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Navigating Work and Breastfeeding: A Qualitative Exploration of Breastfeeding Experiences among Nurses and Support Staff in South India

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What is already known on this topic?

- Good knowledge of breastfeeding benefits and practices.
- Improved breastfeeding practices in successive pregnancies.
- Cultural practices and professional commitments hinder optimal breastfeeding.

What this study adds on this topic?

- Health sector employees struggle with cultural customs and gender preferences.
- Lack of awareness among partners about the importance of delaying post-partum sexual intimacy contributes to stress.
- Lower-cadre employees face job loss and lack health literacy, necessitating the need to address systemic barriers.

ABSTRACT

Objective: The personal experiences of breastfeeding healthcare workers may influence the quality of breastfeeding support provided. This study explored the breastfeeding experiences of nurses and support staff in South India.

Materials and Methods: A qualitative exploratory study using focus group discussions (FGDs) was conducted among nurses and support staff of a newly established tertiary care hospital in South India. Purposive sampling was used, and written consent was obtained. Three FGDs were conducted in English and in local language by trained personnel. Audio recordings were transcribed, coded using Atlas Ti, and analyzed thematically. New themes from each FGD were integrated into later discussions until saturation was achieved in the third FGD.

Results: Participants, primarily aged 30-35 years, encountered cultural pressures, fears of job loss, and insufficient workplace support while breastfeeding. Maternity leave varied with some participants having experienced job loss. Facilitators for exclusive breastfeeding included support from colleagues and friends, private lactation rooms, and adequate leave. Harmful cultural practices suggested limited health literacy. Reduced milk supply, lack of awareness about expressed milk, inadequate storage facilities, and job stress led to a preference for bottle feeding. Participants also highlighted a lack of spousal understanding concerning shared responsibilities and sexual intimacy following delivery. They expressed a desire for paid leave with job security, designated breastfeeding areas, and the normalization of public breastfeeding.

Conclusion: Breastfeeding challenges for nurses and support staff in South India stem from societal pressures and work demands. This study emphasizes the need for multi-level interventions to empower them in effective breastfeeding practices.

Keywords: Breastfeedingnurses, workplace support, maternity leave, workplace lactation

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INTRODUCTION

In recent years, economic growth and rising living costs have driven many women to join the workforce, enhance their families' financial stability, and foster a sense of empowerment.[1] However, the struggle to balance work, motherhood, and family responsibilities can create inner conflicts and impact interpersonal relationships.[2] The challenges faced by working mothers are compounded by societal expectations and the cultural norms surrounding motherhood, which can further complicate their experiences.

A crucial source of support during motherhood comes from nurses and midwives, who play essential roles in various aspects of maternal care.[3] Recognizing their vital contributions,

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the World Health Organization designated 2020 as the "International Year of the Nurse and Midwife," emphasizing the importance of supporting these professionals.[4] However, many mothers report receiving insufficient guidance from healthcare workers on breastfeeding.[5] Factors such as increased workload, staff shortages, and insufficient training have resulted in significant gaps in breastfeeding support services.[6,7]

Additionally, healthcare workers themselves face significant challenges in exclusive breastfeeding.[8] They face issues common among most working women, such as inadequate maternity leave, inflexible working hours, and workplace stress.[9,10] Among Indian healthcare workers, socio-cultural beliefs and practices related to breastfeeding greatly impact their ability to practice optimal breastfeeding.[11] Furthermore, personal experiences of breastfeeding may affect the quality of support provided to mothers. However, breastfeeding practices vary significantly, with lower breastfeeding rates among lower-cadre healthcare personnel due to inadequate knowledge, support, and resource constraints.[12]

While previous research on breastfeeding experiences in the healthcare sector has primarily focused on doctors and nurses, there is a notable gap in understanding the experiences of female support staff. This population plays a crucial role within the healthcare team by maintaining a clean and supportive environment for breastfeeding mothers in healthcare settings.[13] Their attitudes and knowledge about breastfeeding can significantly influence the overall culture of support within a facility. Moreover, support staff often come from diverse socioeconomic and educational backgrounds, which may shape their attitudes, beliefs, and practices related to breastfeeding. Recognizing these complexities can guide the development of targeted interventions and support systems that empower support staff to effectively promote and assist breastfeeding among the women they serve, which is especially vital in resource-constrained countries like India.

This study aimed to understand the breastfeeding challenges encountered by working women in the healthcare sector of South India, focusing on nurses and support staff, and to identify potential solutions for fostering a breastfeeding-friendly work environment.

MATERIALS AND METHODS

Setting and Participants

An exploratory qualitative study using the focus group discussion (FGD) method was conducted among cadres of healthcare personnel comprising nurses, nursing attendants, and housekeeping staff at a newly established tertiary care hospital in the State of Andhra Pradesh in Southern India after obtaining approval from the All India Institute of Medical Sciences, Mangalagiri Ethics Committee (approval number: AIIMS/MG/2020-21/IEC–22, date: July 21, 2020). Participants included in the study were healthcare personnels who had worked at the hospital for a minimum of 6 months, were willing to participate in discussions, had given birth to at least 1 child, and could communicate in either English or in the local language, "Telugu." Exclusion criteria consisted of individuals who were on leave during the study period or those who declined to participate after being informed about the study.All procedures complied with institutional and national ethical standards and the 1964 Helsinki Declaration. Informed consent was obtained from all participants.

Sampling and Study Procedure

Using purposive sampling, 3 FGDs were conducted with participants during separate sessions at times and locations that were convenient for them. Each participant was assigned an identification number to replace her name in the transcripts, ensuring anonymity. Basic demographic information was collected from the participants. The FGDs were conducted using a guide that was developed following a thorough review of the relevant literature. The FGD guide comprised a series of questions designed to explore participants' knowledge and experiences regarding breastfeeding. Participants were asked how they first learned about breastfeeding, with a probing question about who was the first person to discuss it with them. They were invited to share their personal experiences with breastfeeding, particularly those who had given birth multiple times, reflecting on their journeys throughout their pregnancies. The guide included inquiries about breastfeeding practices at the family and community levels, prompting participants to identify practices they found beneficial or harmful. Participants were also asked if they had heard that infants should be exclusively breastfed for the first 6 months and to share their views on this recommendation. Further questions addressed why some women choose to use formula feeds and bottle feeding, as well as whether participants perceived differences in breastfeeding practices between working and non-working mothers. The guide encouraged participants to discuss barriers and facilitators they observed for breastfeeding in the workplace. Additionally, participants were asked what kind of support should be available at home and in the workplace—from family, friends, colleagues, and employers—to make breastfeeding more comfortable for women. Lastly, the guide included questions about participants' awareness of government policies aimed at supporting breastfeeding mothers, their perceived usefulness, and suggestions for how these policies could be structured to effectively promote comfortable breastfeeding in workplaces.

Data Collection

Written consent was obtained from all participants, who also agreed to have the sessions audio-recorded. For those who were unable to provide a written signature, a thumb impression was collected as a form of informed consent. Participants were informed about the study's purpose, and their rights were emphasized, including the option to withdraw at any time without any repercussions. The sessions were conducted separately for housekeeping staff and nursing attendants in their preferred language, "Telugu." The third FGD was held with 8 nursing staff members in their preferred language, English. This approach was crucial in fostering an environment where participants felt comfortable sharing their thoughts and experiences. All FGDs were audio-recorded, with each session lasting between 45 and 50 minutes. Sufficient time was taken between successive FGDs to ensure the transcription and translation of the entire audio recordings.

During the data collection process, the research team actively engaged with the transcripts and notes, performing content

analysis to identify emerging themes. As new themes surfaced in each FGD, they were incorporated into the discussions of subsequent groups, allowing for a dynamic and iterative exploration of the topics. This adaptive approach continued until saturation was reached, which occurred during the third FGD, indicating that no new information was being generated.

Research Team

All FGDs were conducted by researchers trained in qualitative research methodology. The team included a facilitator, a recorder, and a transcriber/translator, all from the Department of Community and Family Medicine at the same institution. The facilitator guided the discussions, the recorder captured key points, and the transcriber/translator managed transcription and translation. This collaborative approach improved data collection and ensured effective communication throughout the research process.

Data Analysis

The analysis began with the researchers listening to the audio recordings and transcribing them verbatim. The "Telugu" transcripts were translated into English. Researchers carefully read the transcribed data multiple times to achieve a deep understanding of the material. All data were anonymized to ensure confidentiality. The transcription and coding were conducted using Atlas Ti, a qualitative data analysis software that facilitated a systematic approach to analyzing the discussions. Two primary researchers independently analyzed the text, identifying key themes, sub-themes, and notable quotes from participants. This independent analysis was followed by a triangulation process, where the researchers compared their findings to verify and finalize the results, ensuring the reliability and validity of the data. This collaborative verification ensured the reliability and validity of the data, reinforcing the integrity of the research outcomes.

RESULTS

Socio-Demographic Characteristics

A total of 22 participants took part in the study. This comprised 8 nurses, 7 nursing attendants, and 7 housekeeping staff. Most participants were in the age range of 30-35 years and had breastfed at least once in their lifetime. None of the participants were breastfeeding during the study period.

Themes

The key themes and sub-themes identified were breastfeeding knowledge and practices of participants (perception of breast milk, sources of information: advantages and disadvantages, personal experiences, challenges); community practices and cultural beliefs (beneficial and harmful practices, superstitions, gender preferences—breastfeeding biases, food restrictions); working vsnon-working mothers (feasibility, diet, self-care, storage of breast milk); enablers and barriers; and suggestions for effective breastfeeding (individual, family, and societal levels).

Breastfeeding Knowledge

Participants consistently viewed breast milk as the best option for infants. The main sources of information on breastfeeding were identified as healthcare workers and older female family members at home. The benefits of breastfeeding included improved health, lifelong immunity, reduced cancer risks, enhanced bonding, and stress relief. They expressed themselves as follows:

Mother's milk is pure and free from impurities, unlike cow or buffalo milk, which must be boiled or sterilized before feeding to a child. We can't always guarantee that milk is properly sterilized and uncontaminated, making mother's milk the best option. (Participant 4)

Breastfeeding Practices

Nearly all participants had breastfed at least once. Many experienced breast lumps or tenderness after extended periods without breastfeeding due to illness or work. Some found it difficult to re-breastfeed after recovery due to low milk production. Participants indicated that they gained a better understanding of breastfeeding in subsequent pregnancies. They also encountered difficulties with initiating breastfeeding after caesarean sections or when the baby required care in an incubator or Intensive Care Unit. They expressed themselves as seen in the following quotes.

First three days I didn't secrete any breast milk as I had undergone a caesarean section. We fed formula feed to my baby for those three days and the baby seemed to get used to it. Even when I started secreting milk, she refused to suck. It took many days for us to gradually wean her off from formula feed and get her accustomed to breastmilk. (Participant 5)

When I rejoined work after delivery, milk would get solidified in one breast and overflow from another breast. I had painful breasts and fever at that time. After coming home, I used to squeeze out and discard the milk which was stored in my breasts since morning and then breastfeed with leftover milk. My mother-in-law told me to do so. (Participant 14)

Community Practices

Most participants considered traditional food practices, such as using fenugreek seeds, garlic, small dried fish, sesame seed extract, and raw or ripe papaya, to be beneficial. Participants were unsure about harmful practices but believed ignoring elders' advice could harm the baby. Most participants were also fed only bread or rice cake with milk or coffee initially. Pulses and non-vegetarian items were avoided for weeks to months. Leafy vegetables and milk with asafoetida were thought to boost milk production, while beans, brinjal, and sorrel leaves were considered harmful. Bottle feeding was considered harmful. This is how they narrated it:

My mother used to make curry from telaga pindi (sesame seeds). She used to say that we secrete more milk if we consume it. (Participant 1)

Bottle feeding is harmful, but every mother has a bottle in her bag. Instead of breastfeeding, they use teats and nipples to quiet crying babies. Even three-year-olds are given milk or water in feeding bottles. (Participant 10)

Cultural Beliefs

Some participants believed tying a cloth around the abdomen after delivery prevented a bulkier abdomen, while others, especially those who had undergone caesarean sections, considered it harmful. Additionally, women were often advised to

apply turmeric to their feet. Many were advised against using cold water for bathing or drinking, fearing it could make babies ill. This is how they narrated it:

After my delivery, I ignored my mother's advice and bathed with cold water while she was at work. Baby fell sick due to that. Everyone was wondering why it was not reducing at all. Later I told my mother that I was bathing with cold water and she scolded me for not following her instructions. (Participant 9)

My mother told me that wiping a baby's lips with a wet cloth after breastfeeding will prevent the lips from turning dark. (Participant 14)

I know a mother who kept various items like a slipper, broom, and lemon around her bed. Despite my concerns about hygiene and infections for the baby, her family insisted these items were necessary to ward off the evil eye and ensure the baby slept well. (Participant 15)

Gender Preferences

Gender preferences were evident, as one nurse recounted a case where a mother with 4 daughters sought a male child and exclusively breastfed the son while neglecting the daughter. Participants noted that dietary restrictions for mothers of male infants lasted longer than for those with female infants, reflecting community beliefs about gender. Additionally, there was pressure on women with female children to conceive again quickly based on the belief that a subsequent pregnancy would likely result in a son.

Working vs Non-Working Mothers

Feasibility

Many participants noted that exclusive breastfeeding is possible for working mothers if they receive 6 months of maternity leave; otherwise, workplaces should provide supportive breastfeeding environments. Night shifts complicate breastfeeding, and while non-working mothers may have more opportunities, they often lack knowledge, whereas working mothers have knowledge but limited time. This is what they had to say:

Reflexes are less in a working woman, so milk production will be less compared to a woman at home. (Participant 1)

Every child has the right to be breastfed, so every mother should get at least six months of maternity leave, regardless of their job type. (Participant 3)

With family support, both working and non-working women can exclusively breastfeed; without it, neither can succeed. (Participant 12)

Diet and Self-Care

Many of the participants said that working mothers lacked time for proper meals and self-care while managing sleep deprivation, diaper changes, and breastfeeding demands. Carrying diverse foods to work was also difficult. Non-working women had more time and flexibility with meals at home. One participant expressed this way:

I was advised to rest after delivery but I tried to do some chores 2-3 days later. My aunt warned me to rest now, as no one would encourage it later. (Participant 6)

Challenges in Exclusive Breastfeeding

Working women often opted for bottle or formula feeding mainly due to time constraints. Working and non-working women also faced common challenges in breastfeeding. This is how they narrated it:

Women these days are not trying enough to breastfeed the baby. Previously women used to make multiple attempts trying different kinds of food, methods etc. to increase the production of breast milk. But this generation is not taking exclusive breastfeeding seriously. (Participant 8)

Bottle feeding is preferred as it is easy (for the child to suck and the baby immediately stops crying. They take some time to stop crying when offered breast milk as they have to make an effort to latch on and suck milk. (Participant 11)

Dresses which have zip system for comfortable breastfeeding are being worn. But I also accept that while traveling in buses and other public transport, women prefer bottle feeding, due to lack of privacy. (Participant 18)

Storage of Breast Milk

Working mothers faced challenges in expressing and storing sufficient breast milk due to a lack of refrigeration facilities and time. This is what they had to say:

The milk once expressed can only be re-expressed after two hours, so in that sense it is difficult for working women to express sufficient milk in the morning for the whole day and store it. (Participant 4)

If breastmilk is expressed and stored, there might be chances for germs to grow in it. So it is better to do direct breastfeeding than store breastmilk. (Participant 10)

Enablers and Barriers in Breastfeeding

Table 1 summarizes the enablers and barriers in breastfeeding among nurses and support staff. Their expressions are illustrated below:

In some families, women cannot stay home for months without working, as both spouses need to earn. In such cases, mothers

Table 1. Breastfeeding Enablers and Barriers Identified by the Participants

Enablers	Barriers
• Supportive workplace policies—paid maternity leave, flexible break time	• Night shifts
• Breastfeeding corners/ lactation rooms	• Emergency duties
• Support of colleagues and supervisors	• Stressful work environment
• Refrigerator and breast pump equipment	• Unsupportive colleagues or supervisors
• Clean, well-ventilated creche with cradles and toys	• Cultural beliefs and practices
• Residing near the workplace	• Distance from family and lactation consultants
• Breastfeeding education and support facilities	• Lack of sensitization among staff

may have to return to work within 2-3 months of delivery else they have to struggle for food. (Participant 5)

There is no designated area in public places to breastfeed the baby. There is no privacy for the mother to breastfeed. (Participant 8)

Suggestions for Effective Breastfeeding

Participants emphasized the need for breastfeeding promotion at individual, family, and societal levels.

Individual Level

Participants expressed the need for education on breastfeeding from knowledgeable health personnel during the antenatal period to enhance their ability to breastfeed effectively. Some participants had these to say:

A mother must be self-motivated to breastfeed. If she is determined, she will overcome obstacles from family or employers. (Participant 7)

Some mothers won't breastfeed the child if they think it affects their beauty or deforms the shape of their breasts. So even if they are not working and are at home, they prefer not to give breastmilk. (Participant 20)

Family Level

Participants expressed several expectations for their spouses, including taking on household responsibilities independently, providing emotional support, and focussing on the mother's nutrition. They emphasized the importance of caring for the baby when the mother is tired by changing diapers, bathing, and playing, etc. Additionally, participants expected their spouses to assist with visitors and traditional ceremonies after delivery. Participants expressed expectations from spouses, including:

Husbands may feel anxious after delivery due to unmet physical needs, but they must understand that new mothers are exhausted and need time to recover, often lacking interest in intimacy. (Participant 18)

Societal Level

Friends can help alleviate stress by breastfeeding the baby when the mother struggles with milk production or needs to work. Participants highlighted the importance of public awareness campaigns, self-help group involvement to dispel misconceptions, ongoing promotion by allied sectors, and integrating breastfeeding education into high school curricula. Participants expressed expectations from the general public, including:

Men should not stare while a woman is breastfeeding, that is the biggest help they can do. (Participant 6)

Sometimes we breastfeed in a hurry and we cannot cover properly. At that time, it would be better if the men move away from that place. (Participant 10)

DISCUSSION

This study explored the experiences of women working in healthcare, given their unique position of supporting breastfeeding in their professional capacity while simultaneously being mothers with their own personal breastfeeding journeys. It also aimed to understand the different factors that influenced breastfeeding practices and to gather practical insights for creating a breastfeeding-friendly workplace.

The results of this study highlight a significant level of knowledge among the participants regarding the advantages of breastfeeding as reported earlier.[14] The significant contributions of healthcare workers and female elder members in shaping breastfeeding practices are consistent with prior research, underscoring their influential role in guiding mothers during this critical period.[14,15]

A key finding of this study is that multiparous participants had improved breastfeeding practices, consistent with previous reports of better understanding in later pregnancies.[10,16,17] This highlights the value of hands-on learning and the need for targeted interventions for new mothers to fill knowledge gaps. A concerning finding from this study is that some participants opted for formula feeding instead of breastfeeding, as reported earlier in a study from India.[18] This is concerning due to the participants' healthcare background and highlights the need for comprehensive training and support, particularly for nurses and support staff.

Additionally, this study found various cultural practices deeply rooted in the community, some of which may not effectively support optimal breastfeeding. The transmission of these customs aligns with previous research, emphasizing the lasting influence of customs enforced by mothers and mothers-in-law.[19,20] Gender disparities were also found to affect the breastfeeding practices, especially among those from lower socioeconomic backgrounds, aligning with previously published data from India.[21,22] Given the significant influence of older women in breastfeeding practices, it is vital to involve them in discussions about safe, evidence-based practices during pregnancy and postpartum.

Most participants reported facing significant challenges in breastfeeding due to professional commitments like emergency duties, night shifts, and long commutes, disrupting their breastfeeding routines. This, along with fatigue and inadequate nutrition, affected milk production and breastfeeding duration. These findings echo past research showing nurses and support staff struggle to exclusively breastfeed due to time constraints and low milk production, often resorting to bottle or formula feeding.[18,23] Many participants also mentioned struggling to find time to express and store milk, lamenting the lack of refrigeration facilities at work, which underscores the logistical challenges in breastfeeding as reported earlier.[23-25]

However, participants noted that both working and non-working mothers encountered the absence of designated breastfeeding areas in public spaces, uncomfortable clothing for breastfeeding, and shared women's concerns regarding their physical appearance while nursing, reflecting a broader concern about the commitment to breastfeeding in contemporary society.[26, 27]

As reported earlier, the participants noted that supportive colleagues, workplace policies like paid maternity leave, flexible arrangements, breastfeeding corners, and well-equipped childcare centers facilitated breastfeeding and enhanced

maternal well-being.[6,23,28] In contrast, the lack of designated breastfeeding areas, night shifts for lactating workers, and inadequate childcare facilities obstructed successful breastfeeding, reinforcing previous research on insufficient workplace support.[28]

For successful breastfeeding, participants emphasized the need for breastfeeding promotion at individual, family, and societal levels. As reported earlier, antenatal education by professionals provides knowledge and confidence to overcome breastfeeding challenges and obstacles.[29] Similar to previous studies, participants stressed the significance of spousal support and shared domestic responsibilities.[30-32] Notably, participants emphasized that men need to recognize that their partners require time to recover physically and emotionally before resuming sexual intimacy. This is especially important in conservative societies with limited communication, which can be improved through public education and professional communication before hospital discharge.[33] At the societal level, participants highlighted the importance of normalizing breastfeeding among the general public, ensuring stigma-free public spaces, and utilizing pre-existing community frameworks in breastfeeding promotion.[26,34]

The strengths of this study lie in its focus on the real-life experiences of nurses and support staff in southern India and the socio-cultural factors affecting breastfeeding practices, offering valuable insights into the barriers and facilitators. The study's limitations include a focus on staff from a single facility, potential biases in self-reported data, and the lack of currently breastfeeding participants, who may have provided valuable insights. Additionally, there was insufficient exploration of cadre-specific discrimination in breastfeeding support and its impact on the women served.

CONCLUSION

This study highlights the personal experiences of women in the healthcare sector in southern India and emphasizes the need for comprehensive interventions to support breastfeeding among nurses and support staff. While participants demonstrated good knowledge, they encountered cultural and workplace barriers. Key facilitators included paid maternity leave and spousal support, while obstacles comprised night shifts and inadequate facilities. Participants recommended a multilevel strategy incorporating professional antenatal education, spousal involvement, workplace support, public awareness, and policy reforms to address systemic barriers.

Empowering families and addressing cultural beliefs are essential for creating a breastfeeding-friendly environment. Future research should examine how the personal beliefs and experiences of nurses and support staff influence the quality of breastfeeding support. Additionally, it should focus on developing interventions to address the significant societal barriers that these healthcare personnel encounter in their efforts to support breastfeeding.

Availability of Data and Materials: The data that support the findings of this study are available on request from the corresponding author.

Ethics Committee Approval: This study was approved by the All India Institute of Medical Sciences, Mangalagiri Ethics Committee (approval number: AIIMS/MG/2020-21/IEC-22, date: July 21, 2020).

Informed Consent: Written informed consent was obtained from the participants who agreed to take part in the study.

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