and when I called them to ask the reason, they said we don't provide these services a third time as I already had received the services twice after my first two babies…which sounded quite strange because my sister also had her third baby one week after my delivery and a CLSC nurse visited her regularly but they refused to provide me the services.*

M4, who also gave birth at H2, explained that she asked the doctors and nurses a lot of questions regarding how to look after her premature baby and about feeding him. However, while most of her questions were answered, some remained unanswered due to the discouraging attitude of some nurses. M9 put forth a reason for doctors and nurses providing no information to second/third-time mothers on feeding babies and expressed her concerns regarding the indifferent attitude of doctors and nurses. She explained:

> *Maybe they don't tell me anything because they know from my record that she has had babies before and she is experienced and…maybe she does not need any more information…but I really needed information because I had twins for the first time which were premature and had low weight, and also because I had the C-Section for the first time. Another problem was that I had babies after nine years gap…and I am 35 years old now…I have forgotten how to take care of babies, I need help.*

M6, who had her first baby, reported not being provided with any information on child care and feeding by the staff at H3. However, she drew attention to an important point in that the

maternity clinics provide expecting mothers with informative literature on regular check-ups and that hospitals also provide an information pack at the time of discharge, which helped her a lot in finding answers to a number of her questions:

> *The information leaflets I received from the clinic during my pregnancy check-up visits and the ones I received after I deliver baby were very good…informative. I read them all. They helped me understand everything. I think most of the women don't read them and throw them away and then complain that no one helped them. Everyone is so busy in the hospital, I don't think they have so much time to explain everything to every mother. All they do is simply ask: "How are you going to feed the baby"? And I replied: "I will give breast milk". And they said: "Good, good carry on with what you are doing".*

M7, who also had her first baby, indicated that the nurses at H1 did not provide her with any such information. She reported that *"The nurse only told me how to put breast in the baby's mouth…she did not tell me anything else…I got all the information and help from my mother who is here with me."* M5, who also had her delivery at H1, stated: *"I was so anxious to breastfeed my baby but each time I went to the nursery, I was told that the baby is sleeping and has been bottle fed…they never asked me what I wished."*

M3, who delivered her baby at H1, stated: "When I tried to wake my baby and breastfeed it…the nurse stopped me to do it and did not tell me the reason why she was doing that… and asked me to let them do what they were doing…and let the baby sleep because it needed rest."

In contrast, only one mother (M2) who had her first baby reported that the H1 nurses provided her with adequate guidance regarding feeding her baby. M2 stated: *"I was provided with information how to look after the baby and feed it after going back home…the nurses told me many things…they told me how to put the nipple in the baby's mouth and how to pump milk."*

4.2 The Feeding Decisions and Experiences

All the mothers had different feeding experiences coloured by their specific circumstances. The only common experience shared by the mothers was regarding their decision to breastfeed their babies, decision which was made by all the mothers during pregnancy.

Two mothers (M4 and M5) gave both breast milk and formula milk to their babies because they perceived having low breast-milk production. M6 also could not produce sufficient milk after delivery and M7 stopped producing breast milk two weeks after the delivery. Both were left with no other choice but to give formula milk to their babies exclusively, despite their ardent desire to breastfeed. M6 explained: *"I did not have enough, and I did not know how much he was taking the breast. So I did not want to take any chances, that's why I completely stopped and I am giving him the bottle completely.* M7 explained: *"I wanted to do breastfeeding but…couldn't do it because of low milk production…milk completely stopped after two weeks, I was frustrated that I couldn't do breastfeeding.*" M2 had to start bottle feeding because the baby had apnea related to prematurity and experienced difficulty in sucking at the breast. The mother chose to bottle feed her baby with breast milk until the breathing problems subsided: *"The baby had breathing problem during breastfeeding…she suckled and suckled and did not stop and she could not breathe…but she was good at bottle, so I gave her breast milk in bottle for a month, but now I give her breast only."*

All the babies except for M7's had to stay in the hospital because of health issues related to prematurity and were therefore given formula milk. M7 breastfed her baby directly right from the start and did not have to wait for the baby to be healthy enough to be shifted to breastfeeding. The interviews also revealed that in-hospital introduction of formula milk were common practice among our sample because the babies were kept into intensive care and in incubators, which delayed the process of babies being breastfed. M6 in particular expressed her frustration at not being able to feed her baby during their hospital stay because the nurses gave the baby formula milk and did not wait for her to come to feed it. She reported:

I was in the maternity ward and the baby was in intensive care…the two wards were at a distance…I had to walk a long way to go there and I told the nurse I want to breastfeed the baby but she said "no…we have to feed baby every two to two and a half hour…we have a feeding chart". I was so sad.

In response to the question regarding how long the mothers planned on breastfeeding their babies, four of the mothers (M1, M3, M5 and M8) indicated that they were undecided and explained that even if they had to stop early, they would keep giving breast milk in a bottle. M3 said: *"It depends, if I see after eight months that the baby still wakes up for milk 3-4 times the night, it's sure I'll start saying no I will perhaps give him something else"*. M2 and M4 indicated that they would continue breastfeeding for "*as long as the baby wants* it". M9 indicated that she planned on breastfeeding for 18 months to 2 years.

4.3 Views on Importance and Benefits of Breastfeeding

All the mothers were aware of the fact that breast milk is beneficial for babies and that it builds antibodies to fight diseases. Some of the other benefits of breastfeeding indicted by mothers were:(i)healthy bones and joints;(ii)psychological and emotional benefits, as it builds bond between the mother and the baby; and (iii) breast milk being economical compared to formula milk. M6 stated that "breastfeeding gives immunity to the baby" and that "it is good for the baby's bones and joints."M1 stated that "breast milk has antibodies which make the baby healthy", and M8 that "God made it for our babies because it is good for babies". M3 expressed quite a few beliefs regarding the benefits of breast milk and stated:

Breastfeeding helps develop an emotional attachment between the mother and the baby. It is beneficial because it gives the baby antibodies to fight against diseases….and it is easier compared to bottle feeding because I don't have to get up and leave bed at night or go to

kitchen at day time to make formula milk in bottle, I simply take out breast and give it to the baby immediately when she is hungry…she is happy with it and I am also happy.

Finally, M9 stated the following: *"Besides all its benefits…breast milk is cheap…formula milk costs a lot of money…we have to buy a new box every two weeks…and has to be prepared…breast milk is available round the clock…makes it easy to feed the baby."*

When asked to compare breast milk and formula milk, M2, M5 and M9 put forth some strong points in support of breast milk and suggested that it can never be replaced by formula. The mothers also pointed out that each type formula milk is rich in certain specific nutrients and not in others, whereas breast milk has all the nutrients and antibodies required for a baby's nourishment and growth, and to develop strength and immunity to fight diseases and develop resistance against invading bacteria. M9 expressed great concern over false marketing and misleading advertising promoting formula milk as an alternative to breast milk. She gave the example of her sister's son who was fed on formula milk since his birth and was prescribed a specific type formula that was making the child overweight: *"My sister's son is six years younger than my nine years old son but he has same weight as my son because the formula milk is making him overweight…it is not healthy."*

While discussing the benefits of colostrum, all the mothers revealed that they were aware of its benefits, but unfortunately only M7 could give it to her baby. All the other mothers could not breastfeed their babies during the early days after delivery because of babies were kept in either the NICU or in incubators in nurseries during this time. M1 said: *"Yes, yes…colostrum very very good for babies, I know but my baby missed it because he was fed through intravenous for the first three days…he was too small and weak…he could not suckle."*

Upon being asked about the source of information on the benefits of breastfeeding, all the mothers said that they basically learned it from their mothers that breast milk was beneficial for the babies. For instance, M9 said:

My mother always says, breast milk keeps the baby healthy and keeps the disease away…my other two children…I breastfed my daughter for 8 months only because she refused to take breast after eight months and then my son I nursed him for two years and seven months…my son is healthier and never falls sick…my daughter gets sick easily because she did not take breast milk for long time.

M2 reported that she obtained information from her mother and from the information leaflets she received from the clinic during her visits for pregnancy check-ups as well as from the hospital after delivery. M1 and M7 said that they obtained a lot of information on the internet. M3 stated: *"I used to make internet searches to get information on benefits of breastfeeding and breast milk"*. M1 and M2 received a lot of information from CLSC nurses. The findings show that mothers coming from traditional breastfeeding cultures know that breast milk is beneficial for the baby. The most common source of information as indicted by a majority of informants was their own mothers (M1, M2, M4, M5, M6, M7, and M8), with some mothers also obtaining information from CLSC nurses (M1 and M2).

4.4 Access to Breastfeeding Information and support

The mothers reported that none of the health practitioners encouraged them or talked to them about breastfeeding. For example, M3 explained: "*No one is promoting breastfeeding and telling the would-be mothers about the benefits of breast milk and breastfeeding"*. Similarly, M5 stated: "Nobody gave me information on exclusive breastfeeding for six months and its benefits, I didn't know that exclusive breastfeeding was so beneficial."

M1 and M2 indicated that CLSC nurses had provided them with some really good advice and piece of information on breastfeeding during postpartum visits. M1 said: *"I received all the information regarding the nurses, the kindergarten, the school for the baby, the day care through the program in the CLSC, they told me everything.*" M2 stated: *"The CLSC nurses provided pamphlets*

and brochures for information on feeding and looking after the baby and different types of community support available for mothers of new born babies which was very helpful."

Only two mothers (M2 and M6) reported that they were seeking help from community groups and regularly visited community groups who were really very supportive during and after delivery. Thus, most immigrant mothers in our sample did not visit community services or groups for help. M9 indicated that she was seeing a chiropractor who provided her with a lot of information on the benefits of breast milk. She revealed: *"I see a chiropractor. He gave me a lot of information on breast milk. As he told me premature babies would not have their intestinal flora…the only thing that develops intestinal flora is breast milk which helps a lot."*

All the mothers revealed that the hospitals and all the staff at all the three hospitals promoted and preferred formula milk. The mothers indicated that even the gynecologist, health professional and pediatrician clinics provide a lot of information on formula milk and suggest that is better, equally nourishing as breast milk, and an alternative of breast milk; they provide pamphlets, brochures, and even formula milk samples, but did not promote or advertise breast milk in this manner. M7 said: "*Whenever I visited my gynecologist's clinic I saw a lot of posters and pamphlets on waiting area table. The formula milk companies sent me samples of formula milk…but no one sent information on breastfeeding."*

The mothers were disappointed and unhappy over the lack of interest shown by doctors and nurses on promoting breastfeeding. M9 stated: *"My CLSC nurse was shocked to hear that I was breastfeeding my twins"*. M3 indicated that her nurse told her *"I gave formula milk to my babies…it takes lot of courage to breastfeed your baby…you are a courageous mum."* M3 further added: *"I was really shocked to hear that despite being a nurse she did not breastfeed her babies"*. These findings reveal that the health professionals with whom the mothers were in contact did not play a positive role in promoting breastfeeding, at least not to the extent the mothers expected.

All the mothers reported that they received information on breastfeeding from their mothers and grandmothers, and received support for breastfeeding from mothers, spouses, other family members and friends. For a majority of mothers, their own mothers were the biggest role model or influence on their decision to breastfeed as they themselves had been breastfed by their mothers; it was therefore natural for them to breastfeed their babies due to it being a cultural norm for them. M1 indicated: *"I had decided to breastfeed while I was pregnant because of cultural influence and also because my mother breastfed me"*. M2 said*: "I decided to breastfeed because it's a tradition in my family, my mother breastfed all her six kids".* Reminiscing on her grandmother's influence, M7 said: *"My grandmother always used to say that breast milk is for the baby, give it to the baby because it is good and healthy and baby needs it".*

4.5 Perceptions on How to Raise Awareness of Breastfeeding and its Benefits

The mothers put forth various suggestions for raising awareness of breastfeeding and its benefits, such as: (i) promoting breastfeeding through advertisements and marketing just like is done by formula milk companies;(ii) arranging special classes on breastfeeding and its benefits for mothers-to-be in hospitals and at community service centers; (iii) that health care providers, gynecologists, pediatricians, nurses, lactation experts and community services volunteers should raise awareness amongst pregnant women and mothers; and (iv) having advertisements on breastfeeding and its benefits in magazines and on TV. M6 elaborated that "Classes should be arranged in hospitals for pregnant women to bring in awareness of breastfeeding and its benefits" and M2 suggested that *"if mothers don't get any information from health providers and nurses, they should themselves search the internet".* M7 further stated that "pregnant women should read books and other material available on breastfeeding and how to look after babies."

M5 also stated that the biggest role for supporting breastfeeding can be played by husbands/partners: *"The husbands should help with the household chores and looking after other*

children to give the mother a relief… and time to rest to breastfeed the baby without feeling tired". Along similar lines, M7 said: *"The community services could provide support by sending nannies or volunteers to help single mothers with chores so as to keep on nursing babies longer",* and M3 suggested that *"nursing mothers should be provided facilities like nannies and community workers or volunteers to help them with household chores so as to get more time to rest and breastfeed the baby*. M6 expressed her belief that breastfeeding mothers should be given incentives or compensations in the form of longer maternity: *"Another way to promote breastfeeding could be to let the mothers stay at home for longer, I mean longer maternity leave to keep breastfeeding babies…or to encourage breastfeeding."*

4.6 Perceptions on Barriers to Breastfeeding

Upon being asked what some of the barriers that stopped the mothers from breastfeeding were and why mothers chose to give formula milk and to bottle feed in Canada, three mothers (M1, M5 and M6) said that they did not know. M3 and M7 thought that the convenience associated with bottles could be the big reason, with M3 stating *"Maybe they find bottle easier*" and M7 stating *"I think they feel that it is easy to make a bottle and it is easier to carry wherever you go and easy to feed in public"*. M2 thought that lack of breastfeeding role models in family and society could be a big reason for a majority of Canadian mothers preferring bottle and formula milk over breast milk and breastfeeding. She explained:

> *You see we have role models, our mothers, our aunts, all the women in our country breastfeeding their babies so it is natural for us to follow our mothers and other women from our country…but…here you see women do not breastfeed so the growing girls don't see any role models and when they become mothers, they do what they saw their mothers and other women doing.*

According to M4, M8 and M9, another factor stopping mothers from breastfeeding is work. They thought that as women have to go back to work, they decide to give formula milk because of issues like the difficulty in pumping breast milk at the workplace and having little time to spend with their babies to breastfeed them. M9 said: "*Definitely work…it is work which forces mothers to give formula milk to babies"*. M4 further stated:

> *Mothers have to go to work and they don't have any place to pump breast milk there and they can't take the baby with them…they have only one other choice…they don't have a 1000 choices available…they have only one other choice…give formula milk". M8 shared her view in these words: "Work…they go to work, they work for long, no time to breastfeed baby…and when they come home they are so tired…no energy left to breastfeed.*

Regarding breastfeeding in public areas in Canada and people's reaction to this practice, the mothers shared different views. M3 stated that she did not have any problem at all in exposing herself in public while breastfeeding her baby because *"It is normal in the culture I come from for nursing mothers to feed openly at public places…we don't feel shy…we don't need to cover because we have different rules for modesty…even here I don't feel shy…I have no problem."* M5 suggested: *"Mothers should either carry breast milk in a bottle or take a shawl or cloth with them to cover themselves while breastfeeding the baby at a public place if they fear that people are going to judge them."* All the other mothers preferred to avoid nursing babies in public because of the fear of offending other people and being judged due to the fact that breastfeeding is not a cultural tradition in Canada. M3 indicated: *"I heard of that incident where a mother was asked to leave a restaurant for nursing her baby there…this is not good…the baby needs food too...the baby can't eat restaurant food (laughs).*" A majority of mothers (M1, M4, M5, M7, M8 and M9) suggested that special family rooms should be arranged or provided at public places for breastfeeding babies (M1, M4, M5 and M7). M2 suggested installing breastfeeding booths at public places. Finally, all the mothers felt that

Canadian society does not accept breastfeeding in public places and that people have reservation regarding this practice, reservations which vary from one individual to the next.

CHAPTER FIVE

DISCUSSION

The current chapter presents a discussion of the study findings in light of certain previous investigations, its benefits, and the breastfeeding challenges faced by mothers of premature LBW babies. This chapter will also present the study limitations, and its implications for theory and practice. This study extended the existing literature by providing insights from immigrant mothers in Canada, who have come from countries where breastfeeding is the usual way to feed new-born babies and who have given birth to low birth weight babies

According to Kelley and Pojda (2000), the two major causes of LBW are prematurity (born before 37 weeks of gestation) and intrauterine growth retardation, a condition in which fetal growth has been constrained. Whereas no unique, the main reason for LBW in this study was premature birth. Premature LBW infants are at high risk of early growth retardation, infectious disease, developmental delay and death. In addition to the high risk of mortality and morbidity, these babies show a growth pattern that differs from that of normal term babies, which means that they require special care during the early days after birth, as was observed in this study in which the participants' newborns had to remain in the hospital for longer compared to normal weight, full-term babies. The findings show that LBW babies were taken good care of after birth during their hospital stay and

were sent home once they became stable. The finding suggests that good postnatal care is provided to immigrant mothers and their babies in Canadian hospitals.

5.2 Challenge of Breastfeeding a LBW Baby

The study findings show that the biggest challenge associated with breastfeeding experienced by the study participants was the difficulty in putting their newborns to their breast because of delayed exposure: they were kept in special care units or in incubators in nurseries during the first days after birth because of various problems associated with prematurity, LBW, and related health problems. Another common feature of LBW babies seen in this study was the difficulty in coordinating suckling and breathing, which caused difficulties in babies being breastfed and resulted in them being fed either intravenously, by gauge or by bottle. These medical conditions clearly made it challenging to shift babies to breastfeeding after they left the hospital and went home.

According to King (2005), to feed efficiently, babies need to develop the ability to coordinate sucking, swallowing and breathing in a temporal sequence and this coordination matures with gestational age and is not fully developed until 35–37 weeks' gestation (Lang 2002). However, it has been observed that this coordination does not take place in LBW babies. LBW babies are therefore at risk for feeding difficulties as suggested by the findings of the current study. Unlike full-term babies who can be placed at the mother's breast immediately after birth, a LBW baby is usually separated from the mother and does not feed efficiently. Because of their immature body systems, these fragile babies are prone to necrotising enterocolitis, apnea and sepsis (Merenstein& Gardner 2006), which can prolong hospital stay and further delay the development of oral feeding. Similar situations were reported by mothers in this study where newborns were kept in the hospital for medical care and supervision for a number of days, which in turn delayed the initiation of breastfeeding.

Hamosh (1994) contends that mothers who deliver LBW babies often have additional problems that can affect breastfeeding, such as establishing human milk supply and getting the baby to suck from the breast. The current study findings also show that in some cases the mothers of LBW infants had either no supply or low supply of breast milk due to early delivery and separation from their baby during their hospital stay. Also, it would seem that mothers were not encouraged to pump their milk or access their babies while in NICU. The current study findings also suggest the use of in-hospital formula supplementation during the maternity stay which led to some difficulties for mothers to start breastfeeding, both during their hospital stay and after discharge. It was also observed that not exposing the baby to breast milk during the first few days after delivery led to milk production reducing oral together stopping. This finding resonates with Chantry's (2014) finding that early formula provision creates or exacerbates problems with infant breastfeeding behaviour and/or maternal milk supply.

5.3 Breastfeeding Practices of Mothers from Traditional Breastfeeding Cultures

For mothers who come from traditional breastfeeding cultures, breastfeeding holds great importance, as they believe that breast milk is what is meant for the baby and that it holds great nutritional and health benefits. Similar views were shared by the mothers in this study. All of them indicated that their decision to breastfeed was normal and natural because of it being their cultural practice and norm; they themselves had been breastfed, and their mothers had always told them about the importance and benefits of breastfeeding. These mothers held the belief that formula milk can never be an alternative to breast milk and does not provide the baby with the essential and natural nutrients that are contained in natural breast milk. These mothers wished to continue the traditional practice of breastfeeding while living in Canada where a majority of mothers give formula milk to the babies and don't breastfeed.

The findings are similar to that of Silva et al. (2013) who report that the myths and beliefs associated with breastfeeding have been a part of everyday life for many centuries and construct the

meaning attributed by women to the act of breastfeeding, whether it be through socio-cultural heritage gained by living in a society, through transmission of values from others, or simply by observing women in the same situation. Breastfeeding holds a similar importance for the mothers in this study who revealed that this practice held great value for them as part of their socio-cultural heritage and cultural practices (Riordan, 2005). The mothers in this study reported that the biggest influence behind their decision to breastfeed their babies was their cultural beliefs and practices. This finding suggests that breastfeeding is a practice that contributes to their cultural and maternal identity. This is a new insight added to the existing literature by this study from Canadian context.

It was also found that some mothers were forced to opt for bottle and formula milk at some stage because of their jobs or work. In such situations, there was no other choice but to either give pumped breast milk in a bottle or switch to formula milk. Wolf (2003) also notes that since more women are working outside the home, they consider bottle-feeding convenient as it is generally regarded as much easier than breastfeeding for the working mother.

The findings show that the people who most influenced the mothers' decision to breastfeed were their own mothers, followed by husbands or partners who supported the decision, and lastly by close relatives and friends. The husbands and partners in the current study were reported by the mothers to be very supportive towards their decision. Similarly, close relatives and friends also showed their support. The main reason for husbands, family and friends being supportive was that they shared the same perspective of breastfeeding being a traditional practice in their cultural group. These findings reinforce Silva et al.'s (2012) findings that state that although it is understood that a woman's decision to breastfeed is linked to their way of life and the importance they give to breastfeeding practice, it is also observed that family support, especially that of the father and maternal and paternal grandmothers, is an important factor in the decision to breastfeed and to continue breastfeeding even if there is low breast milk production and the baby has to be given formula milk. Similarly, Teixeria et al. (2006) report that grandmothers are significant caregivers in

the family, especially towards their daughters during their postpartum phase, as seen in some cases in the current study as well. These grandmothers transmit their practices and their culture, and are often respected and valued for their expertise and experience, especially in caring for newborns.

5.4 Perceptions on the Benefits of Breastfeeding

Immigrant women have varied cultural backgrounds that shape their perceptions towards breastfeeding. A nursing mother's perception and attitude towards breastfeeding is directly related to the start of breastfeeding and sustainment of the process. The cultural environment of a mother and the source of information dictate the decision-making principles on breastfeeding. Some immigrant mothers may tend to rely on their culture while others may rely on health care provider's advice and information.

5.5 The Information and Support available for Breastfeeding

The study findings suggest that the mothers of LBW infants did not perceive that they had received enough information from health care providers and hospital staff for feeding the babies and taking care of them at home. One of the mother's states that hospitals tend to provide the expecting mothers with written information packs or literature during their routine check-ups during pregnancy and after delivery before leaving hospital; there are chances that mothers will not read these documents because they prefer being provided with verbal information on looking after and feeding their babies. This attitude could be motivated by cultural barriers such as language or by a low level of education. As breastfeeding is a traditional embodied practice the cultural group or many immigrant women, it would not make that much sense to transmit knowledge through writing; instead, these women would perhaps feel more comfortable with hands-on, face-to-face coaching on breastfeeding. Nevertheless, breastfeeding is an embodied practice that requires hands-on support that needs to go

beyond words, especially when mothers are having problems either with suckling or milk supply. This finding provided a new dimension to the existing knowledge on the experiences of immigrant mothers of LBW babies and who come from traditional breastfeeding culture.

Another finding was the concerned mothers' perceived attitude of hospitals and medical practitioners' choice on promoting formula milk for their babies, which was shocking and disappointing. In such a context, the main source of information and support regarding breastfeeding and its benefits was the mothers of the interviewees. Other sources of support were the husbands/partners, grandmothers, close family members and friends. In this regard, Purdy (2010) suggested that health care professionals need to develop ethnically sensitive breastfeeding interventions and overcome their own cultural and professional biases towards breastfeeding in order to support mothers throughout the process.

In short, our findings seem to point out that hospital staff would need additional training to identify the kind of support needed by mothers from traditional breastfeeding cultures who give birth to premature LBW babies. Although two of the mothers in this study received some good support and help from CLSC nurses, the majority showed dissatisfaction with the support and information provided by the doctors and nurses. It is important to mention here that the two mothers who reported receiving good support had just had their first baby. One possible reason for the staff not providing breastfeeding information and support to the other could be that staff felt that,as it was the second or third childbirth in most cases, the mothers in question were already aware of breastfeeding and its importance. Looking into similar issues, Barber et al. (1997) proposed that research on the health practices of immigrant populations must build on an understanding of the interests and beliefs of targeted groups within the socio-political context of structural changes affecting them. Callister (2001) also noticed that health professionals often neglect the ways in which patients' experience is shaped by cultural beliefs and therefore may provide inappropriate breastfeeding information to new

mothers. Bernaix (2000) proposed that breastfeeding strategies must be based on the population's cultural background, habits, beliefs and socioeconomic level.

It is also important to note that, in this context, the mothers interviewed also seemed reluctant to seek information, ask questions or contact community groups and services for help. This attitude can be attributed to language barriers, a low education level and the low socio-economic group of the immigrant mothers.

5.6 Perceptions on How to Raise Awareness of Breastfeeding and its Benefits

The suggestions for raising awareness on breastfeeding and its benefits that were put forth by the mothers and that emerged through the findings of this study were the following: (i) promoting breastfeeding through advertisements and marketing the way it is done for formula milk; (ii) arranging special classes on breastfeeding and its benefits for mothers-to-be, both in hospitals and at community service centres; (iii) that health care providers, gynaecologists, paediatricians, nurses, lactation experts and community services volunteers should raise awareness amongst pregnant women and mothers; and having advertisements on breastfeeding and its benefits in magazines and on TV. It was also suggested that in situations where health professionals do not provide information and support on breastfeeding, that mothers should seek out information on their own by reading books or magazines or by searching internet to find answers to their questions on the topic of breastfeeding in public places. As well, it was suggested that the mothers should either carry breast milk in bottle or take a shawl or cloth with them to cover themselves while breastfeeding in public if they fear that people are going to judge them. Interestingly, it would seem that immigrant mothers might have less sensitivity to the hyper-sexualisation of breastfeeding and the gaze of others, yet they seem sensitive to stories heard in the media about mothers being kicked out of stores or restaurants for breastfeeding.

The role of husbands/partners was regarded as the most important since they can support nursing mothers by helping with household chores and looking after other children to give the mothers a reprieve, time to rest, and time to breastfeed without feeling tired. It was also highlighted that the community services could provide support to nursing mothers by sending nannies or volunteers to help single mothers with chores so that mothers have more time to breastfeed and can do so for a longer period of time. Another suggestion was to arrange classes in hospitals for pregnant women to increase awareness on breastfeeding and its benefits. Lastly, it was suggested that nursing mothers should be offered incentives and compensation such as longer maternity leave so that they canstay at home for longer after giving birth in order to keep breastfeeding. It would also appear that the mothers in this study were not aware of the fact that working parents have access to one-year parental leave in Quebec.

5.7 Contributions and Implications of the Study

This study has contributed to existing knowledge on the challenges faced by immigrant mothers from traditional breastfeeding culture when it comes to breastfeeding their babies in Canada. It has also contributed to knowledge on the health facilities available to such women and their babies in Canada and the barriers they face in receiving health care in a new cultural setting. The current study findings hold implications for Canadian immigrants (particularly mothers), community services groups, and health professionals including public health providers, nurses, gynecologists, obstetricians, pediatricians, and lactation consultants. It is hoped that the findings of this study will help health care providers better support the desirable practice of breastfeeding in vulnerable populations (immigrant mothers), particularly among health care providers in primary health care level as they are responsible for providing care to both mother and child after their discharge from

the hospital. At a practical level, this study has also provided suggestions for supporting breastfeeding mothers which were voiced by the mothers themselves.

5.8 Limitations of the Study

This study presents two major limitations. The first is related to the profile and number of new mothers who participated in. On the one hand, I worked with a limited sample of nine participants, mainly due to the difficulties to identify immigrant new mothers of LBW babies in the time frame and resources available for this investigation. That said, women were interviewed twice, and interviews were conducted until reaching data saturation. On the other hand, I only include mothers who did not have any addiction or substance-abuse problems and that spoke either English or French (i.e., the two Canadian official languages). The reason for this decision was that interviewing mothers who could not speak either of the official languages would have been too expensive and time consuming because it would have required hiring an interpreter. Furthermore, mothers with addiction or substance-abuse problems were excluded because they have significant psychosocial problems.

The second major limitation is related to the generalization of the experience of these nine immigrant mothers to the larger population of immigrant mothers in general. As the accessibility to prenatal and postnatal services and support in regard to the breastfeeding practice was a common issue for the majority of mothers, our study raises the hypothesis that immigrant women may in fact not be receiving optimal perinatal care due to healthcare professionals lack of cultural sensibility when delivering care. This issue definitively needs to be investigated in more depth.

5.9 Future Research Directions

Research is not just about systematic inquiry into issues to seek answers and develop understanding; it is also about identifying important questions. As a result of this study, a number of questions have emerged that would require further examination. These questions provide the basis for the recommendations for future research directions.

This study examined the breastfeeding challenges faced by immigrant mothers of premature LBW babies who belong to cultures where breastfeeding is traditional. However, considering the limited scope of the current study, the study informants only included women from nine countries who had given birth in three hospitals in Montreal, Quebec, Canada. The study aimed to shed light on the current role played by health professionals in providing prenatal care as well as breastfeeding support and information for to immigrant mothers in Montreal. One suggestion for future research might be to conduct a study based on the perceptions of immigrant mothers from other cultural groups, and living in other Canadian cities and provinces.

The link between health professionals' lack of knowledge and the breastfeeding support needs of immigrant mothers has been well documented in this study. However, it is felt that there is a need to conduct research to gain insight into the perceptions and views of health professionals, in particular their biases, beliefs and perceptions on breastfeeding, to assess how much they know and how much they need to know in order to provide the required level of support and health care to immigrant mothers, particularly those from traditional breastfeeding cultures. Other investigations should also be carried out to gain knowledge into institutional intervention and support regarding the provision of health care, prenatal and postnatal care to immigrant mothers and their babies in the Canadian heath system – at hospitals, clinics, and by community services groups.

CHAPTER SIX

CONCLUSION

The aim of this study was to explore the breastfeeding experiences of non-Canadian born immigrant mothers of premature LBW babies who belong to cultures where breastfeeding is traditional. The study concludes that immigrant mothers face a number of health and breastfeeding challenges related to breastfeeding premature LBW babies in Canada due to the perceived lack health professionals' cultural sensitivity in regard to their strong breastfeeding cultural background. Whereas the quality of prenatal care should be further explored as well, these mothers stated that they do not receive proper support and information on caring for premature LBW babies post hospital discharge and face further challenges in breastfeeding their babies because of obstacles such as lack of support from the health care system, language barriers, low education level, and low socio-economic status. Another issue presenting a barrier to these mothers is their shyness and reluctance to take initiative, ask questions, or seek help from community groups because of the new cultural setting linked to their immigrant status. The mothers also seemed to avoid reading the information packages provided by the health professionals and hospital and to prefer receiving verbal rather than written information from health professionals and community workers.

The use of qualitative ethnographic interviews provided a framework for deep exploration and understanding of immigrant mothers' perceptions, beliefs, views, attitudes and experiences of giving birth to a LBW baby and breastfeeding in a new cultural setting. This study helped in understanding the issues and challenges these mothers face through the pictures painted in their own words, which helped address the research problem in an effective way and understand the reality as seen through their eyes. It is apparent that practising one's original cultural practices in a new

cultural and institutional setting is quite challenging, and that the challenges faced by immigrant mothers can only be addressed effectively after understanding them, which this study attempted to do.

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Appendix: A

FORMULAIRE DE CONSENTEMENT

Chercheur principal : Danielle Groleau Ph.D.

Co-chercheurs : Sonia SemenicPh.D., Laura Haiek MD, M.Sc., Phyllis ZelkowitzEd.D., Nancy FeeleyPh.D., Charo Rodriguez MD, Ph.D.

Coordonnatrice : MénaïqueLégaré-Dionne

INFORMATION GÉNÉRALE

Vous avez récemment eu un(deux) nouveau(x) bébé(s), ce qui implique des changements importants dans votre vie. Comme votre(vos) bébé(s) est(sont) né(s) avec un poids de moins de 2500 grammes, il(s) a(ont) eu besoin de soins plus particuliers après sa(leur) naissance. Certaines mères choisiront d'allaiter leur(s) bébé(s), d'autres pas. Nous vous invitons à participer à un projet de recherche dont le but est de mieux comprendre l'expérience et la perception au sujet de l'allaitement des mères de bébés nés avec un poids de moins de 2500 grammes. Les témoignages des mères qui n'allaitent pas sont aussi importants pour nous que ceux de celles qui allaitent. Les résultats de cette étude serviront à aider le personnel de la santé à mieux comprendre l'expérience et le point de vue des mères de bébés de petit poids au sujet de l'allaitement et l'utilisation du biberon afin qu'ils puissent améliorer le soutien et les soins infirmiers et

pédiatriques qu'ils prodiguent aux mères. Les conclusions permettront aussi de guider les programmes et les politiques de santé relatives à l'allaitement des bébés nés avec un poids de moins de 2500 grammes et à la santé maternelle afin qu'ils s'adaptent à la vision et aux besoins des mères.

DÉROULEMENT DE L'ÉTUDE

Si vous acceptez de participer à cette étude, une professionnelle de la recherche vous visitera jusqu'à trois reprises à la maison ou à un endroit de votre choix afin de vous interviewer. La première entrevue aura lieu durant le séjour de votre(vos) bébé(s) à l'hôpital, une fois que son(leur) état sera stable. La deuxième entrevue aura lieu trois mois après votre accouchement (si vous allaitez) et la troisième entrevue six mois après votre accouchement (si vous allaitez toujours). L'entrevue consiste à répondre verbalement à des questions qui portent sur votre expérience de la grossesse, votre accouchement, la période post-natale, votre décision d'allaiter ou non et votre expérience de l'allaitement ou du biberon.

Nous vous demanderons aussi de répondre à un bref questionnaire sur votre perception de votre production de lait maternel et vous poserons quelques questions pour mieux comprendre votre niveau d'anxiété, le cas échéant. Lors de la première entrevue, nous recueillerons également des données générales (ex. : âge, niveau de scolarité, etc.). Vous aurez aussi l'occasion de partager vos inquiétudes avec la professionnelle de recherche qui vous interviewera et de discuter avec elle de vos besoins et des ressources à votre disposition qui faciliteraient votre adaptation. L'entrevue sera enregistrée et transcrite pour permettre une étude complète des informations recueillies. La première entrevue (durant l'hospitalisation du(des)bébé(s)) devrait exiger approximativement une heure de votre temps tandis que la deuxième (trois mois post-natal) et la troisième (six mois post-natal), approximativement 30 à 60 minutes de votre temps. Cinq années après la fin de l'étude, les bandes audio ayant servis à enregistrer les entrevues seront détruites en les brûlant en présence de la chercheure principale.

Pour chacune des entrevues à domicile, nous offrirons aux mères une compensation de 20$ ainsi qu'un cadeau pratique pour leur(s) bébé(s) en reconnaissance de leur participation et de leur apport précieux à l'avancement des connaissances et à l'amélioration des services de santé.

RISQUES ET INCONVÉNIENTS

Mis à part votre temps de participation pour répondre à nos questions à votre domicile ou ailleurs, aucun risque et inconvénient à votre santé ne découlera de votre participation à cette étude. Vous avez peut-être des questions ou des préoccupations concernant vos émotions; si vous le désirez, vous pourrez en discuter avez un membre de l'équipe de recherche qui pourra alors vous référer, selon vos besoins, à un professionnel pour une évaluation ou des services.

AVANTAGES

La participation au projet de recherche contribuera à l'avancement des connaissances en obstétrique, en pédiatrie, en médecine familiale, en nursing et en santé publique. En effet, l'étude permettra de documenter le point de vue des mères de bébés nés avec un poids de moins de 2500 grammes sur leur expérience de la période périnatale et de l'alimentation de leur(s) bébé(s). Celles-ci entraînent des besoins spécifiques qui ont des incidences sur les soins et les interventions médicales durant la période périnatale des bébés de petit poids. Les obstétriciens, médecins de famille, infirmières et planificateurs de programmes auront alors accès à des connaissances qui les aideront à conceptualiser et offrir des soins et des interventions qui répondent mieux aux besoins et au contexte des mères qui vivent une expérience semblable à la vôtre et à faciliter leur adaptation à leur nouveau rôle.

LIBERTÉ DE PARTICIPATION

Vous êtes libre de participer ou non à cette étude et votre décision ne vous empêchera pas de recevoir tous les soins dont vous avez besoin, c'est-à-dire le suivi habituel durant la période périnatale par les professionnels de la santé et le suivi particulier à votre(vos) bébé(s) de petit poids. Vous êtes également libre de vous retirer du projet en tout temps sans avoir à vous justifier de votre décision. Vous êtes également libre de refuser d'être enregistrée lors des entrevues.

PERSONNES À CONTACTER

Si vous avez des questions à poser au sujet de cette étude ou si vous désirez vous retirer de l'étude, vous pouvez contacter en tout temps Madame MénaïqueLégaré-Dionne, coordonnatrice de l'étude, au (514) 340-8222 #4397. Si vous désirez poser des questions concernant vos droits à une personne neutre ne faisant pas partie de l'étude, veuillez contacter le représentant des patients de votre hôpital :

Hôpital Général Juif	Madame Rosemary Steinberg, au (514) 340-8222, poste 5833
Hôpital Royal Victoria	Madame Patricia O'Rourke, au (514) 934-1934, poste 35655
Hôpital St. Mary's	Madame Caroline Roy, au (514) 734-2618

CONFIDENTIALITÉ

Les données médicales et de recherche seront utilisées en toute confidentialité. À aucun moment les noms des participantes au projet ne seront diffusés. Seulement des numéros seront utilisés pour codifier les dossiers. Tous les documents relatifs à ces données seront conservés sous clé. Si les résultats de l'étude sont présentés à quelque public que ce soit, votre nom ne sera pas divulgué et votre anonymat sera assuré.

CONSENTEMENT

J'ai eu l'occasion de poser toutes les questions voulues au sujet de cette étude et on y a répondu à ma satisfaction. Je sais que je demeure libre de me retirer de cette étude en tout temps, sans avoir l'obligation de me justifier et sans que cela n'affecte en aucune façon les soins dont je pourrai bénéficier dans l'avenir. J'ai lu entièrement le contenu de ce formulaire de consentement. J'ai reçu une copie signée du formulaire de consentement.

Je, soussignée, accepte de participer au présent projet de recherche à titre de mère ayant récemment accouché d'un(de) bébé(s) avec un poids de moins de 2500 grammes

( ) -

Nom en lettres moulées et téléphone

Signature du sujet Date

Nom en lettresmoulées

Signature du témoin Date

Nom en lettresmoulées

Signature du chercheur Date