'IT WAS NEVER AN OPTION NOT TO BREASTFEED': EXPLORING BREASTFEEDING EXPERIENCES AND INTENTIONS OF MULTIGRAVIDAE IN SOUTHERN NIGERIA.

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ABSTRACT

Exclusive breastfeeding rates are generally modest despite its benefits and pertinence in countries with high childhood morbidity and mortality. In order to understand the complexities of successfully promoting breastfeeding, qualitative research using postmodern research methodologies such as ethnography, grounded theory and interpretative phenomenological analysis, as well as feminist analysis have been employed to explore the experience of breastfeeding by the active participants of breastfeeding-mothers. However, there is a dearth of such studies in developing countries like Nigeria. This study explores accounts of breastfeeding provided by nine pregnant Nigerian women (28-33 years) who had previously breastfed. Participants were interviewed, and data were analysed using interpretative phenomenological analysis. Analyses indicated three emergent themes which highlighted women's experiences of breastfeeding as complex and shaped by proximal and distal influences. Accounts of pain, psychological distress and worries over 'breast addiction' were juxtaposed with pride in perceptions of good mothering, connectedness and upholding cultural heritage. Women's feeding choices were scrutinised and/or stigmatised by family and community members. In the context of feminist "lens", major implication is the potential penalisation for not breastfeeding and hence, a contravention of the right of choice of infant feeding. There is therefore, the need for the incorporation of the right to choose infant feeding methods in breastfeeding campaigns; support for breastfeeding, particularly the inclusion of support for discontinuation; and similar research to explore specific aspects and perspectives on breastfeeding such as those of spouses, to further provide insights that may be useful for the improvement, adaptation and/or development of interventions.

INTRODUCTION

The gold standard for infant feeding is exclusive breastfeeding, which is the giving of ONLY breastmilk for the first 6-months of an infant's life. This is informed by well-documented evidence of the nutritional, physiological, developmental and psychological benefits of exclusive breastfeeding to infants and their mothers, and/or economic benefits to organisations and the society at large (Cattaneo, et.al, 2006; Cohen, Mrtek & Mrtek, 1995; de Jager, Broaddbent, Fuller-Tsyszkiwicz & Skouteris, 2013; Kramer & Kakuma, 2002; Spitzmueller, et.al, 2015).

However, despite these, global rates of exclusive breastfeeding have remained generally modest. In Nigeria, the exclusive breastfeeding rate is only 17%, a far cry from the World Health Organisation (WHO)'s target of 50% by 2025, and recommended 90% (Nelson, 2006; NDHS, 2013; WHO, 2001; 2015). Although most Nigerian women provide their infants with breast milk, a majority supplement this with water and/or formula milk products (Ukegbu, Ukegbu, Onyeonoro, & Ubajaka, 2011). Similarly, disappointing data have been found in other aspects of ante-natal and post-natal care, as well as maternal and infant outcomes in Nigeria (Fagbamigbe & Idemudia, 2016).

A body of research in Nigeria has reported numerous barriers to the maintenance of exclusive breastfeeding for women from varied backgrounds. These include worries around thirst and dehydration of infants, anxieties about slow weight-gain in breastfed infants, mothers' body image concerns, and difficulties in combining breastfeeding with a return to employment (Abasiatti Etukumana, Nyong, & Eyo, 2014; Aniebue, Aniebue & Adimora, 2010; Davies-Adetugbo, 1997; Oche, Umar & Ahmed, 2011).

As expected, such research evidence forms part of ongoing efforts to increase exclusive breastfeeding rates. However, until recently, most of these studies have been quantitative, largely neglecting the subjective perspective of the mothers. This is not surprising given that worldwide, most breastfeeding studies are less 'women-centred' and more 'breastfeeding-centred' (Hoddinott & Pill, 2000). This has often resulted in an incongruence between women's understanding and experiences of breastfeeding and the practices and understanding of professionals (Schmied & Barclay, 1999). This in turn, has necessitated interest in the actual experience of breastfeeding as provided by mothers; hence, there is a growing body of international breastfeeding research that is 'women-centred' aimed at highlighting the potential emotional and social significance of breastfeeding for women (Afoakwah, Smyth & Lavender, 2013).

In the same vein, breastfeeding has been subjected to feminist analyses, in recognition of the need for the employment of social science paradigms in examining the realities of breastfeeding and other health-related issues. The dominant biomedical-scientific approach does not typically provide in-depth knowledge regarding breastfeeding by women in specific socio-political and cultural-historical contexts, and so does not illuminate women's motivations, constructions and experiences of breastfeeding (Spencer, 2008).

These developments have translated to an increased number of qualitative studies employing research methods such as ethnography, grounded theory, interpretative discourse and phenomenology which have been conducted to explore different aspects of the breastfeeding experience such as women's experience of support (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011); their accounts of difficulties (Larsen, Hall & Aagard, 2008), the role of faith and culture (Williamson & Sacranie, 2012) and their views and perceptions around breastfeeding (Forster & McLachian, 2010).

Findings from such studies show that women's experiences of breastfeeding often iillustrate the complexity of breastfeeding and the existence of both positive and negative feelings as well as views around breastfeeding even though mothers almost universally acknowledged that breast milk was the best for their children. This confirms that knowledge of 'breast being best', is not just enough for the promotion of breastfeeding, but that the emotional and social significance to mothers may have far reaching consequences for their engagement in breastfeeding (Hauck & Irurita, 2003).

A series of metasyntheses of such studies construct the breastfeeding experience(s) of mothers as a journey that is personal and absorbing, and that requires dedication from mothers alongside multiple support from different sources (Larsen et al., 2008; Nelson, 2006; Schmied et al., 2011). Whilst women identify and value various sources of support, breastfeeding is still experienced as a 'lonely responsibility' (Nelson, 2006) emphasising the 'personalisation' of the breastfeeding experience. The descriptions women provided of their breastfeeding experiences have been useful in gaining more insight and understanding of breastfeeding and in informing strategies for breastfeeding campaigns (Schmied et al., 2011).

However, the majority of such studies have been conducted in Western countries. In African countries, there are considerably fewer studies, and these have primarily targeted experiences of HIV+ mothers (Coetzee et al., 2017; Levy, Webb, & Sellen, 2010; Onayade, Ijadunola, Obiajunwa, Aina, & Thairu, 2006). In particular, there is a dearth of qualitative research using more critical and constructivist qualitative research techniques which explore the experiences of mothers and which have the "potential to broaden our understanding and facilitate insight regarding clinical practice, applications, policy making and areas in need for further research" (Nelson, 2006: E13).

It is imperative that more of such research is conducted in African countries like Nigeria where there are fluctuations in the rates of exclusive breastfeeding, as well as high infant mortality and morbidity, despite evidence-based and barriers-targeted breastfeeding promotion and interventions (Agho, Dibley, Odiase, & Ogbonmwan, 2011; NDHS, 2008; NDHS, 2013). This can begin by understanding the subjective experience(s) of breastfeeding from the perspective of mothers. There is therefore the need for the extension of the use of qualitative research, particularly, interpretative phenomenological analysis, a specific psychological qualitative research tool that allows for in-depth exploration of health experiences (Willig, 2013), in exploring Nigerian mothers' experiences of breastfeeding.

In the same vein, research on women's breastfeeding experiences have often looked at women of low socioeconomic status based on the rationale that their exclusive breastfeeding rates are often lower than women with higher socioeconomic status (Spencer, 2008). In Nigeria, findings regarding the exclusive breastfeeding rates of women with higher socioeconomic status or of upper class women who often live in urban areas have been mixed. For example, historically, the decline in breastfeeding in Nigeria was associated with a rise in educational and socioeconomic status of women, and acculturation closely associated with modernisation (Ojofeitimi, Elegbe, & Afolabi, 1986).

Data following the introduction of the Baby Friendly Initiative have provided contradictory information about the breastfeeding practices of this group of women. Whilst some findings are indicative of higher exclusive breastfeeding rates (Agho et al., 2011), others are indicative of lower rates (Sadof et al., 2011). There are also assumptions amongst some stakeholders in breastfeeding campaigns in Nigeria that urban women prefer bottle feeding and rural women copy them thinking it is fashionable (Adelaja, 2010). It may therefore be pertinent for breastfeeding research to focus on more affluent, educated women in the population as their experiences could provide insights that may be useful in understanding other factors that may impede exclusive breastfeeding rates beyond understanding the benefits of exclusive breastfeeding, access to uncontaminated water and other barriers to breastfeeding, as they are less constrained by economic and environmental factors.

Therefore, this study explores the accounts of educated, pregnant Nigerian mothers' past experiences and future intentions of breastfeeding and investigates the social and cultural context around their feeding choices and practices. Researchers elected to focus on women positioned between prior and anticipated breastfeeding to understand the strategies and resources they employ on to support breastfeeding and the challenges they face in sustaining exclusive breastfeeding. The study focuses on women who are not constrained by major economic or environmental challenges and explore the individual, proximal and distal influences that shape the accounts of their experience. The study aimed to generate knowledge for developing breastfeeding support mechanisms in a Nigerian context.

Therefore, the research questions for the study are :
What are the lived experiences of breastfeeding of educated and socioeconomically privileged women in Southern Nigeria, and what are their thoughts and preferences about future practices of breastfeeding?

METHOD

Theoretical Background: A phenomenological and hermeneutics theoretical approach using interpretative phenomenological analysis (IPA) was employed. Phenomenology is both a philosophy and a group of research methods that allows for the uncovering of people's experiences of specific phenomenon via a focus on their descriptions of everyday

experiences of such phenomenon (Langdridge, 2007; Smith, Flowers & Larkin, 2009). Hermeneutics on the other hand, is both a practice and a theory that allows textual meanings to be interpreted (Rennie, 1999 as cited in Cassidy, Reynolds, Naylor & De Souza, 2011). IPA, which draws on these two theoretical tenets, allows for a study's findings to be reflective of participants' expression of their experiences, and the researcher's interpretations of what they say, and how they say it, which encompasses their social and personal world inclusive of their emotions, thoughts and reported behaviour. This allows for a meaning-making of their experiences and the researcher's interpretation of this meaning-making (Smith, Flowers & Larkin, 2009).

The principle of phenomenology is employed in IPA via its focus on the experiences of a small number of individuals in similar circumstances – indeed the detailed and contextualised subjective reports of individuals are said to be the currency of an IPA (Osborn & Smith, 1998). IPA is interpretative in that analytic outcomes are the combined reflections of participants and researcher(s) (Smith et al., 2009); hence, acknowledging the centrality of participants' ability of enunciating thoughts, emotions and experiences and researcher's ability of reflection and analysis (Brocki & Wearden, 2006).

Hence, IPA is often employed in exploring the views, perceptions, understanding and experiences of research participants (Reid, Flowers & Larkin, 2005). The method allows for the exploration of the perspectives of insiders, and takes into cognisance the dynamism of the research process, providing contextual and insightful information that quantitative research alone cannot provide; it also allows the participants to control the research to some extent, rather than the researcher (Willig, 2013). This makes it an appropriate method for examining people's experience(s) as lived in every day circumstances.

Participants: Purposive sampling with explicit inclusion and exclusion criteria was employed. Nine Nigerian women aged between 28 and 33 years who had breastfed their previous infant for a period of at least four months (and within the last 12 to 18 months) and who were in the middle or final trimester of a subsequent pregnancy were recruited to the study. Woman also had to be fully literate in English, the official language of Nigeria. All women resided in the South-South geopolitical region of the country but were from a variety of tribal/regional backgrounds (5 were Igbo, 2 were Niger-Deltas, 1 was Yoruba and 1 was Hausa). The sample included both Christian and Muslim women who were recruited via ante-natal clinics at a private healthcare facility. All women were married, well-educated and lived in urban areas.

Design: Different methods of collecting data are employed in IPA research, these include face-to-face interviews, email interviews, telephone interviews, written narratives, diaries, observational notes, and online blogs. Face-to-face semi-structured interviews are the most widely employed data collection methods in IPA research (Brocki & Wearden, 2006); hence, this study employed individual semi-structured interviews which were audiotaped (Smith, 2003). Although other methods have their advantages, face-to-face interviews specifically semi-structured interviews, facilitate the ability of participants to provide their own narrative accounts in their own words, and clarifications and/or expatiation can be made; hence, fulfilling a pivotal premise of IPA (Smith et al., 1997); and is in congruence with the major aim of IPA which is the exploration in details of an area of concern in a manner that is flexible (Smith & Osborn, 2003).

Key Materials and Measures: An audiotape was utilised to record interviews in order to allow for verbatim transcription. The interview schedule (Appendix A) was developed following research into breastfeeding in a Nigerian context and from the regional perspective of observations and experiences of the first author who is both a Nigerian mother and researcher.

Identification and Management of Ethical Aspects: Ethical approval for the study was granted by the Faculty Research Ethics Committee of De Montfort University, Leicester, UK, and the Ethics Committee of the private health facility in Nigeria from which participants were recruited, in line with requirements of the Ministry of Health in Nigeria. All participants were given information sheets that provided detailed information about the research, as well as consent forms that outlined the confidentiality and anonymity of their responses, and their freedom to withdraw from the study at anytime; research-based issues that could be of concern to participants and contact details of the researcher(s). Participants were also required to sign three copies of the consent; one of which was kept for their reference, one kept by the health facility from which they were recruited from, and the third kept by the researcher.

Procedure: Before commencement of interviews, the information sheets providing details of the study were given to participants. Participants were then given informed consent forms that covered their right to confidentiality, withdrawal from study at anytime during the interview, and not more than 7 days after interviews. Participants' signature on the form was taken to imply participants' confirmation of voluntary and informed willingness to participate in the study. All recruited participants who had provided informed consent were then interviewed. All participants were interviewed individually by the first author using a semi-structured schedule in a location of their choice (typically in their own home). Interviews were conducted in English but with some phrases in pidgin English (used frequently in everyday interactions in Nigeria) and local dialects with which the interviewer (a Nigerian woman) was fully familiar. Interviews were recorded and typically lasted between sixty and ninety minutes; but, anonymised as participants picked pseudonyms. Data were analysed using IPA which favours in-depth analysis of a small number of detailed accounts from participants who are seen to be 'experiential experts' in the phenomenon being researched (Smith et al., 2009). We utilised a variant of interpretative phenomenological analysis informed by social constructionism, which develops interpretations around accounts of individual experiences whilst situating these accounts within cultural and socio-political discourses (Leeming et al., 2013).

***Analytic Strategy*:** In line with the principles of data analysis using interpretative phenomenological analysis (Willig, 2008), the researcher familiarised (through multiple readings) with the contents of individual transcribed interviews, to get a general "feel" of the participants' descriptions. Strategy involved a seven-stage process that started with the researcher's immersion and familiarisation with a participant's transcribed interview at a point in time. This was followed by an identification of initial codes in left-hand margins of transcripts, which included ideas of researcher's interpretation of participant's accounts, and interesting language utilised by participants.

This was followed by the development of simple themes that emerged, which were noted on the right-hand margin. These themes were then listed and connections between them considered, leading to the clustering of themes, largely through the use of superordinate or higher order concepts. A table of coherently ordered themes was then produced. This was done independently for each participant's transcribed interview. Finally, an exploration of patterns was done across all participants' tables of themes and super-ordinate themes, which were then put in a table consisting of major themes and/or sub-themes across the nine transcribed interview (Appendix B).These were cross-checked with other colleagues involved in IPA research.

Analysis was significantly refined within all three members of the research team with some themes being relabelled and re-organised significantly. Six super-ordinate themes were identified but three themes have been selected for inclusion in the article. These were

selected for a number of reasons. Firstly, they were present in the accounts of at least two-thirds of participants' accounts (six out of nine). Secondly, in selecting themes for the present paper, we included material believed by the team to represent a useful, original and culturally nuanced contribution to the literature and which we felt were most useful in regards to the research question and provided experiences which can help inform our understanding of breastfeeding in a Nigerian context.

FINDINGS

Three inter-woven themes relating to the women's experiences are presented below.

In each case, a small number of illustrative extracts taken from the transcripts has been selected. As we introduce the themes, we signpost constituent sub-themes for clarity in italics. Each theme is subsequently supported by a brief commentary and is subsequently discussed in line with theory, research and policy in the discussion.

Balancing the Benefits and Burdens of Breastfeeding

Participants perceived several benefits to breastfeeding for both themselves and their infants including bonding and health outcomes. The process of breastfeeding was perceived to have dividends and challenges peculiar to the different stages of initiation, maintenance and discontinuation. However, most women cited important support from faith and family.

The accounts of breastfeeding experience by the women were characterised by difficulties ranging from *physical discomfort through pain and engorgement*, as well as *emotional distress, body image concerns and loss of independence*. They describe their *resilience and support from family members and God*.

> *The pain and the pain of the incision (from Caesarean section), those were just the things that made me emotional and the fact that I really wanted to breastfeed my baby and I did not want to use the pains as an excuse not to breastfeed my baby. So I was still breastfeeding even in the pains (Ajery, 95-99, p.3)*

> *hhh like, oh Go(hhhh)d, you just find yourself crying sometimes, you just cry because, because erm, (.), how will I put, sometimes you just pity for yourself, that one child is just erm,(.) demanding so much from you (Rhema, 203-207,p. 6)*

> *one challenge I had was (.).. my breasts were full and you know I couldn't get it out, so it was so, so full, that was like the biggest challenge, it was horrible, the pain was so much (Egoh, 197-201,p.6))*

Similarly, most of the women felt tied down by breastfeeding with loss of freedom to move around, restrictions to activities, restrictions to fashion/style, and expressed concerns over having to dress appropriately in order to breastfeed, particularly in public.

> *I was not having a time of my own, even if I am in the bathroom having my bath, she would be busy crying, so whatever I am doing, I time myself to be fast so that the next thirty minutes I am there to attend to her (Favour, 56-60,p.2)*

> *...my clothing, ha, ha, hah, that is really a problem, as at now, I`m thinking of sewing gowns, I`m thinking of letting(.), you know, may be it brought about my own new designs, ha, ha,ha. I`m always thinking of new designs, you know, let me, as in, whenever I`m sewing clothes, I`m thinking of putting a zipper in front, instead of at the back so it`ll be comfortable for breastfeeding, and because I`m covering(.); I always had to, even when I didn`t want to wear*

> *my hijab, I always had to wear my hijab so I`ll put the baby under the hijab and breastfeed her (Zee,1574-1584,p.34)*

For some women there were anxieties about how breastfeeding would affect the shapeliness of their breasts leading to concerns about remaining sexually attractive to their husbands. However, whilst these difficulties were acknowledged, sustaining breastfeeding was typically prioritised:

> *I had concerns but I felt breastfeeding is more important than me losing the shape of my breasts (Zee, 1078-1081, p.23)*

These difficulties generally did not deter the women from breastfeeding, given their quest to meet social and cultural expectations to breastfeed and to prove themselves as good mothers especially with a prized first infant. Suckling was reinforced by their families and local communities who provided approval and practical support such as through a tradition popularly referred to as 'Omugho' which roughly translates as a ‘rooming in’ period (Dike, 2013) This is a cultural norm in Southern Nigeria where a mother spends several weeks with her daughter after delivery of her grandchild and although the term itseslf is Igbo, women descended from other tribes in the area describe the same practice. Omugho requires grandmothers to be fully present for as long as three months to provide emotional care and practical support to ensure that new mothers meet societal expectations of being ‘good’ mothers.

> *Ok, according to my tradition, my mum was around for what we call Omugho so she was helping me with bathing the child and also with erm, with some other traditional things, you know like bathing with hot water and all that and every other thing, house chores and then the other things around (Sandra, 111-118,p.3)*

Apart from support from grandmothers, many expressed looking up to the spiritual for help with some of the difficulties of breastfeeding.

> *I believe that if you put your mind to something, and then you ask God for grace, well, I am a christian, and you ask God for grace for something, He would give you the grace to do that (Ajery, 206-209,p.6)*

On the whole, the women expressed a strong commitment to breastfeed even in the face of adversity.

In keeping with regional and national trends, some mothers fed expressed milk and/or used formula supplements, infants were routinely nursed ‘on demand’. However, suckling at the breast was viewed as the best way to feed, partly because it was perceived to be the more natural and "motherly" way to feed the infants, and the best way to create a bond between mothers and their babies.

> *...the bottle, the baby is looking directly into the bottle, but breastfeeding, the baby is looking directly to you...the contact, eye to eye contact. (Favour, 396-400, p.11)*

While this promoted mother-infant attachment, it also led to concerns over ‘breast addiction’ and children becoming ‘clingy’.

> *The bonding thing is very good but for me now my son is too attached to me. At this point where he is going to school, I will have to stay with him a little bit before I leave him so he does not start crying because he would just be pulling at my dress and everything. (Ajery, 384-393, p. 11)*

There was tension for women navigating the challenges of breastfeeding while still trying to get the dividends they identified. This was particularly true with regard to the closeness

between the mother and child expressed as a gain of breastfeeding, and also as a challenge, as it often led to a loss of independence for mother and particular difficulties when breastfeeding ceased.

Reinforcing Maternal and Cultural Identity

For all the participants, initiation and maintenance of breastfeeding was constructed as an inevitable part of mothering rather than an autonomous choice – although largely a practice with which they accepted compliance. Despite issues around pain and frustration at some of the personal and social restrictions which could result from breastfeeding, most women spoke of the *rewards of breastfeeding* as '*joyous*' or '*exciting*'. This theme also includes material about the *celebration of African maternal identity* and *both acceptance and expectation pressure to breastfeeding in public spaces.*

It's not easy but I find joy breastfeeding my baby so that keeps me going. (Rhema, 83-84, p.3)

It helped to boost their self-worth and reinforced their identity as 'good African mothers' continuing a time-honoured tradition:

> *Coming from an African setting, it seems abnormal not to want to breastfeed your own child. For me it was never even an option not to breastfeed. Especially for an African woman – from the outset it is just as if it is part of our psyche to breastfeed. (Joba, 435-439, p.7)*

> *The fact that I could look at the baby's eyes and it created this closeness, this bond between you and the baby and it was something that only you can give to your baby. No other person could. (Caroline, (273-277, pg. 6)*

The women reported how there was a public affirmation and approval of breastfeeding that made it easy for them to breastfeed in public. For example, Joba describes how it is normal to the public for a mother to breastfeed her child.

> *But, even then, in Africa, it is normal for a woman to breastfeed her child, so the public, I don't think the public even notice that you are breastfeeding. It is only normal, you have a baby, your baby is hungry, you breastfeed (Joba,293-297,p.8)*

The affirmation and approval of breastfeeding by the larger society, however takes away some level of freedom of choice from the mothers, as some members of the society, particularly older women, felt obligated to not just encourage younger mothers to breastfeed, but insist on this almost to the point of ''intimidating'' them to breastfeed. An example of this was presented by Rhema's description of an older woman's insistence on her breastfeeding her infant.

> *... I was just paying attention to what was going on and then an elderly lady that sat in front of me just turned back and <u>ASKED WHY I WILL NOT JUST BREASTFEED THE CHILD WHERE I WAS SITTING,</u> and I now said but in the whole, in this erm congregation, how can I do it and she was like IF YOU DON'T DO IT, I will bring those breasts out and I will give it to this child and I just got up and I went to the back to breastfeed the child. (Rhema,229-235, p.7)*

Through strong affirmation and approval of breastfeeding by the larger society, breastfeeding was thus constructed as the ultimate performance of a mother's love for her

child and an expression of her authentic "African-ness". Breastfeeding promoted an embodied symbolism of good mothering and reinforced cultural and maternal identities. However, this could extend to a perceived requirement to perform on demand nursing in situations where women preferred not to breastfeed. The difficulties women found negotiating private and public spaces are illustrated further in the final theme.

Navigating Patriarchy and Stigma

This theme has two main components – *the dominance of husbands' wishes and the stigma attached to not breastfeeding*. As indicated previously, the participants often felt their performance of breastfeeding was scrutinised and regulated by others – both in the familial or community milieu. Within the domestic sphere, the preferences of fathers were very important, often to the extent of over-riding the mothers' wishes. One husband insisted that his wife ceased breastfeeding because feeding the infant 'on demand' threatened their sexual intimacy. Another participant discussed her wish to discontinue breastfeeding after a period of eight months.

> *My husband refused. He said I should breastfeed for one year. I felt I needed my freedom too so I wanted to stop but he said I had to continue. (Egoh, 172-173, p.5)*

In the public sphere, several of the participants discussed occurrences when members of the community shamed women into feeding their infants in public. Appearing to resist breastfeeding brought highly stigmatising claims that the mother might be HIV+ or the child illegitimate. As mentioned previously, other women in particular appeared to see an infant's right to be suckled on demand as of cardinal importance.

This support for breastfeeding, in line with the societal/community expectation that good mothers breastfeed translated to a potential and actual penalisation of mothers who do not breastfeed. There was a social outrage over a mother's inability, reluctance or refusal to breastfeed her child. Such outrage was often expressed as stigmatising verbal attacks:

> *Whenever a child cries outside everybody tends to shout at you to tell you to put the child to suck. When you refuse to do that, that is when they rain abuses on the woman saying she is not worthy of motherhood, she is not fit to be a mother and probably the child is not hers. (Sandra, 234-240, p. 6)*

In this context, the option of not breastfeeding was almost unthinkable, as mothers who do not breastfeed were presented to be not only deviant as mothers but 'unAfrican' with the likely attribution of other stigmatising characteristics.

DISCUSSION

In keeping with other recent research (Coetzee et al., 2017) findings indicated that study participants strove to breastfeed their infants for the six-month period promoted by the World Health Organisation although some struggled to maintain exclusive breastfeeding for various reasons. Perhaps surprisingly, there was little evidence (in relation to their own or others' experiences) of some of the constructions of the superiority of bottle feeding amongst middle-class Nigerian women which have been expressed by breastfeeding campaigners (Adelaja, 2010).

Women experienced many of the challenges reported widely in the literature including pain, engorgement, and emotional distress (Berridge, Mcfadden, Abayomi, & Topping, 2005; Williamson, Leeming, Lyttle, & Johnson, 2011) and coped with these challenges through personal attributes such as resilience (Nelson, 2006) and spiritual and family support especially through the period of Omugho (Olaore & Drolet, 2017). Faith was an important element in persevering through breastfeeding challenges and as recognised by other authors (Williamson & Sacranie, 2012; Coetzee et al., 2017) breastmilk was often viewed as God's gift.

Also key to the women's experiences was a marked sense of maternal identity and the importance of breastfeeding as a signifier of good mothering. Like most African countries, Nigeria has a strong pro-natalist cultural ideology with motherhood viewed as empowering and raising women's roles '*from the subordinate position of wife to the more auspicious category of 'mother'* (Dike 2013, p.43). As writers like Makinde (2004) theorise, giving birth and nourishment to a healthy infant not only enhances psychological well-being but also elevates a (married) woman's status significantly within the family.

However, as noted by Makama (2013) amongst others, most communities in Nigeria remain deeply patriarchal and in the present study although both parents agreed on decision to breastfeed their child (with little differences in opinion reported in regard to this), it was typically the husband who decided how long breastfeeding was sustained for (Agunbiade and Ogunyele, 2012).

There are other challenges inherent in the association of breastfeeding with good mothering – especially where there were instances of women being stigmatised for not breastfeeding and/or pressured into feeding in situations where they did not feel comfortable. Indeed, it has been argued from some feminist perspectives that the association of good mothering with breastfeeding can contravene women's right of choice to infant feeding options for their babies. As our findings attest, breastfeeding advocacy and promotion continue to be complex issues for feminists especially in poorer countries where increasing exclusive breastfeeding is a pivotal part of reducing infant morbidity and mortality (Dudgeon & Inhorn, 2004; Kukla, 2006), yet where women experience pressures from others about how to use their bodies alongside consistent social and economic disadvantage.

Study findings differ from some other work in a Nigerian context as all participants were committed to breastfeeding their infants and intended to breastfeed the babies they were expecting. However, whilst participants recognised the developmental and immunologic benefits of breast milk; as indicated in other studies, few of the women breastfed exclusively (Coetzee et al., 2017) and lacked confidence in sustaining exclusive breastfeeding with their next infant. Consistent with larger-scale research, most supplemented breast milk with water and/or formula and sometimes herbs believed to be essential for the baby's vitality (Ayoade, Oshiname, & Arulogun, 2013).

Support around breastfeeding and child-rearing more generally was most commonly provided by mothers or mothers-in-law who moved in during the postpartum period, called 'Omugho' typically for two to three months. As well as fathers of infants, who were instructive in breastfeeding decisions in terms of initiation, duration and exclusivity. However, very little support (either practical or emotional) is provided for women around the discontinuation of breastfeeding which is a time which women in the study and others report finding challenging (Odom, Li, Scanlon, Perrine, & Grummer-Strawn, 2013). Again, in the context of a feminist approach, the challenges in managing the fathers' expectations alongside the lack of resources, including in many cases a reported lack of professional support, affected the women's ability to breastfeed fully in line with their wishes and raises social justice concerns (Van Esterik, 1999).

Interpretative phenomenological analysis aims at accessing and interpreting in-depth accounts of embodied and contextualised experiences which can limit the wider applicability of findings (Smith et al. 2009). In addition, when considering the transferability of study findings, it is important to remember that whilst a range of women from various ethnocultural backgrounds were recruited, all participants and their spouses were educated with good access to healthcare and clear evidence of familial support. They are also drawn from the South-South geopolitical region which has a very different mixture of communities from other

areas of the country and where rates of exclusive breastfeeding have been reported to be at higher rates than most other regions (Ogbo, Agho, & Page, 2015).

The current research presents some of the challenges beyond poor breastfeeding knowledge and thus provides additional information to help ensure that interventions are properly developed, well-focused and multi-faceted rather than being entirely educative. Significant structural change is difficult to facilitate especially in countries with several urgent health-related priorities. However, as suggested by Kinanee and Ezekiel-Hart (2009) promoting greater but equal-status involvement of fathers in antenatal and postnatal care and counselling wherever possible may be a small step in the right direction as may additional father-focused education on the benefits of both exclusive and extended breastfeeding (Dugeon & Inhorn 2004).

Furthermore, fuller development of peer-support networks (both around breastfeeding and wider health and well-being) especially for women who do not have access to supportive ethno-kinship circles would also be welcomed. Community centres at places of worship such as churches and mosques may be an effective venue for the development of such groups (Badejo et al. 2017) especially as faith is a commonly reported coping resource.

Alongside the development and evaluation of such initiatives, future research that explores accounts of various family members within breastfeeding 'systems' is likely to provide a more developed picture. In addition, follow up research may benefit from recruiting women who actively reject and resist breastfeeding.

Although small in scale, study findings provide an insight into some of the key issues facing a sizeable contingent of Nigerian women who have generally been given a limited voice in breastfeeding research. Unlike some previous theorising, there was very little evidence that breastfeeding was not valued by middle-class, urban-dwelling women, indeed breastfeeding had celebratory and self-affirming components for all the participants.

However, findings also show how the regulation of breastfeeding by others (both intra and extra-familial) could be oppressive and argue that Nigerian breastfeeding promotional work needs to ensure that a consideration of women's rights is central. The reinforcement of cultural and maternal identities and discourses around children's right to receive breast milk may be useful to promote breastfeeding duration and exclusivity but need to be used very carefully as they have the potential to position women who are unable and/or reluctant to breastfeed very negatively.

There is, therefore, the need for the incorporation of the right to choose infant feeding methods in breastfeeding campaigns; support for breastfeeding, particularly the inclusion of support around the timing and practice of discontinuation; and similar research to explore specific aspects and perspectives on breastfeeding such as those of spouses and grandmothers to further provide insights that may be useful for the improvement, adaptation and/or development of interventions.

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All Appendices (including transcripts and table of themes) can be accessed via email requests to corresponding author