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# Impact of Migration and Resettlement on Attitudes and Perspectives on Breastfeeding Practices

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**Impact of Migration and Resettlement on Attitudes and Perspectives on  
Breastfeeding Practices**

by

Florence Orionzi

A Thesis

Submitted to the Graduate Faculty of

St. Cloud State University

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### **Abstract**

Researchers have observed that people who are raising children in a culture that they were not born in, especially immigrants and refugees, will experience conflict due to acculturation (Harley, Stamm, & Eskenazi, 2007; Lowe, 2011). Whether or not there is a relationship between change in environment and breastfeeding practices is an important consideration when immigrant and refugees resettle in a new country.

In this study 10 immigrant and refugee mothers who have lived in the St. Cloud area for an average of 10 years were interviewed. The research design used in the study was qualitative using individual semi-structured interviews with parents to study attitudes and practice of breastfeeding.

The results of the study show that attitudes towards breastfeeding remain the same but the practice is different. The actual experiences and related behaviors are different than they would have been in their home countries. The mothers expressed dis-satisfaction with the overall experiences of breastfeeding, believing that extended support would be helpful. Policy and practices to support immigrant and refugee mothers were explored.

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## Chapter 1: INTRODUCTION

Breastfeeding is a practice that starts and facilitates the relationship building process between a mother and an infant, which leads to secure attachment. This is not to say that all children must be breast fed, but to say that if one is able, it is the easiest way to continue the relationship that began when the baby was in the womb. I have always been interested in learning more about how the process of attachment begins. Research by Mawani (2001) suggests that development of the emotional bond involves parents providing nurturing, comfort and safety while sensitively responding to their child's needs. Breastfeeding is one of the roles mothers discussed as being important as they care for their children (Mawani, 2001). Kathleen Sebelius, former Secretary of United States Department of Health and Human Services, stated that the ability to breastfeed is a gift and helps mothers and babies bond (Lowe, 2011).

Researchers have observed that people who are raising children in a culture they were not born in, especially immigrants and refugees, will experience conflict due to acculturation (Harley, Stamm, & Eskenazi, 2007; Lowe, 2011). Practically, one acquires the knowledge and awareness to breastfeed from one's environment. Societal and cultural support and encouragement are vital in influencing people's awareness and knowledge about the practice and the importance of breastfeeding in an infant's development.

To underscore the importance of breastfeeding, the United States Surgeon General declared supporting breastfeeding as a major public health issue (Lowe,

2011). Also the Affordable Care Act which was signed into law in 2010 (American Academy of Pediatrics, 2010), has a provision that requires reasonable break time for nursing mothers and health plans to cover breastfeeding support and supplies.

### **Statement of the Problem**

Whether or not there is a relationship between change in environment and breastfeeding practices is an important consideration when immigrant and refugees resettle in a new country. Many studies have been conducted on the impact of migration and resettlement on breastfeeding attitudes, perspectives and practices among refugees and immigrants from other cultures. There is limited literature focused on new African immigrants to the United States. Examples of studies that have been conducted about this topic include, *Attachment across Cultures* (Mawani, 2001), *The Effects of Time in the US on the Duration of Breastfeeding in Women of Mexican Descent* (Harley et al., 2007).

Transition to a new home impacts the perception about breastfeeding practices among the new African immigrant and refugee population. Mothers are choosing to formula feed their infants after birth due to culture shock, lack of support and knowledge around breastfeeding and the availability of free resources, for example formula. They assume that formula feeding is the right way (Mawani, 2001). In the US the availability of programs and services such as Women, Infant and Children (WIC), Supplemental Nutrition Agricultural Program (SNAP) provide assistance to women and their children so they do not have to stick to providing breast milk to their infants. A report by Lind, Perrine, Ruowei, Scanlon, and

Grummer-Strawn (2011) states that WIC provides less intervention services to promote breastfeeding to blacks than whites. A study in Canada *Attachment Across Cultures* (as cited in Mawani, 2001) concluded that people get confused as they try to adjust to a new culture, new system and new environment about practices of raising children including breastfeeding (Mawani, 2001).

The basic goal of the proposed study is to identify the impact of immigration and resettlement on breastfeeding behaviors and cultural attitudes in African mothers who have lived in the St. Cloud area for 15 years or less. The results could inform cross-cultural education and be a resource to families, prenatal providers and other community-based service providers.

### **Definition of Terms**

**Breastfeeding:** The practice of feeding a baby from mother's breast.

Breastfeeding is seen as an important role a mother plays in showing love and caring for a child's emotional and physical needs (Mawani, 2001).

**Immigrant:** is a person who relocates to live in another country due to economic or educational reasons (Sussner, Lindsay, Greaney, & Peterson, 2008).

**Refugee:** is defined by United Nations as a person who is unable or unwilling to return to his or her country of origin because of a well-founded fear of persecution, *The Middle Of Everywhere* (Pipher, 2002).

**Culture:** beliefs, values and attitudes of a group of people (Mawani, 2001).

**Acculturation:** is defined as the degree to which the majority culture is adopted by minority culture (Sussner et al., 2008).

**Initiation:** is the act of starting the experience of breastfeeding between mother and baby after birth (Harley et al., 2007; Mawani, 2001).

**Frequency of breastfeeding:** Number of times a baby nurses in a day (Mawani, 2001).

**Duration of breastfeeding:** is defined as the number of months that infants are breastfed before weaning them (Harley et al., 2007).

**Co-sleeping:** is when a baby sleeps on the same bed as the parents (Fogel, 2009; Mawani, 2001).

**Attachment:** is the deep emotional bond formed between a child and one or more adults, usually a parent or caregiver (Kim et al., 2011; Mawani, 2001).

**Wean:** To terminate a baby from breastfeeding (Mawani, 2001).

**Psychosocial:** Social factors that relate to mental health, for example social isolation, English as a second language, closeness to child, postpartum depression (Lowe, 2011).

**Culture Shock:** Physical and emotional upset caused by changes in familiar environment or boundaries (Mawani, 2001).

In this study I wish to identify effects of immigration and resettlement on breastfeeding behaviors and cultural attitudes in African mothers who have lived in the St. Cloud area for 15 years or less. It is important because the number of immigrants and refugees from Africa is increasing in the community, therefore it would be equally important to understand if there are changes in their attitudes and perspectives about breastfeeding. This would lead to finding ways to provide support

to mothers about breastfeeding. This also helps to keep cultural values that are positive for child well-being alive.

## Chapter 2: REVIEW OF LITERATURE

### Introduction

The literature review explored research and practices relating breastfeeding, attachment and immigrants. The search process included:

- a) Academic Search Premier from 2000-2015 found on the St. Cloud State University (SCSU) library database. The key terms used were, **breastfeeding, breastfeeding and attachment, immigrants, refugees, attitudes, perspectives and practices.**
- b) Google search with **breastfeeding attitudes of immigrants and refugees, impact of immigration on breastfeeding attitudes** as key terms was also used.

The literature review includes five areas: 1) History of breastfeeding practices in USA; 2) Benefits of breastfeeding; 3) Factors that influence breastfeeding practices; 4) Immigrant Mothers; 5) Summary and Research Questions.

### History of Breastfeeding Practices

According to Fogel (2009) history shows that the practice of breastfeeding newborns has fluctuated over decades. In the developed countries, including United States of America, a high percentage of mothers breastfed their newborns before the turn of 20th century. The percentage dropped and went up again around 1966. A similar trend is described in the US Surgeon General's Call to Action to Support Breastfeeding report (Lowe, 2011).

Historically, class, age and education are factors (Fogel, 2009) that have always influenced the number of people who breastfeed. In the United States, more mothers, who have higher income, are college educated and are over 30 years of age typically breastfeed than those who are poor, young and have less education. The poor and uneducated in developing countries do not have any choices so they breastfeed their infants exclusively and that is what they know to do culturally.

**Initiation of breastfeeding:** In the US, on average, 69% of mothers initiate breastfeeding at the birth of a baby but only 13% continue to exclusively breastfeed at 6 months. The rate of continued breastfeeding varies with different races, Hispanics and Whites having the highest rate compared to African- Americans (Harley et al., 2007; Lally, 2013; Lind et al., 2011; Lowe, 2011). Hispanics have 73% mothers initiating breastfeeding. An earlier study shows, 71.8% of whites initiate breastfeeding (Center for Disease Control, n.d.). Another study shows, 43.4% still breastfeed at 6 months, 22.7% continue to breastfeed for up to a year (Flaskrud, 2013). 8.5% of African- American mothers are breastfeeding exclusively at 4 months (Harley et al., 2007). Culture, social support and socioeconomic status affect the initiation of breastfeeding (Mawani, 2001; Miranda-Woods & Morelos, 2010) indicate that infants sucking reflex is strongest within a short period after birth. The whole process of breastfeeding and the associated attachment benefits can be disrupted if feeding does not start right away. Lally (2013) notes this critical period to be within 3 hours after birth. This probably would depend on the circumstances because premature babies are able to start breastfeeding after a few months in Neonatal

Intensive Care Unit (NICU). In western hospitals, babies used to be separated from the mother for some time and it had a negative effect on successful breastfeeding according to Mawani (2001) fact sheet 2.

**Duration and termination of breastfeeding:** The American Academy of Pediatrics recommends exclusive breastfeeding for the first 6 months of life and then to continue along with complementary foods until the infant is at least 12 months (Harley et al., 2007). The same study finds that in the U.S., only 13% of infants are exclusively breastfed at the age of 6 months and only 16% are still receiving breast milk at the age 12 months. The World Health Organization (WHO) recommends infants to be exclusively breastfed for the first 6 months and then breast feeding should continue for at least 2 years with supplemental foods (Lowe, 2011; Yan, Liu, Zhu, Huang, & Wang, 2014). According to the U.S. Surgeon's report (Lowe, 2011), for 25 years, each Surgeon General who held the office worked to protect, promote and support breastfeeding. They kept their focus on policies that improve the rate of breastfeeding in the United States.

**Frequency of breastfeeding:** In western culture, babies are brought up to be independent from early age therefore feedings are timed with long intervals between feedings. In non-western countries babies are fed frequently and are believed to be totally dependent on care givers in early age (Mawani, 2001).

### **Benefits of Breastfeeding**

**Health benefits:** Human breast milk is considered the best food for infants (Harley et al., 2007; Lowe, 2011). Fogel (2009) notes that the health of the mother

and infant is enhanced in many ways by breastfeeding. Breast milk (colostrum) has the nutrient that the infant needs immediately after birth. Breastfeeding practice can help prevent infant death especially in developing countries as well as helping the mother's recovery from childbirth. Infant's sucking stimulates the release of hormones (oxytocin, prolactin) that cause the uterus to shrink leading to faster loss of weight by the mother.

Studies in the U.S. (Sussner et al., 2008; Yan, et al., 2014) conclude that breastfeeding is a significant protective factor against obesity in children. The studies also suggest that breast milk is safe and contains antibodies. Those antibodies reduce the risk of neonatal infection, gastrointestinal infection and pneumonia during infancy. Flakerud (2013) reports that breastfed infants have a lower risk of sudden infant death syndrome.

According to the study in Canada, *Attachment Across Cultures*, "Breastfeeding is not only for feeding a child. It can also calm, soothe, relax, and demonstrate love for child." The study stated that breastfeeding can be a great source of pleasure for the mother and infant, especially in quiet family time (Mawani, 2001).

**Attachment research:** Breastfeeding helps infants' brain regulate the body when mother responds to the need of hunger which leads to secure attachment (Mawani, 2001). The need for touch, cuddling and play is also fulfilled during breastfeeding which also contributes to the attachment process.

Research by Wilkinson and Scherl (2006) reports that "breastfeeding is assumed by many to create enhanced physical and emotional closeness between

mother and child. Health professionals also frequently assume that breastfeeding mothers are more emotionally attached to their infants than formula-feeding mothers” (p. 7).

It has been observed that the tendency for exclusive breastfeeding in mothers who had secure attachment style as infants themselves continues to be strong as they have their own children (Akman et al., 2008). Also researchers found that on-demand extended breastfeeding is considered essential for attachment in various cultures (Flaskerud, 2013).

### **Factors that Influence Breastfeeding**

**Barriers.** Barriers to breastfeeding that have been found across the board in the various literature reviews include, mother’s age, lack of knowledge, social norms, poor family and social support, embarrassment, lactation problems, employment, absence of paid leave, race, child care, and barriers related to health care (Akman et al., 2008; Flaskerud, 2013; Harley et al., 2007; Lally, 2013; Lowe, 2011; Yan et al., 2014). Many of these factors can be overcome with the proper professional support and awareness by mothers.

In some developed countries acceptability of breastfeeding in public is low because breasts are associated with sex, this makes women uncomfortable to breastfeed in public (Mawani, 2001). The U.S. Surgeon General’s report (Lowe, 2011) suggests that some business places tell women to cover up or move to a private area so that customers are not scared away or offended. Also friends and family members sometimes stay away from breastfeeding mothers because it makes

them uncomfortable. Studies in the US found that implementation of practices that support breastfeeding is low in facilities where there is a higher percentage of black residents (Lind et al., 2011). The facilities referred to include health care and employment facilities. This may include the refugee and immigrant population that is being studied that do not get support.

### **Programs that Support Breastfeeding**

The Surgeon General's call to action is in regards to policies that the government can implement to support breastfeeding for mothers and their families in communities. Health care facilities and places of employment are good locations or areas to provide support. Research, surveillance and public health infrastructure also must support breastfeeding (Lowe, 2011).

Studies show that peer and professional support are important to the mother's willingness to breastfeed and have a positive experience while breastfeeding. Miranda-Woods and Morelos (2010) and Lally (2013) write about capitalizing on the initial hour or the sensitive period after birth by providing immediate support to mothers through a project which promotes early attachment and in turn promotes breastfeeding. The skin-to-skin contact was a performance improvement project started to examine new ways to promote early attachment and increasing exclusive breastfeeding rates in a medical center. Nurses took it as their challenge to create an environment of change and promote the evidence-based research on the benefits of early attachment, keeping mother and baby together and encouraging breastfeeding.

A staff nurse explained the success of the project this way, “Mothers provide the habitat, babies breastfeed, fathers and nurses protect the dyad and keep them together”. The nurses saw themselves as having a duty to promote evidence-based practices and to be advocates for their patients.

The study by Wallis and Harper (2007) reported that supporting mothers in the hospital when the babies are born with atypical conditions is important. They state, “Mothers need constant support and encouragement to breastfeeding” (p. 20). This study focused on what nurses should do to help mothers initiate breastfeeding for infants who are born prematurely. They believe the mother’s touch and breast milk help infants get better faster. As described above, keeping the mother and child close together right from the beginning, even for normal situations promotes attachment and encourages breastfeeding.

The use of Doulas is another way families receive support with pregnancy and child birth. A doula is a non- medical person who assists mothers-to-be before, during and after child birth. A doula works with a pregnant mother and her family to support them in what they want for the birth of the child. A doula listens, advocates and provides information and support about pregnancy and delivery without making any decisions. I agree with the following quote, “All over the world there exists in every society a small group of women who feel themselves strongly attracted to giving care to other women during pregnancy and childbirth. Failure to make use of this group of highly motivated people is regrettable and a sin...” D. Kloosterman Chief of OB/GYN, University of Amsterdam, Holland (Sorensen, 2015), *Ma Doula, A Story Tour of Birth*.

In this book the author describes that after the baby is born, if everything is well, mother, child and Doula spend some hours before the baby is cleaned and clothed, initiation of breastfeeding occurs during this time. She also states that a baby can establish a good milk production by nursing on demand.

### **Immigrant Mothers**

**Changes in attitudes and practices.** According to the article, “The Effects of Time in the US on the Duration of Breastfeeding in Women of Mexican Descent” (Harley et al., 2007), the rate of women breastfeeding decreased with the length of time lived in USA. Those who have lived the longest have the lowest rate of breastfeeding. Those who have lived in the country for five years or less have the highest rate. Initiation, duration and exclusive breastfeeding decreased with time lived in the USA. Reasons for the drop in the practice of breastfeeding are similar to the ones described as barriers earlier. These included women returning to work, not enough breast milk, mother didn't want to breastfeed anymore, baby didn't want to nurse anymore, sore nipples, baby is biting, baby is old enough to stop nursing. U.S. born Mexican mothers had a lower duration of breastfeeding than those who were Mexican born. It also concluded that the rate of breastfeeding varied with age and socio-economic characteristics. Older and more educated women had higher duration of breastfeeding.

Studies in Canada (Mawani, 2001) reported that immigrants and refugees from developing countries often are conflicted about breastfeeding in western culture.

They perceive that formula feeding is the preferred practice because of lack of support in public and at the work place for breastfeeding and easy access to formula.

Immigrant and refugee mothers who breastfeed may respond to their child's needs by responding to the child's hunger leading to secure attachment. They may opt to stay home so that they are close to the baby. Barriers to breastfeeding immigrant and refugee mothers face include, socioeconomic status, lack of social network, lack of awareness of community support, discomfort with seeking support, and discrimination (Mawani, 2001).

**Practices that support breastfeeding from country of origin.** Some practices that support breastfeeding in non-western countries are described below.

**How a child and mother are clothed:** In non-western countries mothers may go bare chested or wear clothes that fit loosely to allow easy access for the baby to breastfeed (Mawani, 2001).

**How babies are carried:** In many countries babies and infants spend most of each day being carried by their mother which provides close contact and allows baby to readily feed (Mwani, 2001).

**Co-sleeping:** If babies are trained to nurse as needed, parents tend to sleep on the same bed with baby. Where babies are trained to feed at timed intervals, babies more frequently sleep in a separate room (Fogel, 2009; Mawani, 2001). In the United States there are concerns about Sudden Infant Death (SID) as a result of co-sleeping.

### **Practices that support immigrant mothers' breastfeeding.**

***Family and community support for breastfeeding:*** In developing countries, long postpartum rest time for new mothers is given. At this time the mother's job is to take care of herself and feed the baby so she is exempted from household chores. Family members and community members help with house hold tasks (Mawani, 2001). This is in contrast to mothers in the U.S. who are mostly isolated from family and have pressure to go back to work since they may not receive paid parental leave as in other countries.

### **Summary and Question**

Ability to begin and continue breastfeeding behaviors depend on cultural norms, both social and professional support and encouragement (Harley et al., 2007; Lowe, 2011). If the rate of breastfeeding decreases for immigrants from Mexico, it can be assumed that this would also happen with African immigrant and refugees too.

Immigrant and refugee mothers from Africa who live in St. Cloud could be just as conflicted and confused about practices of breastfeeding as those in Canada. Lack of support from immediate family members, for example, mother, aunts, and sisters who usually encourage new mothers as they care for their newborns may prevent initiation of breastfeeding. Also if a mother can be provided with free formula, then they do not have to breastfeed. I hope to find out through my research how African immigrant mothers in the St. Cloud community think about breastfeeding and how their behavior is influenced by different factors identified in the literature.

**Research Question**

How has immigration and resettlement impacted the attitudes and perspectives about breastfeeding practices among African immigrants and refugees in the St. Cloud area?

## **Chapter 3: METHOD**

### **Introduction**

Immigrating to and resettlement in another culture may impact the attitudes and perspectives about breastfeeding practices among African immigrants and refugees in the St. Cloud area.

In my research I interviewed 10 immigrant and refugee mothers who have lived in the area for an average of 10 years. The participants were recruited with the help of African Women's Alliance a local organization that empowers African immigrants and refugees through advocacy, education and support.

### **Procedure/Data Collection Method**

I met with the participants individually face to face. Most of the interviews occurred in participant homes or their work place. One occurred at my home. Appointments were scheduled by phone calls. The interview process included some demographic questions and some questions that reveal both behavior (breastfeeding practices) and attitudes. Participants completed the demographic questions on paper. All questions were answered during the interview.

A consent form for parents to review and give their permission to participate was obtained from all participating parents before the interview was conducted. The sessions were audio-recorded and transcribed.

### **Research Design**

The research design used in this study is qualitative using individual semi-structured interviews with parents. Open-ended questions were used to learn about

mother's attitude and behaviors around breastfeeding. The formulation of the research questions were based on the literature review from Mawani, (2001) and Sussner et al. (2008) (see Appendix B).

**Sample size:** The sample size included mothers, 20-50 years of age who have lived in the St. Cloud area for an average of 10 years. All participants are originally from Africa and 10 mothers were interviewed. A convenience sample was recruited through the African Women's Alliance (AWA), a community organization in St. Cloud area.

**IRB process:** Approval was received from St. Cloud State University IRB committee before research was conducted. Resources from Women Infants and Children (WIC), and St. Cloud hospital were available to participants if they requested. It was the advice of the IRB to have resources available in case they were needed. The consent form approved by the IRB committee can be found in the Appendix C.

### **Data Analysis**

A descriptive analysis of the demographic responses was completed to identify the background characteristics of the participants. Themes were identified from the open-ended research questions. The themes from the open-ended questions were compared to the research literature.

## Chapter 4: RESULTS

### Introduction

This research was conducted to identify the impact of migration and resettlement on breastfeeding behaviors and cultural attitudes in the African mothers who have lived in the St. Cloud area for an average of 10 years.

Ten questions (see Appendix B) were designed to gather information about breastfeeding in different categories. The first category included questions 1 and 2 that asked for responses about **breastfeeding practices**. These questions focused on practices of breastfeeding while growing up and the rationales and factors that influenced participant's choices about breastfeeding. A Second category, questions 3, 4, and 5 asked for responses about **attitudes toward breastfeeding**. These questions focused on beliefs about benefits and the length of breastfeeding. The third category was the **differences between factors that influenced breastfeeding**. Question 7 focused on changes in practices here in the U.S. and attitudes from country of origin. The fourth category had to do with the **support systems for breastfeeding** and questions 6, 8, and 9 addressed this topic. Sources of support, desired support and support for breastfeeding in the home country were discussed. In this chapter the results from these questions will be summarized and changes in practices and attitudes from the country of origin will be identified.

### Sample Demographics

Ten women from five different African countries of origin participated in the study. They came to the United States as immigrants looking for better educational

and job opportunities or refugees for resettlement. Seven are married, two are not married and one is widowed. Education level varied as follows; 4 have bachelor's degree or higher, 2 have some college experience, 3 have less than high school level, and 1 did not indicate. Three of them work full-time out of the home while five work part-time. Two do not work out of the home. Seven out of the 10 do not have relatives in the USA. The women range in age from 28 to 50 years of age, half of them being in their 30s, two in 20s and one is in her 50s. The number of children range from 1 to 4, ages 1 to 16 years old. Number of years they have lived in St. Cloud range from 5 to 15. Table 1 below summarizes the demographic data.

Table1

*Demographic Data*

Participant	Country How long in SC	Language	Extended Family	Age	Marital Status	Number of children & age	Education	Income \$	Job out of home
1	Togo		No	-	Married	2- 3 & 5	Less than HS		Full-time
2	-	-	-	-	Married	1-5	Bachelor+		Full-time
3	Kenya, 15years	Kikuyu	In another state	35	Married	3- 5, 3,1	Bachelor+	30,000-60,000	No
4	Somalia, 6years	Somali	No	28	Married	3-8,6,5	Some college	>30,000	Part-time
5	Somalia 8years	Somali	No	50	Widowed	3-16,15, 14	Less than HS	>30,000	No
6	Brazil	Congolese	Yes	38	Married	3-8,5,2	Bachelor	30,000-60,000	Full-time
7	Kenya, 6	Luo, Swahili, English	No	38	Living together	-	Bachelor +	>30,000	Part-time
8	Kenya, 11	Somali, English	-	34	Married	-	Less than HS	>30,000	Part-time
9	Somalia, 5	Somali	Yes	36	Married	4-15y,12y, 5y,3y	-	-	Part-time
10	Somalia	Somali, English	-	29	Not married	1	Some college	>30,000	Part-time

**Breastfeeding practices and experiences in own country.** All the participants stated they were breastfed as babies. The duration of breastfeeding varied, four of them did not know, but two were told stories that they stopped on their

own, one stopped because she loved food and preferred to eat what the rest of the family ate and the other stopped because a dog drank out of her bottle. Six participants reported the duration they were breastfed to be from 1 year to 2 years.

**Breastfeeding practices with own children in U. S. A.** All the participants reported choosing to breastfeed their own children. One exclusively breastfed for one and half years, stopped after realizing that she was pregnant, otherwise she would have continued until the baby did not want to nurse anymore. She did not work out of the home and was the most highly educated. This agrees with the previous study which showed poverty and employment as barriers (Lowe, 2011) to breastfeeding duration.

Over half of the participants reported introducing formula early, (at birth, 3 months, 4 months, 6 months) because of insufficient breast milk production, with doctor's advice. Two participants stopped their babies from nursing at nine months old because of the next pregnancy, one of them had all her children in her country of origin.

The reasons participants gave for insufficient breast milk had to do with C-section delivery and lack of time spent with their babies since they had to go back to work. Difficulty with using pumps, broken pump, storage of milk and lack of space to nurse or pump at work place were some of the reasons given that made them use formula more. Two of the participants who had caesarian section delivery reported they were not able to initiate nursing immediately after birth and the babies preferred bottle feeding to breastfeeding afterwards. Four of the participants had children

before coming to the U.S.A, they breastfed longer in their country of origin than when they had children here. Some also stated the babies not showing interest in nursing so they had to put breast milk in the bottle.

Table 2

*Comparison of Questions 1 & 2*

	Was Breastfed	Breastfed my kids	Initiation	Exclusive Duration	Formula Introduced
Country of origin	all	all	at birth	12 months	No
USA		all	at birth & after 4 or 5 days	3, 4, 6, 9, 12 months	Yes

As can be seen in the table above, all the women were breastfed as children and all chose to breastfeed their children in their country of origin and here in U.S.A.

In the U.S some of them were not able to initiate breastfeeding at birth due to C-section delivery. Exclusive breastfeeding lasts for a short time before formula was introduced for many of the participants here in U.S. Those who had children in their country of origin did not introduce formula and they breastfed for at least 12 months.

**Beliefs about Benefits of Breastfeeding**

Participants reported several benefits of breastfeeding. The first benefit they all agreed on was the health of the baby. For example, all the participants reported that mother's milk is the best nutrition for infants, two of them mentioned colostrum having the right nutrients. Several mentioned prevention of sickness and help with immune system.

A second benefit of breastfeeding was the mother's recovery. All women reported that mother's recovery from child birth is enhanced by breastfeeding and they believed that she gets stronger faster.

The third benefit of breastfeeding was the mother-child relationship (attachment) and brain development. They all reported that breastfeeding helps with the creation of mother-child closeness and a couple of them mentioned the word attachment. One mother talked about breastfeeding being good for healthy brain development and another said science tells us that breastfeeding is good.

A fourth benefit of breastfeeding mentioned by the participating mothers was the traditional /religious beliefs. Half of the participants reported that breastfeeding is required by tradition and religious beliefs. I wish I had asked a follow up question for them to explain the religious part.

The last but not least benefit of breastfeeding shared by the participants was convenience. The fact that the breast is ready and available to the baby without preparation is convenient. On the other hand, a baby waits for formula to be mixed and bottles need to be washed and kept clean and safe from contamination. This creates more work and babies can become sick from contaminated bottles.

One participant summed up these themes together beautifully as follows; "Breastfeeding is traditionally and religiously required, baby grows stronger, mom gets stronger too. Breastfeeding prevents 12 diseases, the process is healing, for example, when baby gets a cold or fever baby recovers quicker, they will always nurse even if they do not have appetite, being close to mom while nursing helps. A

baby is happier, sleeps more and feels relaxed you can see it in their face”. Another participant equated the importance of breastfeeding to carrying a baby and she put it this way, “When a baby is picked while crying, they thank you. Carrying a baby in a car seat was shocking to me because it seems like one is carrying something, not a baby”.

**Attitudes about length of breastfeeding.** Most of the participants stated that how long a child should be breastfed depends on individual mother, situation, availability of resources and time or the baby’s condition. Two of them said in their country of origin they observed children being breastfed up to 2 years. One stated that two and half years is recommended since she believed breastfeeding prevents pregnancy and also because of religious reasons.

Religion encourages mothers to breastfeed because it is natural and a belief that pregnancy is prevented. Contraception is not allowed so breastfeeding may help extend the time between pregnancies.

Another participating mother believes that babies should be breastfed for 6 to 14 months while another thinks babies should be exclusively breastfed for 6 months then introduce other foods but continue to nurse for 12 months. One’s suggestion or idea is to breastfeed for 15 months, start introducing other foods at 6 months. Yet another participant said as long as mom and baby are comfortable, she knows a child with mental health issues who nursed until 8 years old.

In summary the belief about the duration of breastfeeding varied greatly ranging from 6 months to 2.5 years.

**Feelings and beliefs of living in country of origin.** First the mothers identified initiation of breastfeeding as similar in both settings with some reservations about feelings of support in the U.S. Eight out of the 10 participants reported no major changes in feelings or attitudes about initiation of breastfeeding after the baby is born except being a little nervous around the nurses or whoever was present, which would not have been the case if they were in their country of origin. The other two stated that the stress of delivering by C-section affected the process of initiating breastfeeding. They believed that with more support from their family and community they would have felt more relaxed and not have to pump milk to feed the baby with, in a bottle. One stated it this way, "With family support, I would have less stress than here, C-section with all three children I had a lot of stress, just me and my husband".

A second area where some difference was reported was how long babies would be breastfed. All participants reported that they would have breastfed longer if they were in their country of origin, may be not as long as their own mothers did.

The third area where difference was reported was reduction in milk production. The participants reported attributing the reduction in milk production to stress and less time spent with baby. It was one of the main reasons for introducing formula early in the baby's life.

The fourth area where a difference was reported was the time spent with baby. Participating mothers reported that in their country of origin, they would spend more time with their babies because they would be a stay at home mother or have longer

maternity leave. This means that there would be sufficient breast milk being produced and formula would not be necessary.

Fifth area where a difference was reported was going back to work early. Participants reported going back to work early contributed to the use of pumps, reduction in milk, less time spent with baby which then led to the introduction of formula.

Feelings and beliefs about duration, reduction in milk, time spent with baby, and going back to work can be summarized by the quotes from three participants as below.

If I had my daughter in Africa, I would have done breastfeeding exclusively for a longer time. I would not have experienced reduction in milk production at three months because I would spend more time with the baby due to long maternity leave. There would not be a need to introduce formula early in the baby's life.

Back home, I would not work out of home, I would spend more time with my baby. Here I have to pump milk because of work, baby-mother time is limited here but back home it is constant.

I would not use bottle because there would be enough milk and I would not work out of house.

A sixth area where some difference was reported were the problems in pumping milk. Participants reported that even though the availability of pumps was a good thing they still experienced problems. Examples were, anxiety, broken pumps and no space to pump at work. These are some of the comments reported:

I fed breast milk in a bottle for four months then the pump broke, just continued with formula only.

Pumping can be a problem because the machine uses electricity that may cause disease.

The final area where some difference was reported was breastfeeding in public. Participants reported that in their country of origin it is not a problem to breastfeed a baby in public. They mostly expressed surprise and shock that it would not be appropriate to feed a baby in public, and when they became aware of it they had to adjust their attitude about breastfeeding in the public. They still believe that the focus should be on the welfare of the child.

**Support for breastfeeding.** On the question about support for breastfeeding here in the U.S., participants listed family, friends and health care providers or professionals or agents or clinics as the sources of support.

The first source of support reported was family. Many of the participants reported receiving support from family, husbands and mothers mostly. One said that it was just her and her husband who had to work, so she was stressed out all the time. The other one has a mother that lives in another state but always came to help her after delivery. Yet another reported calling her family from Togo for advice. They reported families supported by being there, helping with chores and errands, encouragement and advice, especially those who had other children in Africa.

The second source of support reported was friends. A couple of the participants mentioned receiving support from friends. Friends provided support by being there, running errands and helping with chores. They also received encouragement and advice.

The third source of support reported was the health care professional. All the participants received support through health care. Some mentioned prenatal visits,

hospitals, and nurses coaching them about breastfeeding. Half of the participants reported getting support from Women, Infants and Children (WIC) program. WIC provided information, pumps and formula to those who had to start using formula early.

The fourth source of support reported was books and internet. One out of the ten participants reported reading books and using internet to get information about breastfeeding, especially with the first baby.

Participants reported not being discouraged by anyone about breastfeeding but noticed comments about body image. Two of them said they would not have accepted being told not to breastfeed. One was told that breastfeeding hurts but she decided to focus on the baby's needs instead of her comfort. Two of the participants talked about the surprise they experienced about breastfeeding in public. Both started nursing their baby, one in a church the other in a restaurant, when they were looked at funny. One said her husband had warned her before but she didn't believe him.

**Influences on decision to breastfeed.** Question 7, on influences on decision to breastfeed has similar responses as question 3 on benefits and question 5 on factors. The factors reported by half of the participants include tradition, religion, importance of breastfeeding for both the mother and the baby, relationship, health and bonding. Stress of C-section delivery, going to work and having no family support were factors that interfered with breastfeeding practice.

**Desired support for breastfeeding.** The response for question 8 on desired support for breastfeeding by the participants was similar. The support of their families especially mothers, and mother in-laws were the most wished for by the participants. One said she would have been more comfortable with her sister than the lactation nurse in the hospital. Basically they said the social environment in their country of origin would have allowed them to breastfeed exclusively for a longer time.

**Expected support in country of origin.** Responses to question 9 identified different themes about the support mothers would have expected if they had children in country of origin, starting with teaching and encouragement. Participants reported that they would have enjoyed the wisdom of the community elders and the family, mother, mother in-law or sisters. They stated that there would be help with breastfeeding initiation. One expressed it this way,

Family members would have been my biggest support. Even though my mom is here, I would have trusted my sister more, she would be more honest. My mom had children long time ago, my sister has current knowledge. I would be encouraged and taught to be close to the baby.

A second important area of support would be that meals would be provided.

The participants remembered that all their meals would be provided by family members. There would be emphasis put on foods that are good for production of milk, and they would not have to worry about food.

Participants also reported that they would be exempt from house hold chores for up to 3 months so they could focus on taking care of themselves and the baby. One summarized the idea of meals provided and exemption from chores in the following quote.

In my country of origin, I would have breastfed without any questions. The support I have would allow me to stay with my baby for six months to a year, where all I do is to take care of myself and the baby. Meals would be provided and I would be exempt from some chores.

A second participant described the support this way; “I would be pampered and exempt from doing chores. I would be taken care of by my family”.

Another mother described the importance of community celebration as a form of support. She was missing the fact that the whole community celebrates when a mother and new born arrive home from the hospital, both get new clothes.

### **Final Thoughts**

Finally, mothers were asked if there was anything else about breastfeeding they wanted to add.

They all reported they would encourage all mothers to breastfeed because it is very important even though the environment is different. The attitudes seem to be the same but the actual experiences and related behaviors are different than they would have been in their home countries. The mothers expressed dis-satisfaction with the overall experiences of breastfeeding, believing that the babies may have missed secure attachment and the experience was not joyful. But they accepted the situation and did what needed to be done and were grateful for the provision of formula and pumps.

One of the participants who had C-section delivery with all her children talked about the stress she experienced. Also the fact that she could not initiate breastfeeding immediately after birth meant it took her longer to produce milk. She expressed her feelings this way,

We miss the welcoming of the new mom and her newborn. She would have loved being taken care of after C-section. I appreciated the African Women's Alliance (AWA) Welcome Baby party for my 3<sup>rd</sup> kid because laughter was brought to my home for a moment. With C-section you know when the baby is coming, so you try to be prepared. My breastfeeding experience was very much influenced by C-section. With the 1<sup>st</sup> child it was a more positive experience because I didn't work out of the home. With the 2<sup>nd</sup> child I didn't produce milk for 5 days. With the 3<sup>rd</sup> child, it took 4 days to produce milk. The stress of where to leave the other child while going to the hospital was great.

## Chapter 5: DISCUSSION

### Interpreting the Findings

This study examined whether or not migration and resettlement have impacted the attitudes and perspectives on breastfeeding practices in the refugee and immigrant community in St. Cloud. I believe that breastfeeding is important because it helps to strengthen the relationship that started between the mother and the child when the baby was still in the womb. Also the social environment in which a mother lives influences whether or not the experience of breastfeeding will be successful and joyful.

The focus of the study was on the following factors, previous and the current experiences, choices, importance and benefits of breastfeeding, duration and support received with breastfeeding at the birth of babies in comparison with experiences in their countries of origin.

Ten questions were asked and they can be categorized in five groups to describe the important areas of study for the purpose of discussion.

The first category is the breastfeeding practices; included in this are the personal growing up experience, rationales, and factors that influenced parents' choices. The second category is the attitudes about breastfeeding. Described in this area are the beliefs about benefits of breastfeeding and the duration of breastfeeding. The third category is the changes in practices versus attitudes from country of origin. The fourth category is the support for breastfeeding; included in this category are the sources of support, desired support and support in home country.

The last category is the summary of important findings which describes practices and attitudes, factors that influenced mother's choices.

Breastfeeding practices do differ according to environment. The research I conducted showed that all the participants had been breastfed as children and all chose to breastfeed their own children in this country. What is clear is that the belief in the importance of breastfeeding did not change but the practice is different. None of the participants had questions about whether to breastfeed or not. All believed that breastfeeding is an important practice for mothers.

Only one out of the ten participants exclusively breastfed her children for more than six months while living here in the U.S. and she attributed this to the fact that she didn't work out of the home. She happens to be the one with the highest education level. This coincides with the previous research that indicated that level of education is one of the factors which influences the number of women who breastfeed longer (Fogel, 2009).

Those who had children before coming to the U.S. reported differences in the duration of breastfeeding in the two cultures. In their country of origin, they breastfed exclusively for over 1 year, but here in US formula was introduced early. One can conclude that the formula becomes a competing factor because it is readily available and free or low cost and convenient as discussed in the literature review in Chapter 2.

Those participants who started having babies here in the U.S. introduced formula as early as at birth, 3 months, 4 months, and 6 months old. Two of the

participants who delivered by caesarian section started formula right at birth and they expressed sadness because they could not initiate nursing right at birth. The sadness was due to the fact that babies preferred the bottle to the breast so they had to pump their breast milk to put in the bottle. The factors that influenced introduction of formula as stated by the participants were, less time spent with baby since mother had to go back to work, delayed initiation, insufficient milk production, baby not being interested to nurse. Little time spent with the baby led to insufficient production of milk and therefore babies stopped nursing on their own.

It seems that immediate initiation of breastfeeding is necessary for the comfort of the baby. The mothers who were not able to breastfeed right away felt like they failed their baby. Also nursing on demand and mother-child closeness create on going production of breast milk. Previous research stated that 69% of mothers initiate breastfeeding at the birth of a baby but only 13% continue to exclusively breastfeed at 6 months in the U.S. (Harley et al., 2007; Lally, 2013; Lind et al., 2011; Lowe, 2011). Miranda-Woods and Morelos (2010) and Mawani, (2001) report that infants sucking reflex is strongest within a short period after birth. The study concluded that the whole process of breastfeeding and the associated attachment benefits can be disrupted if feeding does not start right away. Lally (2013) notes this critical period to be within 3 hours after birth. So the mothers who delivered by C-section are right to feel sadness about their situation. This critical period may depend on the conditions where the birth takes place because premature babies can initiate breastfeeding after months in the NICU.

There was general agreement about the importance and benefits of breastfeeding by the participants. They talked about things like mother's milk is the best nutrition for infants, colostrum having the right nutrients at the beginning of infant's life after birth. They continued to state that breast milk prevents sickness, helps with immune system and brain development. Also the process of attachment (they described this as mother-child closeness) starts with breastfeeding and mother's recovery. These are the benefits that were reported in the previous review of literature for example, Fogel (2009) stated that the health of the mother and infant is enhanced in many ways by breastfeeding. He continued to say that breast milk (colostrum) has the nutrient that the infant needs immediately after birth and breastfeeding practice can help prevent infant death especially in developing countries as well as helping the mother's recovery from childbirth. This is because it was stated that infant's sucking stimulates the release of hormones (oxytocin, prolactin) that cause the uterus to shrink leading to faster loss of weight by the mother.

Some of the mothers reported that breastfeeding is required by tradition and religion. This was demonstrated by the fact that they continued to feed breast milk in the bottle after baby did not want to nurse anymore. One of the participants expressed this beautifully as follows:

Breastfeeding is traditionally and religiously required, baby grows stronger, mom gets stronger too. Breastfeeding prevents 12 diseases, the process is healing, for example, when baby gets a cold or fever, baby recovers quicker, they will always nurse even if they don't have an appetite also being close to mom while nursing helps the baby. A baby is happier, sleeps more and feels relaxed you can see it in their face.

This was shown in the previous research studies (Sussner et al., 2008; Yan et al., 2014) that suggest breast milk is safe and contains antibodies. Those antibodies reduce the risk of neonatal infection, gastrointestinal infection and pneumonia during infancy. Flaskerud (2013) reports that breastfed infants have a lower risk of sudden infant death syndrome.

According to the study in Canada, *Attachment Across Cultures*, “Breastfeeding is not only for feeding a child, it can also calm, soothe, relax, and demonstrate love for child. Breastfeeding can be a great source of pleasure for the mother and infant, especially during quiet family time” (Mawani, 2001). I believe this supports secure attachment.

There was a general consensus among the participants that the duration of breastfeeding depends on individual circumstances or as long as mother and baby are comfortable. Two to two and half years is what they observed in their country of origin but most of them said they would not breastfeed that long. Breastfeeding for 12 to 15 months, with introduction of table food at 6 months, given the right conditions was believed to be ideal.

Previous research agrees with the participants’ views, the American Academy of Pediatrics recommends exclusive breastfeeding for the first 6 months of life and then to continue along with complementary foods until the infant is at least 12 months (Harley et al., 2007). The World Health Organization (WHO) recommends that infants to be exclusively breastfed for the first 6 months and then breastfeeding should continue for at least 2 years with supplemental foods (Lowe, 2011; Yan et al., 2014).

According to the results the mothers did not choose how long they wanted to exclusively breastfeed their children. Lack of milk production, having to return to work, then eventually baby giving up were the factors that forced them to introduce formula early.

Previous research also supports this as found in the American Academy of Pediatrics, that in United States, only 13% of infants are exclusively breastfed at the age of 6 months and only 16% are still receiving breast milk at the age of 12 months (Harley et al., 2007).

### **Parent Attitudes**

As far as feelings and beliefs are concerned, the participants expressed no change but feel dissatisfaction with how things went with the breastfeeding process, especially resulting from going back to work early. They reported they would have exclusively nursed longer if they were in their country of origin.

Participants also expressed surprise about people not being comfortable seeing a mother nurse in public. To them a baby is having a meal and it should not be treated differently than when anyone else eats. They did report becoming self-conscious while in public but did not get discouraged about breastfeeding.

In the previous research reviewed in Chapter 2, barriers such as social norms, poor family and social support, lactation problems, employment, absence of paid leave, child care apply here. Age, lack of knowledge, embarrassment do not seem to have an effect as barriers on this community (Akman et al., 2008; Flaskerud, 2013; Harley et al., 2007; Lally, 2013; Lowe, 2011; Yan et al., 2014).

It is apparent that the process of breastfeeding requires a great deal of support. Participants reported receiving support through prenatal care and during delivery from nurses and other health care providers. Some mentioned friends, husbands, WIC, others received support from their mothers, some even called their families abroad for advice. The importance of family and community support for breastfeeding was discussed in previous research as follows; in developing countries, long postpartum rest time for new moms is given. At this time the mother's job is to take care of herself and feed the baby so she is exempted from household chores. Family members and community help with house hold tasks (Mawani, 2001).

None of the participants would expect to be discouraged by anyone about breastfeeding even though they heard comments about things like body image. They believe that the focus should be on the child's welfare and development.

All the participants interviewed chose to breastfeed their children. They stated factors that influenced their decisions included, benefits of breastfeeding for both mother and the baby, tradition, and religion. C-section and lack of family support were cited as factors that interfered with the process.

Traditional family support would have been appreciated. What was interesting to me was the fact that a participant would have appreciated her sister being around as well even though her mother was with her. They seem to have missed the experience of constant support, joy and being celebrated by family and community. The African Women's Alliance created the "Welcome Baby" program as a way to extend country of origin practices to current community.

Previous research study by Wallis and Harper (2007) shows that supporting mothers in the hospital when the babies are born with atypical conditions is important. They reported that, “Mothers need constant support and encouragement to breastfeeding” (p. 20). It seems that this kind of support should be extended to all mothers after delivery. According to Lally (2013), this kind of support is called social womb, the mother is supported like a baby in the womb.

### **Summary**

In summary, the important findings in this research are that refugees and immigrants:

- were all breastfed as babies and chose to breastfeed their own children.
- continue to believe that breastfeeding is important for both the infant and the mother but the duration depends on individuals or situations.
- believe that constant family and professional support is important and mothers miss what they could have experienced in their own countries of origin.
- reported that it is difficult in this culture to breastfeed exclusively for more than 6 months.
- reported that babies stopped nursing on their own very early.
- described factors that influenced their choices and this included, the importance of breast milk and the attachment process related to breastfeeding.

- described as negative factors, returning to work and having less time with baby.

Even though the babies grow up fine, the daily life style in this society is different and does not seem to support the breastfeeding process that contributes to strong bonding that is created between mother and child over time during infancy. This kind of bonding would in turn make the child totally dependent on the mother and the mother accountable to the child. In a previous study it was reported that, “immigrant and refugee mothers who breastfeed may respond to their child’s needs by responding to the child’s hunger leading to secure attachment. They may opt to stay home so that they are close to the baby” (Mawani, 2001). This is the kind of relationship that makes it hard for the two to be apart even for a short time.

In my opinion lack of time spent with the baby makes it easy for the baby to give up nursing and lose dependence on breastfeeding. In the previous studies, it is reported that in the United States babies are trained to feed at intervals and sleep in separate rooms while in other cultures babies are trained to nurse as needed therefore parents may sleep on the same bed and babies spend most of each day being carried by the mothers (Fogel, 2009; Mawani, 2001).

Sorenson, (2015) states that bonding is optimum when there is uninterrupted contact between mother and baby.

**Implications for practice and policy considerations.** The implications for practice and policy considerations are that programs that support mothers should be extended and enforced.

**Health care system-use of pumps and information.** Even though the participants appreciated the provision of pumps and information at the beginning, they believed that continued connection to the hospital or clinic personnel would have helped. Once they became busy with work and life as the baby grew they stopped looking for support from professionals including not replacing a broken pump. Families should have easy access to pumps and be provided with continued information until the baby is 6 months old.

In my opinion every parent-to-be should have access to the services of Doulas and this should be part of hospitals and clinics to provide constant coaching and teaching as previously described in the literature review. A doula is a non-medical person who assists mothers-to-be before, during and after child birth. A doula works with a pregnant mother and her family to support them in what they want for the birth of the child. A doula listens, advocates, provides information and support about pregnancy and delivery without making any decisions (Sorenson, 2015). I agree with the following quote, “All over the world there exists in every society a small group of women who feel themselves strongly attracted to giving care to other women during pregnancy and childbirth. Failure to make use of this group of highly motivated people is regrettable and a sin...” D. Kloosterman Chief of OB/GYN, University of Amsterdam, Holland (Sorensen, 2015).

**Parent Education-family support and information.** Parent Education programs should collaborate with, health care systems, to provide on-going home visits about breastfeeding until the baby is 6 months old, even if the baby is

developing normally. Early Childhood Family Education should be encouraged to all families, with stronger incentives for participation, such as not charging fees and bringing consultants to parents through home visits.

**Policy around work and parental leave, public nursing issues.** Policy makers and business communities must accept to providing, in the same way it is provided in other countries. According to the documentary “Raising of America” USA is the only industrialized country that does not provide paid maternity leave to all families.

**Limitations of the study-small sample size and what they represent.** One of the limitations of the study that may have affected the validity is the small sample size. Although the sample size is small the results seem to have corresponded to the previous research done in Canada and about Mexican immigrants in United State. Also I believe that there would not have been much difference in the results even if more people were interviewed.

Personal bias is one of the limitations that may have affected the study. On personal note, I identify with these participants because I would have given the same responses if I were interviewed. My first child I had in the U.S., I do not even remember how old she was when she stopped nursing. I did not go through the process of weaning her. I went back to work when she was 6 weeks old, I really feel badly about that. With my last child who was born here, I stayed home for 2 years and I breastfed until he stopped by himself at about 18 months. He never got used to sucking from the bottle. It was a sacrifice surviving on one income but it was worth it.

**Ideas for future research.** Based on the findings of this study, support is needed for both mother and child to form the close bond that promotes nursing. The next research question should be about identifying programs that support breastfeeding in the St. Cloud area community and how long the support continues after the baby's birth. The study will review records of whether extended support results in prolonged duration of breastfeeding in other communities.

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## Appendix A: Demographic Questionnaire

### 1. Where did you immigrate from?

- a) What tribe or group do you belong to?
- b) How long have you lived in the US?

### 2. Which languages are spoken in your household?

### 3. Do you have extended family here?

### 4. Your age \_\_\_\_\_

### 5. Are you currently...?

- Married
- Living together in a marriage-like relationship
- Separated or divorced
- Widowed
- Not married

### 6. Children

- a) number                      b) age(s)

### 7. What is the highest grade or year of school you completed?

- Less than high school
- High school graduate or GED
- Some college, associate degree, or vocational/technical/business school
- Bachelor degree or higher

**8. Approximately what was your household's income from all sources last year before taxes?**

- Less than \$30,000
- \$30,000 to \$60,000
- More than \$65,000

**9. Do you have a job outside the home?**

- Full time = 35+ hours
- Part-time

**Name** \_\_\_\_\_

**Date** \_\_\_\_\_

## Appendix B: Research Questions

Formulation of the questions were based on the work of Mawani, (2001) and Sussner (2008).

1. Were you breastfed as a baby? How long?
2. Did you choose to breastfeed your children? (How long?)
  - a. Did you use both breastfeeding and bottle feeding together? Why?
3. What do you believe are the most important benefits of breastfeeding?
4. How long do you think children should be breastfed?
5. How would your feelings and beliefs be different if you were living in your country of origin?
6. Who provided support for breastfeeding? How did they show support? Did anyone discourage breastfeeding? How?
7. What factors most influenced your decision to breastfeed or not to breastfeed?
8. What support would you have appreciated?
9. What support for breastfeeding would you have experienced if you were in your country of origin?
10. Is there anything else?

## Appendix C: Informed Consent

Title of study: Impact of Migration and Resettlement on attitudes and perceptions on Breastfeeding Practices.

Interviewer: Florence Orionzi

Department: Child and Family Studies, St. Cloud State University.

The aim of this form is to facilitate informed consent by communicating with participants in language that they can understand.

Purpose of the Study: As part of the requirements for Master of Science in Child and Family Studies at St. Cloud State University, I have to carry out a research study.

The study is concerned with understanding the impact of migration and resettlement on breastfeeding attitudes and practices.

What will the study involve: The study will involve interview sessions of **1 hour** which will consist of a set of demographic questions and open- ended questions about breastfeeding attitudes and experiences.

Why have you asked to take part: You have been asked because you are an African born immigrant woman living in St. Cloud and your experiences as an immigrant mother will help to understand changes in attitudes and practices around breastfeeding.

Do you have to take part: No, participation is voluntary. You have the option of withdrawing before the study commences (even if you have agreed to participate) or

discontinuing after starting the interview. You get to keep the information sheet and a copy of the consent form. Your participation in the study will be kept anonymous. I will ensure that no clues to your identity appear in the thesis. Any extract from what you say that are quoted in the thesis will be entirely anonymous. The data will be kept confidential for the duration of the study. On completion of the thesis, they will be retained for a further one year and then destroyed. The results will be presented in the thesis and a copy will be kept in the SCSU Learning Resources Center. The study may be published in a research journal.

I don't see any negative consequences for you in taking part in the interview process. An approval has been given by the Institutional Review Board (IRB). If you need any further information and you are interested to have a copy of the result, you can contact me; Florence Orionzi, 320-293-5470, [orf11201@stcloudstate.edu](mailto:orf11201@stcloudstate.edu) or my supervisor, Dr. Glen Palm, 320-420-0348, [gfpalm@stcloudstate.edu](mailto:gfpalm@stcloudstate.edu)

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**Consent Form**

I \_\_\_\_\_ agree to participate in Florence Orionzi's research study. The purpose and nature of the study has been explained to me in writing.

- I am participating voluntary
- I give permission for my interview with Florence Orionzi to be tape-recorded.
- I understand that I can withdraw from the study, without repercussion at any time whether before it starts or while I am participating.
- I understand that I can withdraw permission to use the data within two weeks of the interview in which case the material will be deleted.
- I understand that anonymity will be ensured in the write-up to protect your identity.
- I understand that excerpts from my interview may be quoted in the thesis and any subsequent publication.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Informed Consent

### Impact of Migration and Resettlement on attitudes and perceptions on Breastfeeding Practices

Interviewer: Florence Orionzi

Department: Child and Family Studies, St. Cloud State University.

The aim of this form is to facilitate informed consent by communicating with participants in language that they can understand.

Purpose of the Study: As part of the requirements for Master of Science in Child and Family Studies at St. Cloud State University, I am conducting a research study. The study is concerned with understanding the impact of migration and resettlement on breastfeeding attitudes and practices.

What the study involves: The study involves interview sessions of **1 hour** which consist of a set of demographic questions and open- ended questions about breastfeeding attitudes and experiences. You do not have to respond to any questions you do not feel comfortable with.

Why have you asked to take part: You have been asked because you are an African born immigrant woman living in St. Cloud and your experiences as an immigrant mother will help to understand changes in attitudes and practices around breastfeeding.

Do you have to take part: No, participation is voluntary. You have the option of withdrawing before the study commences (even if you have agreed to participate) or discontinuing after starting the interview. You get to keep the information sheet and a copy of the consent form. Your participation in the study will be kept confidential. It is possible that you may be identified by direct quotes used in the study results so please only share what you are comfortable with. Any extract from what you say that are quoted in the thesis will be entirely confidential. The data will be kept confidential for the duration of the study. On completion of the thesis, they will be retained for one year and then destroyed. The results will be presented in the thesis and a copy will be kept in the SCSU Learning Resources Center. The study may be published in a research journal.

There is minimal risk to participate in this study. If you need any further information and you are interested in a copy of the result, you can contact me; Florence Orionzi,

320-293-5470, [orfl1201@stcloudstate.edu](mailto:orfl1201@stcloudstate.edu) or my supervisor, Dr. Glen Palm, 320-420-0348, [gfpalm@stcloudstate.edu](mailto:gfpalm@stcloudstate.edu)

You were previously contacted and interviewed related to the study above. By signing below, you are giving me permission to use the information collected during your interview as part of my research study. Confidentiality will be maintained and data aggregated as noted in the earlier consent form.

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Signature\_\_\_\_\_

Date\_\_\_\_\_

**Appendix D: Request Form**

The cooperation and permission of \_\_\_\_\_  
is requested to assist in identifying and recruiting participants for my thesis research.

Signature \_\_\_\_\_ Date \_\_\_\_\_