

## Research paper

# Nourishing body and spirit: exploring British Muslim mothers' constructions and experiences of breastfeeding

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### What is known on this subject

- British Asian women are more likely to initiate breastfeeding than British white women, but attrition rates appear to be similar, and most women from both ethnic groups do not maintain breastfeeding to 6 months' duration.
- Breastfeeding promotion features in sacred Islamic texts such as *The Holy Qur'an*, but little is understood about British Muslim women's interpretations and constructions of the practice.
- Recent research has shown that health practitioners who interact with women from Muslim backgrounds often employ stereotypical understandings around breastfeeding choices and behaviours.

### What this paper adds

- British Muslim women integrate contemporary health promotion and passages from historic scripture in informing and supporting the practice of breastfeeding.
- '*Nourishment*' is constructed in culturally specific ways which may need to be explained to health and social care practitioners who are unfamiliar with Islamic beliefs and customs.
- Successful breastfeeding has the potential to enhance Muslim women's psychological well-being and reaffirm their religious and maternal identities, whereas significant breastfeeding-related problems may challenge mothers' mental health.

## ABSTRACT

This study explored experiences and representations of breastfeeding reported by British Muslim women. Six mothers who breastfed their infants for at least 3 months were interviewed on two occasions, namely during the breastfeeding period and again once the provision of breast milk to the infant had ceased. Accounts were analysed using a social constructivist version of interpretative phenomenological analysis. Participants utilised interwoven constructions of breastfeeding which fused Islamic and biomedical understandings. Breastfeeding was simultaneously viewed as beneficial to the child's health and as a deeply spiritual act through which the mother's attributes as a 'good Muslim' nourished the child and promoted his or her moral development. Making reference to sacred texts such as the Qur'an and Hadith, the women believed that they would be rewarded for breastfeeding by Allah, and that some past sins would be forgiven. Helping breastfeeding mothers was viewed as a collective responsibility involving family and community members.

Lactation was supported by ritualised practices relating to the consumption and restriction of certain foods, whereas breastfeeding problems such as pain and infection were managed in consultation with health professionals. The importance of maintaining standards of modesty caused challenges for participants feeding in public, but the segregation of men and women in the domestic sphere when socialising, and the wearing of dress coats, such as the abayah, facilitated discrete feeding at home. It is important that those working with British Muslim mothers have an awareness of these constructions to ensure the provision of high-quality and culturally sensitive healthcare and education in the perinatal period. Methodological issues relating to reflexivity and data collection and analysis paradigms within culturally embedded accounts of the lived experience of intimate embodied practices such as breastfeeding are also considered.

**Keywords:** breastfeeding, interviews, Islam, mothers, phenomenology

## Introduction

Breastfeeding is recognised as yielding significant health benefits for both mothers and infants, and is promoted worldwide (Horta *et al*, 2007). Guidance from the World Health Organization and other agencies suggests a gold standard of exclusive breastfeeding for at least 6 months and the provision of some breast milk for the first 2 years of a child's life (Kramer and Kakuma, 2002).

British policies and practices relating to breastfeeding promotion and support are highly influenced by the UK's participation in the UNICEF Baby Friendly Initiative (UNICEF, 2012a), which promotes a number of strategies to facilitate and encourage successful breastfeeding, particularly in the immediate postpartum period. The initiative is endorsed by the National Institute for Health and Clinical Excellence (NICE), and hospitals and other healthcare facilities are able to apply for four stages of recognition, from a Certificate of Commitment to full, stage 3 accreditation. Full accreditation demonstrates standards of excellence in an institution's policies and procedures about breastfeeding support mechanisms, staff training programmes and the consistency of care provided to mothers and infants; accreditation is reviewed periodically. However, it should be noted that there are currently significant regional differences in the number of fully accredited facilities across the UK, and nationwide such facilities represent a minority of British institutions (UNICEF, 2012b).

Breastfeeding rates in the UK are monitored on a regular basis, most notably through a quinquennial Infant Feeding Survey (IFS). Although breastfeeding initiation rates have increased in the UK in recent years, rates of maintenance and exclusive breastfeeding continue to fall short of government targets. The 2005 IFS found differences in breastfeeding rates across ethnic groups, with black (97%) and South Asian (93%) women more likely than white women (75%) to initiate breastfeeding. There were also differences in the number of women from different ethnic groups feeding their infants with (any) breast milk at 6 months (57% of black women compared with 37% of Asian women and 23% of white women) (Bolling *et al*, 2007).

Women's experiential accounts of the act of breastfeeding are highly heterogeneous, especially with regard to how they respond to the embodied experience (Nelson, 2006). A recent meta-synthesis of several studies reported two overarching themes in the literature: first, a mismatch between mothers' expectations of breastfeeding and the lived reality, and secondly, the ways in which women respond to the physicality of breastfeeding on an emotional level, which have been described as '*discourses of connectedness or*

*disconnection*' (Burns *et al*, 2010, p. 201). Researchers have also discussed the perceived moral imperative of women to breastfeed that operates through the hegemonic '*breast is best*' message which is central to breastfeeding promotion, but which potentially aligns formula feeding with '*bad mothering*' (Hoddinott *et al*, 2012). Others have investigated the motives and subject positions of those women who feed their infants with expressed breast milk (Johnson *et al*, 2009), and have explored the impact on mothers' mental health in cases where breastfeeding breaks down (Mozingo *et al*, 2000).

Discourses about breastfeeding in Britain and other developed nations are complex and potentially contradictory. Locke (2009) notes how breastfeeding is constructed simultaneously as a natural, age-old process and a behaviour that needs to be learned and supported by expert guidance from health professionals such as midwives and health visitors. Furthermore, breastfeeding is represented as both a process and a product, leading to numerous debates, for example, about the desirability of feeding on demand and pumping breast milk.

Within this corpus of literature, there is often an under-appreciation of socio-cultural influences on breastfeeding, and there is currently little research which has investigated how religious affiliations in particular influence the lived experience of breastfeeding. This paper aims to go some way towards beginning to address this deficiency by exploring accounts of breastfeeding among women of the Islamic faith in the UK, where Muslims form the second largest religious community (Pew Forum on Religion and Public Life, 2011). Although some researchers have explored elements of the perinatal care of women from Asian backgrounds more generally, and in some cases incorporated participants from British Asian communities into studies investigating breastfeeding experiences (e.g. Shaw *et al*, 2003), there appears to have been little previous research that explores the way in which British Muslim women's breastfeeding choices and experiences are shaped by their religious beliefs.

It is not currently possible to provide estimates for breastfeeding rates or trends within British Muslim communities which are highly diverse. Figures from the 2007 IFS were collected on broad ethnic self-categorisations of '*Asian or British Asian*', which combines Muslim women with those from Sikh and Hindu backgrounds, as well as other smaller religious communities, including Jain, Buddhist and Christian. The categorisation excludes British Muslim women of non-Asian ethnicities, such as some diasporic African or Eastern European women, and white British women who have converted to Islam. Disentangling religious and ethno-cultural identities is a sensitive and challenging issue for theorists, researchers and policy makers, not least because research demonstrates

that these identities are fluid and may be utilised, performed and experienced as integrated and distinct in complex ways by individuals at various times and in different contexts (Mir and Sheikh, 2010).

Although Ali and Burchett (2004) highlighted examples of cultural insensitivity and discrimination in Muslim women's experiences of maternity services specifically, most British researchers in reproductive health who have conducted studies in this area have favoured sampling along more objective and arguably less sensitive criteria of migration patterns and ethno-cultural background, often using multi-ethnic samples. For example, Puthussery *et al* (2008) found considerable evidence that some healthcare professionals involved in the care of expectant and new mothers systematically draw on stereotypes when describing women from various ethnic minority backgrounds. White health professionals' reported views of women from Pakistani and Bangladeshi backgrounds suggest automatic expectations of a high level of breastfeeding uptake (Shaw *et al*, 2003), although recent research has suggested an impact of acculturation on breastfeeding behaviours within these communities (Choudhury and Wallace, 2012). Therefore we may expect to see attrition in breastfeeding rates as women of South Asian family origin become increasingly accustomed to white British culture, where bottle feeding is arguably more consistently viewed as a legitimate infant feeding option (Scott and Mostyn, 2003). Indeed, despite the high levels of breastfeeding initiation, the 2005 IFS found that only 5% of all mothers in the British Asian ethnic category were exclusively breastfeeding their infants at 4 months postpartum (Bolling *et al*, 2007). It is therefore clear that there is scope for more detailed exploration of ethnic minority women's experiences beyond the secular biomedical context associated with the monitoring of breastfeeding in the UK.

In order to situate Muslim women's lived experiences of breastfeeding, we need to explore the influence of both cultural norms and sacred texts. Muslim theologians have illustrated that breastfeeding is enshrined within the religion through its inclusion in the Islamic scriptures on which Shariah law is based, namely the Qur'an and the Hadith, which are accounts of the sayings and reported acts of the Prophet Muhammad. References to breastfeeding appear in six *sura* (chapters) in the Qur'an. Verse 233 of the second chapter of the Qur'an is mostly commonly cited, and is interpreted as being an exhortation that infants are suckled for 2 years by the biological mother or a wet nurse (Krieger, 2006). Shaikh and Ahmed (2006) note how breast milk is referred to as '*white blood*' within some Islamic communities, to represent the continuity in maternal nourishment of the child between the intrauterine and extrauterine environments. Cultural norms in many Asian and African Islamic societies suggest that breastfeeding should be discontinued

after 2 years, partly because of its contraceptive and child-spacing functions (Pedro-Nustas and Al-Qutob, 2002).

British Muslim women are exposed to both biomedical and Islamic ideologies and discourses relating to infant feeding which appear to promote a prolonged period of breastfeeding. In the present study we aim to explore how women from these communities construct and experience breastfeeding through the application of a phenomenological methodology.

## Method

### Theoretical background

Data were collected by means of semi-structured interviews, and were analysed using interpretative phenomenological analysis (IPA) (Smith *et al*, 2009). The aim of IPA is to analyse in depth accounts gathered from a small number of individuals who are seen as *experiential experts* in the phenomena under investigation. Purposive sampling is therefore employed to ensure that the participants share key characteristics, and are relatively homogeneous and relevant to the experience that is being investigated. Analysis moves from the idiographic to the general, with each participant's account being viewed as a detailed case study in the first instance. Themes that are generated from an analysis represent a co-construction of meaning making between the participant, who interprets and articulates the experiences of interest, and the researchers, who aim to understand the subsequent account provided. This feature is known as a *double hermeneutic* (Smith *et al*, 2009). We have paid particular attention to experiential elements, while also considering the ways in which discursive resources and constructions shape the accounts provided by the women (Larkin *et al*, 2006). All of the participants were interviewed on two occasions, namely while breastfeeding was ongoing and subsequently when breastfeeding of the infant had ceased and the woman had had time to reflect upon her experiences more holistically.

### Participants

The inclusion criteria for the study were that participants must be women who were British citizens, self-identified as Muslim, and who practised their faith through self-reports of following the five pillars of Islam, including *salah* (performance of prayers five times daily). For the first interview the women needed to have had contemporaneous, ongoing experience of breastfeeding of at least 3 months' duration of an

infant of no more than 12 months. No restrictions were made on parity. The second interviews took place as soon as practicable once the participants had indicated to the researchers that breastfeeding of the infant had been completed (i.e. no breast milk was being fed to the infant by any method). The duration of breastfeeding varied from 3.5 to 24 months, although most mothers provided some breast milk to the infant for over a year.

Participants were recruited through snowballing in Muslim communities in a multi-cultural city in the Midlands. Six married women aged between 32 and 42 years at the time of the first interview took part in the study. All of them selected pseudonyms to protect their anonymity, and the names of infants, husbands and other family members who were mentioned were changed as the data were transcribed. Three of the women (Fatima, Ayesha and Nasreen) had one child, Zainab had three, Raheema had five and Maryam had six. Most of the women attended the mosque regularly. The women varied in their style of dress. Maryam and Raheema routinely wore a full-length *abayah/juba* (long coat-dress) with *hijab* (head-scarf) and *niqab* (facial veil), while Nasreen wore the *abayah* with *hijab* only. Zainab, Fatima and Ayesha favoured more Western forms of dress, although Ayesha covered her hair with a *hijab*. The women generally reported good health for both themselves and their infants, although Raheema disclosed during her first interview that she had alpha thalassaemia. Four of the women had been raised as Muslims from birth, but Nasreen and Ayesha had converted from Sikhism to Islam upon marriage. Zainab was born in Malawi and had moved to the UK as a child. The other women had been born in the UK. Four were second-generation, and their parents had come to the UK from India (Nasreen and Ayesha), Kenya (Raheema) and South Africa (Maryam), while Fatima's grandparents had come to the UK from India. All of the women had participated in further or higher education and were able to speak and read English fluently, although only Fatima described having been raised with English as what she labelled her 'main language' at home. The mother tongue of Raheema, Zainab and Maryam was Kutchi, whereas Ayesha and Nasreen spoke Punjabi.

## Procedure and management of ethical issues

Ethical approval was granted by the De Montfort University Division of Psychology Ethics Management Committee. All of the participants were provided with information sheets before agreeing to participate, and were asked to sign a consent form before each interview. Interviews were conducted primarily in English by the second author, who speaks

a number of community languages, including Kutchi. Participants were interviewed in their own homes following appropriate risk assessment procedures relating to lone working. Using the semi-structured schedule, participants were asked about their breastfeeding decisions and experiences in a broadly chronological fashion on each occasion. Both interview schedules consisted of a series of open, non-leading questions which were used very flexibly. During the first interview, participants were asked about why they had chosen to breastfeed, their positive and negative experiences of breastfeeding, and their views and practices in relation to breastfeeding in public. In the second interview they were asked in more detail about their views and experiences of a range of infant feeding practices, and there was a greater focus on exploring the nature of support that they had received from health professionals.

All interviews were audio-recorded and transcribed in full. In all instances, participants were provided with a complete transcript a few days after the interview and given the opportunity to edit any element of what they had said.

## Analysis

Following several readings and careful coding of the transcribed data, each account was initially analysed ideographically, and a set of themes for each participant was produced independently in the manner suggested by Smith *et al* (2009). Subsequently, the set of transcripts was viewed collectively, and a set of master themes which appeared to capture shared elements of breastfeeding experiences was produced. Analysis was carried out by both authors, one of whom is an insider (Langdridge, 2007) to the experience under scrutiny (i.e. she is a Muslim mother who breastfed her daughter), while the other is an outsider (i.e. a childless, non-Muslim man). We believe that this allowed us to interrogate the data through rather different lenses employing hermeneutical processes relating to both empathy and scepticism (Finlay, 2009).

## Findings

The analysis presented here is based around three of the themes which were developed from the data set, namely '*spiritual nourishment*', '*cultural and ideological synthesis*', and '*navigating modesty*.' Themes are illustrated with verbatim quotations from the transcriptions in all cases. On occasion, in the interests of economy and clarity, we have made minor edits to the

quotations. These are indicated by three ellipsis points in parentheses (...).

Before exploring the themes it should first be noted that all of the participants perceived breastfeeding as in some way imperative for Muslim women, rather than as a neutral feeding choice. Raheema stated that '*breast milk is the only milk for our children*', while Fatima referred to breastfeeding as '*an Islamic law*.' She continued:

The main reason I never thought twice about breastfeeding my child was because of my religion. Everyone I knew breastfed their babies. You didn't ask if they were breastfeeding, you just assumed.

Breastfeeding was generally endorsed by close relatives and friends. Interestingly, this finding contrasts with those of other researchers who have interviewed South Asian women, such as Bowes and Domokos (1998), Meddings and Porter (2007) and Twamley *et al* (2011), who found that many of their participants of Pakistani and Indian origin were discouraged from breastfeeding by family members, especially their infant's grandparents, who eschewed the provision of colostrum, distrusted the practice as providing insufficient milk, and perceived the provision of formula milk in bottles as reflecting a modernity and an indicator of affluence to which they aspired. Although some of our participants mentioned views like this within their extended families, only one stated that a close relative, her Sikh mother, had expressed such opinions. The nature of our sample and differences in education, socio-economic status and the migration patterns of the communities from which women in the various studies were drawn may go some way towards explaining these differences. It is also important to note that these papers focus primarily on the ethnic background of participants, rather than their religious affiliations and identities. We did not explore the extent of faith identity or the practices of the participants' families in detail, and so cannot draw conclusions about the extent to which these facets influenced the reported endorsement of breastfeeding.

### 'Spiritual nourishment'

All of the participants made reference to the '*breast is best*' message of breastfeeding promotion campaigns, and spoke positively of the role of breastfeeding in supporting their infants' healthy development. However, in addition to this recognition of the health-related benefits, they drew on an additional representation of breastfeeding as imparting moral and '*spiritual nourishment*' from mother to infant:

There is a lot of literature on the benefits to their [the child's] health, and I believe that it's the inner warmth, the

spiritual attachment that the child is getting when the mother holds her child in her arms.

(Maryam)

Maryam goes beyond standard representations of connectedness and bonding that are prevalent in both academic research and lay discourses relating to women's experiences of breastfeeding (Burns *et al*, 2010), by adding a religious dimension to the experience when she speaks of a '*spiritual attachment*' which is achieved through breastfeeding. Other participants expressed a similar idea:

I knew all the nutritious bits about breastfeeding, I read about it in books, but this was all about helping the baby's development as a person. You know all the goodness inside me as a person would be transferred to Hunzala through my milk.

(Ayesha)

There's a lot of virtue in it [breastfeeding], and spiritually it fills your baby. Every goodness of the mother is taken into the baby.

(Raheema)

Both Ayesha and Raheema use the concept of the '*goodness of mothers' milk*' by employing juxtaposed meanings of 'good' in both moral and nutritional senses. The act of suckling at the breast contributes to the infant's religious well-being through their receiving the milk of a loving mother and dutiful Muslim. Participants spoke of their joy in following Allah's will and the model set by the wives of Muhammad. Thus the act of breastfeeding becomes akin to an act of worship for the mother. The women also spoke of the rewards that breastfeeding mothers may expect in the afterlife:

I believe that every drop we feed our child, it's rewarding and we get rewarded for it, and it's like your sins are forgiven.

(Ayesha)

Every drop of milk that we produce that our babies drink, we get rewarded for every single drop (...) Our status is higher as a woman and as a mother.

(Fatima)

Some of the participants drew on a passage from the Hadith in which Muhammad describes the breastfeeding mother as being feted by angels and having her sins forgiven at the end of the ascribed 2 years of breastfeeding (Eaton *et al*, 2007):

On every drop the child takes, the angels are there tapping her on the back congratulating her, you know, on giving life to a person because every single bone and flesh is made of that milk.

(Raheema)

Furthermore, the act of suckling at the breast was believed by the participants to strengthen the child's moral character and bond with the mother:

They get all the good out of it [breast milk] and it cleans (...) their character and their personality.

(Nasreen)

It's to do with respect as well. Later on as the child grows they are reminded to respect their parents (...) The mother has a higher rank and a lot of it has to do with not only carrying the child for 9 months but also for breastfeeding. The child realises that it's because of the mother that the child is living in the world and is the person he (sic) is.

(Raheema)

The beliefs that breastfeeding would help to raise children who were more devoted to Allah and loyal to their families were a strong motivator when the mothers experienced breastfeeding pain or sore nipples:

I know the goodness that he is getting out of this [breastfeeding]. I know that this is going to make him a better person and that's what makes me more determined.

(Maryam)

The importance of breastfeeding went beyond the provision of breast milk to the infant. The act of suckling at the breast appeared to be central to the spiritual and psychological nourishing of children. Unlike white participants, who often report multiple benefits of expressing milk (Johnson *et al.*, 2009), our participants generally had little enthusiasm for pumping breast milk:

I've never tried it and I'm not for it. I feel that direct from the breast is what I want to give my child because it's the best you can give. I think the child gets more benefits when it's straight from you than from expressed.

(Raheema)

Most of the other participants in the study agreed that the benefits derived from just the 'product' of expressed breast milk were fewer than those received by the child from nursing at the breast:

When you breastfeed you are passing on these characteristics of personality through your milk to your child (...) The love and affection that a mother feels when she is nursing and the bond, the bonding processes begins here and is strengthened when you're nursing. All that as the child is feeding that's what you're putting into the child as well as the nutritious bits.

(Maryam)

All of the participants shared complex interwoven constructions of breastfeeding which saw the practice as helping to ensure the child's physical, moral and religious development while supporting mother-infant bonding and furnishing the mother with spiritual

rewards. In their accounts the women switched between Western biomedical and Islamic constructions of breastfeeding to explain its benefits. In a similar way they also integrated these influences when explaining how breastfeeding was managed and maintained.

### 'Cultural and ideological synthesis'

A significant body of literature alludes to antagonism between faith-based health ideologies and the secular biomedical model of health which is dominant in the Western world (Knott and Franks, 2007). However, contemporary health promotion and Islamic teaching about the superiority of breast milk over formula feed share similar end points, with World Health Organization targets of 2 years of provision of breast milk matching recommendations from Muslim clerics.

Zainab, reflecting on her decision to breastfeed her first child, commented:

I was actively encouraged by my midwives and (...) everything positive that has been said in the Shariah.

Nasreen developed her knowledge of the benefits of breastfeeding from antenatal classes and discussions with '*sisters at my mosque*':

I went for these antenatal classes where they [midwives] gave me leaflets on breastfeeding with diagrams (...) They were promoting breastfeeding a lot now as well as talking about the same benefits that I knew from going to the mosque.

This symmetry allowed the women to draw on ideas and advice from both sources which mutually supported breastfeeding and subsequently allowed the women an extended repertoire of options for supporting the practice of breastfeeding and managing difficulties when they arose. Thus breastfeeding was managed on a daily basis through a synthesis of culturally specific rituals and modern medicine.

Lactation was primarily promoted through a combination of diet and family support. The provision of sufficient breast milk was seen as a collective responsibility, with typically mothers and/or mothers-in-law restricting certain foods and preparing drinks that were believed to foster milk production:

Everyone in the family (...) all take part in helping the mother eat healthy and appropriate food in order for her to maintain the milk supply. Not only that, we have foods like laai, it's a milk drink with almonds and other herbs. It's excellent for making breast milk and for soothing mothers' nerves, as breastfeeding is stressful.

(Maryam)

My mother-in-law tried everything on her part to help me get as much breast milk through diet, you know. All the food cooked in ghee. No chilli powder just black pepper and ginger eaten with roti or naan. No rice or anything

starchy. She also made this drink called rub made out of ghee, flour and gur or jaggery.

(Ayesha)

However, whenever difficulties such as mastitis or cracked or bleeding nipples arose, the women utilised medical products such as nipple shields, creams or antibiotics:

In the beginning my nipples were sore, but then I started using this shield thing. I tell you that shield works bloody miracles!

(Fatima)

I had really sore nipples. I overcame that with lots of creams and nipple shields.

(Zainab)

### 'Navigating modesty'

'*Hay'a*' roughly translates from Arabic to English as 'modesty', and represents an important concept in Islam which is often overly simplified in Western discourses about the ways in which Muslim women dress and behave (Boulanouar, 2006). '*Hay'a*' is a multifaceted concept that informs the dress of both sexes. Standards of bodily modesty are derived from several sources in the Qur'an and the Hadith, and can be understood through the Arabic term '*awra*', which translates as '*that which must be covered*' (El Guindi, 1999, p. 142). The maintenance of modesty when breastfeeding was imperative to the participants, and influenced their engagement in both domestic and public breastfeeding. However, what constituted appropriate standards of modesty varied considerably among the women. Although all of them felt that it was '*haram*' (forbidden) for a woman to breastfeed openly in front of any man but her husband, the women had different views about breastfeeding in the presence of female friends and relatives, and how secluded the mother should be during breastfeeding sessions. The participants generally entertained male and female visitors in their homes in a sex-segregated manner, with men and women in separate rooms. Under these circumstances some of the participants were comfortable with breastfeeding in front of other women:

I just used to cover myself. I mean we have a room for men and a room for ladies so it was easy.

(Maryam)

I'd just tell my husband if there are any male visitors to just take them in the other room and I'd be there with the female visitors and I'd just breastfeed my child with something just covering his head or like if they were close family members, females, I'd be in full view of them so there wasn't a problem like that.

(Zainab)

When visiting others, the participants generally adapted to the circumstances of various social gatherings:

Whenever I visited my in-laws we have two sitting rooms, one for the ladies and one for the men, so I didn't have any problems. I just covered myself up just in case a male member of the family entered the room, or if they were sitting with the ladies I would just go upstairs.

(Ayesha)

The issue of breastfeeding in public elicited a varied set of experiences, and represented a particular challenge for some of the women who were generally not in favour of feeding expressed breast milk from a bottle, and eschewed supplementary formula feeding. For Maryam this meant returning home whenever the baby needed feeding:

We feel we can't feed the baby in public.

For others it meant trying to find private space to feed the infant, either in shops or other facilities with specific feeding facilities, or in public toilets:

I've never fed in public. I used to go into 'Mothercare', the feeding rooms. I'm a bit shy. I can't just pull up and start feeding in front of anyone. I'm not comfortable.

(Ayesha)

I have found myself sometimes like in a public loo somewhere and breastfeeding my child which is not very nice (...), but there was nowhere I could go to find a discrete corner to breastfeed (...) sometimes the toilets were really filthy.

(Zainab)

The women tended to carry blankets and scarves to cover themselves when feeding their infants away from home. Some believed that their style of dress facilitated feeding in public. Women who routinely wore the *abayah* said that this meant that they could wear garments underneath that facilitated feeding the baby comfortably and discretely:

Loose clothing also helps. Normally I would wear something with a front opening and have blankets with me at all times so when you're shopping and out of the house you can cover yourself and feed your baby.

(Raheema)

Recently introduced legislation in the UK upholds and protects the rights of women to breastfeed an infant of up to 26 weeks in public areas (Home Office, 2010). However, many researchers (Bartlett, 2002; Boyer, 2011) have shown how discomfort about the performance of public breastfeeding and the need for observance of breastfeeding etiquette which favours discretion and perceived propriety influence the behaviours and emotions of women across cultural groups.

## Discussion

In this closing section we discuss the findings further in relation to extant theory and research, and consider their implications and applications. We also reflect on some of the ways in which the researchers' perspectives and experiences may have shaped both the accounts that were collected and the sense that we have made of them.

Although the women were from varied backgrounds, there were high levels of convergence in their accounts of breastfeeding, especially in relation to religious aspects and influences. One area of variability concerned the topics of managing feeding outside the house, and the desirability of expressing milk. One participant (Fatima) spoke about expressing in generally favourable terms, as a pragmatic solution to feeding in public and sharing feeding responsibilities with other family members. Her views are similar to those voiced by other British women (Johnson *et al*, 2009), but they differed markedly from the views of the other participants, many of whom endured significant pain with teething infants, and chose to manage their activities around the ability to nurse their infant privately. This area may be a fruitful avenue for further investigation. It may also be advantageous to expand the research to a more diverse group of Muslim women, drawing from communities which were under-represented in this study, such as white and less educated Muslim women. The infant-feeding decisions and experiences of individuals and communities who share a faith are also shaped by a multitude of structural and ecological influences at both micro and macro levels. Furthermore, theorising and researching religious influences and identities and how these merge and diverge is challenging, especially in relation to maintaining methodological rigour and determining how findings can best be represented in a climate of cultural Islamophobia (Vakil and Sayiid, 2010). Nonetheless, the apparent salience of and frequency of reference to sacred texts and Islamic values about motherhood and modesty suggest that, although our sample was small, our findings may have some transferability to other groups of Muslim women, especially those residing within Western countries with similarly organised health and education systems.

Our findings have implications for health professionals who work with Muslim women. They indicate a marked need for tact in areas such as promotion of the practice of expressing breast milk. They also suggest that Muslim women who have severe difficulties with breastfeeding may be especially vulnerable to distress. One woman in our study (Ayesha) experienced significant feeding difficulties. She was advised by doctors to discontinue exclusive breastfeeding when her infant was three and a half months old,

because he was markedly underweight, failing to thrive and required several days' hospitalisation for dehydration. Ayesha described an emotional reaction to the premature cessation of breastfeeding and said that she felt guilt, self-blame and a sense of inadequacy as a mother and as a Muslim. She reported that her relatives were mystified that Allah's gift of breast milk should prove inadequate for any child's development. Other women in the study also believed that Muslim mothers who were unable to breastfeed were likely to become depressed because of the religious significance of the act. This suggestion of a relationship between happiness and successful breastfeeding is borne out by the findings of a quantitative study of British Muslim women from Bangladeshi and Pakistani communities (Noor and Rousham, 2008). It was found that those women who exclusively breastfed their infants reported significantly more positive affect than those who used either formula or mixed feeding methods. The correlational nature of some of Noor and Rousham's results may reflect the effects of postnatal depression on breastfeeding participation, as has been suggested elsewhere (Dennis and McQueen, 2009). Nonetheless, their findings, alongside our own, suggest that culturally specific interventions that promote the maintenance and duration of breastfeeding may serve to facilitate maternal well-being. Such initiatives may be most effective at community level. Most of the women in Noor and Rousham's study were unemployed prior to becoming pregnant, and only 15% reported attending antenatal classes. However, breastfeeding promotion is an ideologically and ethically complex arena (Kukla, 2006), and it is essential that interventions do not inadvertently position women who are unable or unwilling to breastfeed as 'bad' mothers. Recent research has shown how overzealous employment of the hegemonic '*breast is best*' discourse can have harmful effects on women who are struggling with breastfeeding (Williamson *et al*, 2011), and given the additional religious significance of a continued period of breastfeeding voiced by our participants, Muslim women who experience breastfeeding difficulties may be at particular risk of mental health problems.

It is also beneficial for health professionals to be aware of some of the cultural rituals practised by some Muslim women and their families, and useful for these professionals to see how family support systems and strategies operate. Our findings with regard to modesty show that, for women who require longer periods of hospitalisation following the birth of their infants, issues related to ensuring privacy of breastfeeding on the ward are likely to be of paramount importance, even when visitors are (male) family members.

Within the social sciences, we are accustomed to ideologies of biomedicine and faith being positioned as opposed to one another. However, the findings of this study show how the juxtaposition of scientific and

faith-based discourses can, on occasion, prove to be synergistic, despite deriving from very different ontological positions. In engaging and responding to both sets of resources, our participants had an increased range of material, social and psychological tools to draw upon to support their breastfeeding. Islamic constructions also appeared to acknowledge the labour and challenges of breastfeeding for mothers, something which can be under-recognised in other contexts (Dykes, 2005).

Interpretative phenomenological analysis aims to give voice to and make sense of participants' accounts (Larkin *et al*, 2006). By conducting the research in the participants' homes, with a Muslim interviewer who was able to speak some of the community languages spoken by the participants, this study went some way towards ensuring that the women felt at ease when discussing an intimate behaviour. Institutional Islamophobia remains widespread in the UK (Laird *et al*, 2007), and scholarly research into everyday Muslim practices is rare (Abu-Raiya and Pargament, 2011). These factors may have led to reticence on the part of our participants, especially with regard to how we would interpret and report their data. Much of the material relating to our theme of 'spiritual nourishment' was given by the women in the third person rather than the first person, and/or using a plural rather than individual voice, resonant of collective cultural understandings. IPA adopts a critical realist ontology, and is premised on both the generation of unique individualised accounts and the representational validity of language (Eatough and Smith, 2008). Participants may be unable or unwilling to articulate some elements of embodied experience, especially those of an intimate, symbolic and metaphysical nature. It may be that IPA is not adequately developed to capture shared understandings which draw heavily on cultural discourses. Breastfeeding narratives are rarely easy for women to provide. Through the use of a follow-up interview, we aimed to create a context of trust and continuity to elicit the disclosure of personal experiences. It is possible that the employment of a phenomenological paradigm might be further enhanced through a less intrusive method of data collection, perhaps by the use of daily written or audio diaries. Fuller exploration of collective understandings and constructions as voiced by the women is also merited, and might benefit from the utilisation of focus group methodology.

A developed account of reflexivity is a key criterion of an IPA analysis (Reid *et al*, 2005). We have tried at all stages of the research process to engage with the material through what Trinh (1989, p. 78) has described as a '*self-reflexively critical relationship*.' The interviews were conducted by a Muslim woman of a similar age to the participants, who was born in Malawi but who was raised and now resides in the

UK, who practises her faith by aiming to observe the five pillars of Islam, and who had largely positive experiences of breastfeeding her own infant. It is arguable that a potentially pro-breastfeeding and pro-Islamic discourse was introduced at an early stage to the research process and to related materials which may have influenced which women agreed to take part in the study and the accounts given by those who did so. Basit (2010) cautions against the creation of a halo effect in which encouraging interviewees draw out accounts which match their own knowledge or expectations and fill in contextual gaps as required. The data were analysed jointly by the interviewer and the first author, who has a long-standing interest in Islam, is sensitised to the extent, nature and currency of Islamophobic discourse in contemporary Europe, and who has worked as an anti-racist practitioner in the areas of health and education for many years. Drawing on the work of Chaudhry (1997), we have reflected on the ways in which our motives to produce a set of findings that can enhance intercultural understandings and show Islamic influences in a positive way, for reasons both personal and professional, shaped our analysis. In a relatively large data set, however systematic and rigorous their analytical strategy and processes, qualitative researchers inevitably prioritise some data over others, and are likely to be drawn to those utterances that resonate with their own experience or world view. We have not aimed to suppress material that might be seen as problematising aspects of Islam or breastfeeding, but the selection of and commentary on the extracts that form the core evidence of an analysis is not a neutral process, however cognisant researchers are of their own perspectives. In the spirit of the interpretational framework that we have employed, we offer these observations not as confession but rather as a lens through which we encourage the reader to consider the findings we present.

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## Conclusion

We interviewed a small sample of well-educated British Muslim women who offered accounts of breastfeeding which blended biomedical and Islamic constructions and discourses of breastfeeding with the more culturally specific representations typically being prioritised. The perceived guidance of Islam appears to unite the women's perspectives on breastfeeding, even though they trace their heritage to various parts of Asia and Africa. An understanding of these constructions, their salience and implications is essential for health practitioners working with mothers of the Islamic faith.

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#### CONFLICTS OF INTEREST

None.

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