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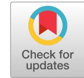
Reasons for Stopping Exclusive Breastfeeding Between Three and Six Months: A Qualitative Study



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ABSTRACT

Purpose: Scant published qualitative literature exists focusing on why exclusive breastfeeding rates decline between three and six months. This study aims to develop an understanding of why exclusive breastfeeding tails off so dramatically between three and six months after birth in New Zealand.
Design and Methods: A generic qualitative methodology was employed in this study and social constructionism selected as the main epistemological framework underpinning the research. This study was carried out between September 2013 and July 2014, involving face-to-face interviews with 30 women who were characterised as highly motivated to complete six months exclusive breastfeeding prior to the birth of their child. In order to gain an in-depth understanding of the research material, thematic analysis of the interview transcripts was completed using manual coding techniques.
Results: After thematic analysis of the data four key themes were identified: 1) The good employee/good mother dilemma. 2) Breastfeeding is lovely, but six months exclusively is demanding. 3) Exclusive breastfeeding recommendations should be individualised. 4) Introducing solids early as a cultural practice.
Conclusions: Most studies have linked barriers to six months exclusive breastfeeding to difficulties within the mother-infant dyad, as well as negative maternal socioeconomic and socio-demographic characteristics. However, this study has shown that the maintenance of six months exclusive breastfeeding is also challenging for this group of mothers who were socially advantaged, well-educated and highly motivated to breastfeed their babies exclusively for six months.

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Introduction

Six months exclusive breastfeeding provides complete nutrition for healthy growth and protects babies from life-threatening diseases such as respiratory infections and diarrhea (AAP, 2012; Binns, Lee, & Low, 2016; WHO, 2016b). However, globally the rate of six months exclusive breastfeeding is very low (Ahlqvist-Björkroth et al., 2016), and the introduction of solids or liquids before six months is a common practice (Becker & Remmington, 2014). A recent study in the Asia-Pacific region (Binns & Lee, 2014), identified that the prolonged duration of exclusive breastfeeding decreases the rate of morbidity and mortality in exclusively breastfed infants compared to those not exclusively breastfed. It is also documented that formula fed babies grow faster than breastfed babies and that breastfed babies have a normal and steady growth (Binns & Lee, 2014). Therefore, accelerated growth due to formula feeding or early introduction of solid foods is a significant risk factor for obesity in childhood and in adulthood (Binns & Lee, 2014; Wallby, Lagerberg, & Magnusson, 2017). Childhood obesity is a primary concern in the Asia-Pacific region. In New Zealand, 11% of children aged 2–14 years are obese and the statistics among Maori and Pacific children are even worse at 15% and 30%, respectively (Ministry of Health, 2015).

In spite of the importance of six months' exclusive breastfeeding, the maintenance of exclusive breastfeeding between three and six months is a major public health issue particularly in New Zealand where data on exclusive breastfeeding duration indicate that it tails off after three months (Ministry of Health, 2012, 2015). For example, in New Zealand in 2014, more than eight out of ten infants were exclusively breastfed at discharge from hospital; at three months 42% of infants were exclusively breastfed and at six months only 16% were breastfed exclusively (WHO, 2014). This number is lower than the global average of 38% (WHO, 2016a) and far below the World Health Organisation's target rate of 50% six months' exclusive breastfeeding (WHO & UNICEF, 2014).

Since 2000, the implementation of the World Health Organisation's (WHO) infant feeding policy in the Asia-Pacific region was the main reason for the reduction of infant mortality from 44 to 17 per 1000 live births over ten years (Inoue & Binns, 2014; UNICEF, 2014). The New Zealand Baby-Friendly Hospital Initiative (BFHI) has provided training, research, accreditation services and essential breastfeeding knowledge

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for both health professionals and maternity services in order to protect, promote and support breastfeeding (NZBA, 2016).

As a result of the WHO initiative, the number of baby-friendly maternity facilities in New Zealand has increased dramatically from zero in 2000 to almost 96% in 2011 (NZBA, 2016). At the same time, the rate of exclusive breastfeeding at discharge increased sharply from around 55% in 2000 to approximately 85% in 2011 (Martis & Stufkens, 2013). In 2014, 96% of New Zealand hospitals were baby friendly which means that their staff are provided with up to date knowledge about breastfeeding and trained to support mothers to breastfeed their newborns successfully. Another reason for the successful increase of exclusive breastfeeding rates in New Zealand, is the significant breastfeeding support from the health professionals who work in the community including community midwives and nurses who work at Plunket.

New Zealand has a unique maternity and well child care system, in which the Lead Maternity Carer (LMC) midwives who are funded by the New Zealand Ministry of Health provide free maternity care for women who are booked with them from the first trimester of pregnancy until six weeks postpartum, at which time the care of the infants will be transferred to the well child nurses as selected by the woman and her family (the mothers' care is transferred to their family doctor or general practitioner (GP)). One of the well child service providers is Plunket, a New Zealand not-for-profit organisation; nurses who work at Plunket practice in the community as the main well child providers for infants and children under five years; the rest of the well child providers are contracted by the Ministry of Health to provide similar services to those of nurses who work at Plunket. During the home visits LMC midwives and well child nurses provide a full physical assessment of the infant as well as advice and information related to infant care and breastfeeding.

There are some external factors that influence the mothers' intention to maintain breastfeeding or to stop; these factors are multidimensional including the effect of significant others, health professionals, community and culture (Alianmoghaddam, Phibbs, & Benn, 2017a,b). Most studies on factors affecting breastfeeding initiation and duration focus on the influence of education for new mothers around the health benefits of breastfeeding or the disadvantages of formula feeding (Kukla, 2006; Williamson, Leeming, Lyttle, & Johnson, 2012). This consideration of the mother as an education target in breastfeeding studies individualises breastfeeding, while breastfeeding research needs to look beyond the mother-infant dyad and focus on breastfeeding as a dynamic sociocultural practice (Dykes, 2006; Tiedje et al., 2002; Williamson et al., 2012). Research has shown that in order to increase the rate of exclusive breastfeeding the influence of significant others, health professionals, community services, the whole society and culture should be considered (McFadden et al., 2017; Tiedje et al., 2002; Williamson et al., 2012).

This article is part of a larger qualitative study (Alianmoghaddam, 2017), and explores the views of women interviewed regarding the challenges that they faced to maintain exclusive breastfeeding between three and six months.

Methods

The main aim of the research was to highlight the influence of sociocultural contexts on infant feeding behaviour and to consider the limitations of approaches that treat the mother-infant dyad as the main target for the promotion of exclusive breastfeeding. Within qualitative social science research, social constructionism is a broad epistemological framework that enables the researcher to understand an individual's behaviour through their social relationships, interactions and contexts (Chell, 2000; Kahlke, 2014; Merriam, 2009). Therefore, a generic qualitative methodology was employed in this study and social constructionism was selected as the main epistemological framework underpinning the research.

Recruitment of Participants

A qualitative study was conducted involving face-to-face interviews with 30 women. The research was carried out between September 2013 and July 2014. The research participants were recruited from the lower North Island of New Zealand. Initial data were collected via a short questionnaire administered before the birth to record demographic information and to establish antenatal intention to breastfeed exclusively [see Tables 1 & 2]. The face-to-face interviews were conducted 4–6 weeks after the birth; lasting up to an hour in length. The reason for choosing the time frame of 4–6 weeks after the birth was that breastfeeding was already established and that most postpartum complications which might have interfered with their participation in the research would be resolved.

The interview focused on factors that facilitated or impeded the establishment and maintenance of exclusive breastfeeding. The research participants selected the time and venue for the interview, with all of the interviews taking place at the participants' homes. Only the interviewer and the interviewee were present during the meeting. The interviews were recorded digitally and transcribed verbatim. Interviews were conducted in English which was the first language of most participants. In order to track the duration of exclusive breastfeeding practice each participant was followed via short monthly audio-recorded telephone interviews until giving up exclusive breastfeeding or until six months after the birth. There was another face to face interview for women who gave up breastfeeding exclusively earlier than six months to discuss what circumstances led them to decide to stop breastfeeding exclusively before their intended duration.

The epistemological framework underlying this research is social constructionism. According to the social constructionist point of view, there is no existing external truth as all understandings of the social world are mediated through language (Anderson & Goolishian, 1988). Language is more than a way of communication and interaction; human beings exist in and through language which does not simply reflect the world but actively constructs social reality (Galbin, 2014). Human realities, assumptions and beliefs are artefacts which are fabricated through socially constructed discourses (e.g. breast is best). The main target of interviewing is an exploration of the use of language as a symbolic way of communicating everyday realities (Bruce & Howard, 2012). As language plays a critical role in social constructionist theory, we focused upon using in-depth and follow-up interviews as a tool for collecting qualitative data. There was thus no identified need to record field notes.

Participant involvement in the research terminated following the first postpartum face-to-face interview if the participant chose not to

Table 1
Maternal demographic information (n = 30).

Age (years)	
<25	2
25–35	18
35<	10
Education	
Some high school but did not finish	3
Completed high school	3
University degree	24
Employment	
Employee on maternity leave more than six months	19
Employee on three months maternity leave	1
Homemaker	10
Marital status	
Married	23
Living with a male partner	7
Ethnicity	
New Zealander of European decent	21
European	3
Maori or Maori/Pakeha	3
Asian	1
Middle Eastern	2

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