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Family and religion's influence on Arab immigrant mothers' initiation and exclusive breastfeeding

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ABSTRACT

Breastfeeding is known to provide health benefits for newborns and breastfeeding mothers. The World Health Organization and Health Canada recommend exclusive breastfeeding for the first six months of an infant's life. However, the rates of exclusive breastfeeding practices among Arab immigrant mothers are lower when compared with rates for non-immigrant Canadian mothers and mothers in the immigrants' countries of origin. Critical ethnography was used to explore the breastfeeding practices among immigrant Arab mothers in Alberta, Canada, and factors influencing their decision or ability to breastfeed exclusively. Face-to-face interviews were conducted with 10 participants, followed by thematic analysis of the qualitative narrative data. The results indicated that family and religion are the sociocultural factors that primarily influenced the mothers' initiation and exclusive breastfeeding practices. The findings from this study can facilitate culturally safe and sensitive interventions to address Arab mothers' breastfeeding needs and promote exclusive breastfeeding within this population in Canada.

Key Words: Exclusive breastfeeding, Critical ethnography, Arab mothers, Breastfeeding, Canada

1. INTRODUCTION

Breastfeeding is universally recognized as the most appropriate method of infant feeding.^[1] WHO and Health Canada recommend breastfeeding as the sole source of nutrition for healthy, full-term babies,^[2,3] with no supplementation of any liquid or solids apart from vitamins, minerals, and medications where appropriate for at least the first six months of an infant's life.^[4] This practice is known as exclusive breastfeeding. Although breastfeeding initiation rates in Canada are high immediately after birth (90.3%), by six months of age, only 13.8% of babies are breastfed exclusively.^[5] Therefore, breastfeeding practices within Canadian society are considered a public health issue due to the many associated health benefits and cost savings to health care.^[6-8]

New immigrants in Canada are more likely to initiate breastfeeding than their Canadian-born counterparts.^[9,10] However, by 16 weeks postpartum, immigrant mothers are significantly less likely to opt for exclusive breastfeeding (50.7%) in comparison to non-immigrant Canadian mothers (70.9%) and mothers in the immigrants' countries of origin.^[11] Several studies reported that the most crucial factor that led mothers to breastfeed rather than bottle-feed was support from the infant's grandmother or other family members.^[12,13] Nikaiin et al. found that lack of social support from parents and spouses was a source of discouragement for continuing the practice of breastfeeding among Arab mothers living in Qatar.^[14] Consistent with results from other studies, they found an association between social support for breastfeeding, especially from the infants' grandmothers, and maternal-infant feed-

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ing choices. Among Canadian mothers, Millar and Maclean observed a sharp drop in breastfeeding within a few weeks of leaving the hospital where social support was absent.^[15] A lack of reinforcement by the family or community also resulted in low exclusive breastfeeding rates.

Traditionally, roles in Arabic society are delineated according to gender,^[14,16] which can inhibit breastfeeding among Arab mothers. The role of women is restricted to child-bearing, child-rearing, and house chores. The role of men is to provide for the family and ensure that their financial needs are met. Men are rarely involved in aspects related to child-rearing.^[14,16] Under such circumstances, women's lives become busier postpartum, particularly among working women who are also expected to continue maintaining the traditional child-rearing roles.^[17,18]

In Arab society, customs around childbearing and child-rearing are informed by the religion of Islam, which supports breastfeeding. Islamic religious beliefs also prohibit the exposure of intimate parts of a woman's body in front of those not considered as close family members.^[19] Many Muslim mothers are thus unable to breastfeed due to a lack of privacy in hospitals or public places (e.g., shopping malls), causing them to wean early.^[19]

From the literature, it is evident that understanding the family context and religiously endorsed cultural values and practices of breastfeeding among Arab mothers during the postpartum periods is necessary to initiate and sustain successful exclusive breastfeeding. In the current literature, few studies have examined breastfeeding among immigrants in Canada. Secondly, an extensive search of the literature failed to identify an in-depth understanding among health care practitioners (HCPs) of the sociocultural factors that influence Arab mothers' breastfeeding practices in Canada. Therefore, this qualitative research aimed to explore the sociocultural factors that influence the initiation and exclusive breastfeeding practices among Arab immigrant mothers. The findings from this study can contribute to the development of mother-centered services and health education programs that support the initiation and sustainment of exclusive breastfeeding practices among Arab mothers.

2. METHODOLOGY

2.1 Theoretical framework: Critical Social Theory (CST)

The theoretical foundation for this qualitative study was based on Critical Social Theory (CST), which emphasizes language, power relations, and the social processes associated with knowledge. Thomas (1993) suggested that this theoretical framework advocates for a type of consciousness

that recognizes, acknowledges, and understands how social structures, like family and religion, work to influence Arab women's experience.^[20]

Carspecken's critical ethnographic method (1996) is used in this study as immigrant women of Arab origin come from cultures significantly different from those in Canada.^[21] Further, immigrant mothers can be subjected to discrimination due to their racial and cultural orientations, which inhibits their level of access to opportunities.^[22] Findings from various studies highlight the historical marginalization of visible minorities in Canada with immigration status, gender relations, and cultural values creating a background that influences infant feeding practices in recently immigrated mothers.^[9,10] Critical ethnography, which has CST as its theoretical foundation, facilitates Arab mothers to have more authority to express their perspectives, challenges, and desires using the language of their choice. It also empowers them to address unequal power relations and gain a new understanding of factors that influence their health care practices through empowerment and critical thinking.^[23]

Participant inclusion criteria were as follows: Arab mothers living in a metropolitan city in western Canada; who were within six months postpartum; aged 18 or older; able to give informed consent; and residents of Canada for less than five years as the duration of immigration is known to influence breastfeeding initiation and exclusive breastfeeding.^[24] Participants were excluded if the babies were born before 37 weeks of gestation or had congenital abnormalities. Postpartum Community Services (PCS) was a significant place for attendance by members of the Arab community. Key personnel in PCS were informed about the purpose of the study, the scope of their participation, and their voluntary commitment to assist with the recruitment of participants. All Arab mothers identified as potential participants were provided detailed information about the study, its purpose, and the eligibility criteria by the first author (X). Purposive sampling and snowball sampling techniques were used for recruiting. Recruitment was ongoing until data saturation was reached, which occurred after ten interviews.

All mothers enrolled in the study were interviewed face-to-face in their homes within six months after their infant's birth. Information about the research, including the consent form, was provided in Arabic and English based on the women's preferences. All participants chose to be interviewed in Arabic. X engaged in reflexive journaling during the research process paying careful attention to her social, cultural, and professional positioning and the potential influence on her actions and thoughts in the field and eventually her interpretation of the data.

2.2 Data collection and data analysis

In this study, Carspecken's (1996) five-stage process for doing critical ethnography was followed. Individual in-depth interviews were conducted with ten Arab mothers.^[21] A semi-structured questionnaire was used with open-ended questions such as "Tell me more about the beliefs and values that influenced your decision to participate in breastfeeding" and "What comes to your mind when I say, "exclusive breastfeeding?" Additional probing questions were used to explore, illuminate, and clarify Arab mothers' breastfeeding experiences in greater depth.

Before starting the recorded interviews, the physical environment of each data collection site was briefly but keenly observed to identify issues that might need further exploration with the participant during the interview. The participants' behaviors, activities, social interactions, tone of voice, gestures, body movements, and facial expressions were also noted and used during the interviews to ask subsequent questions. Preliminary reconstructive analysis was used for analyzing the record and reconstructing meanings from the observations collected. When reviewing the primary record, X identified relationships between meaning reconstruction, power, and roles influencing participants' breastfeeding experiences.

The interviews were conducted for approximately 60 to 90 minutes in duration in Arabic, the participants' primary language, and with permission from participants, were audio recorded. The interviews were then transcribed and translated into English. Data coding included three aspects: description, analysis, and interpretation of culture the Arab mothers shared. Data coding and categorization were undertaken using NVivo software. Data were coded into categories and themes using low-level coding to group initial data. High-level coding of abstraction was then generated by linking categories to provide coherence and meaning to themes. Throughout the research process, the data were revisited several times and reconceptualized to move beyond data categorization to the more in-depth synthesis and construction of these meaning fields. The validity of the findings with respect to macro-level social theories was determined through debriefing and consulting with the research team members, participants' member checking, and review of the relevant published literature. Three participants were interviewed a second time for member checking to achieve trustworthiness, credibility, transferability, dependability, and confirmability of meaning reconstructions. Additional information from these interviews was incorporated into the research results.

Four primary components of support emerged from the analysis of the participant interviews: knowledge, family, religion,

and infant feeding practices. Because a complete discussion of all four themes would be very lengthy, this paper is limited to family and religion as crucial sociocultural factors. Knowledge and infant feeding practices are presented in a separate document.^[25] All participants' names used in this paper are pseudonyms.

2.3 Family

Family members traditionally exert a strong influence on the childrearing practices of Arab mothers. This was evident in the mothers' decisions on initiating and sustaining breastfeeding. All participants identified that family members, particularly mothers, strongly influenced their breastfeeding practices. They identified their mothers as a source of information about breastmilk. For example, Rania said: "My mother knows basically everything about breastfeeding. I heavily rely on my mother's advice." Like Rania, Sara relied on her mother's encouragement to breastfeed because of the benefits of breastfeeding for the infant, saying: "My mother told me that a mother's breastmilk makes a child mentally and physically healthy..." Both Sara and Rania took their mothers' advice with seemingly little hesitation showing that trust in their mothers' knowledge impacted their decision to breastfeed their infants.

The participating mothers' narratives communicated a clear understanding of the importance of proper nutrition for quality breastmilk and optimal lactation. Here again, advice from their mothers (i.e., the infants' grandmothers) was significant. Haneen's mother provided her with diet tips appropriate for a lactating mother to increase milk supply. She said: "She [her mother] knows what kind of foods have more vitamins, and which foods help to increase the secretion of milk."

Five of ten participants spoke about the support they received from their mothers in dealing with breastfeeding-related complications such as sore nipples. Sara exemplified this:

One time, my breasts hurt a lot; there was blood coming out. I did not know why. I asked my mother if I should stop breastfeeding. My mother said no, you should get this oil and this and that. . . I did what she told me and got all the things needed. I put the oil on my nipples, and the pain decreased.

Seeking support and advice from mothers extended beyond encouragement of breastfeeding; physical care and domestic support with daily living activities were viewed as other primary facilitators to participants' breastfeeding.

Haneen and Nadia were fortunate enough to have their mothers come to Canada to visit. Their presence was instrumental

in a variety of ways, as was evident in Haneen's account:

I am an immigrant here and do not have any family members to help. So, it was great that I had my mother visiting from back home. My mother focused on the right diet and nutrition. She would tell me to sleep whenever the baby is asleep to help me mentally and not feel stressed. She would clean the house for me and cook for me, which is less stressful. I just have to focus on the baby.

Nadia explained, "The days she [the mother] stayed with me, she was helping me a lot. She would take care of the baby in the morning, and that helped me to have enough sleep . . . when I slept well, I could feel the milk next thing in the morning." Both participants asserted that having their mothers physically present and assisting with daily activities reduced their daily domestic responsibilities. As a result, they were relieved of stressful physical work experiences. Both of the mothers pointed out that the assistance promoted increased secretion of milk for their infants. However, once their mothers left, the support decreased significantly; they experienced stress associated with increased engagement in daily domestic chores and their milk secretion was inhibited.

The other eight participants were not fortunate enough to have their mothers' direct support after delivery. They relied on telephone communication, (e.g., Skype, WhatsApp), which limited the support they received. As immigrants living in Canada without extended family members, these mothers consequently experienced difficulties breastfeeding their infants. They were overwhelmed with their domestic responsibilities and felt tired, stressed, and sometimes depressed; feelings that negatively impacted their breastfeeding practices. Sara shared her experience, saying:

I must take care of my 4-year-old a lot, and I do not have anybody to help me, which causes stress and anxiety. Back in Iraq, if somebody gives birth, everyone is helping, cleaning, and helping around the house. . . here [in Canada] when I got out of the hospital, I could not do things for my baby, I was so tired. . . every time I face difficulty with my baby and breastfeeding, I would cry. . . I do not have the help I needed. . . my milk was probably reduced from all the stresses.

Sara recognized that her stress and anxiety stemming from living in a different environment and society as an immigrant impacted her milk production. She explained, ". . . the main

reason for being stressed is to be an immigrant in a country away from my family and because I am in a completely different environment. . ."

The participants' mothers were influential in whether they could trust their healthcare professionals' advice or guidance regarding breastfeeding, although in different ways. For example, when Asma was having problems with her breastmilk supply, and the doctor told her to give formula to the baby as a supplement, her mother told her:

. . . not to listen to what doctors said here [in Canada]. She advised me to be patient, and eventually, the milk will come out. I had given it a try, yet she would cry immediately as soon as I start breastfeeding her [the baby]. However, I end up giving her formula feeding. It is my first baby, and I was afraid to take the risk.

In attempting to be supportive, Asma's mother, who was advising her from Egypt, created conflict and insecurity for Asma. In contrast, Haneen's mother held an opposing view. Her mother advised her to abide by the doctor's advice. Haneen said: "She [her mother] would always tell me to ask the doctors and make sure I follow their suggestions because they have the education and more experience in this field." The provision of conflicting information based on the advice of some of the mothers and the doctors presented a significant challenge in terms of making decisions on breastfeeding. There was evidence of mistrust towards the information provided by healthcare professionals (HCPs) among mothers who experienced profound influence from their more culturally conservative families. Self-determination is often the desired approach to rational decision-making. However, exposure to conflicting information sources causes confusion, and the ultimate decision may be constrained by personal bias. In such situations, mothers were presented with a trade-off between following the traditional advice from family members and continue exclusive breastfeeding or following the established medical norms and integrate formula feeding as advised by some Canadian HCPs. The extent to which each side's advice was mainly adopted depended on the Arab mothers critically evaluating the advice from both sides and arriving at a decision that they believed would yield optimal outcomes for the infant.

Husbands were another source of support for the participants, although their role was primarily limited to encouraging their wives to breastfeed and meeting their families' financial needs. Within the context of breastfeeding decisions, they were seldom involved. The Arab culture on the distribution of gender roles is critical in establishing and maintaining this

status quo, as evidenced by the review of existing literature. In this cultural context, women in this study were considered responsible for all domestic chores and taking care of the newborn and the family. They were also responsible for making decisions in these respective areas. Not surprisingly, the men had few domestic skills and, at best, a limited capacity to take care of the older children. Having been enculturated into these roles, the mothers expressed discomfort in accepting help from their husbands, even if it was offered. Lena clarified this saying:

I did not like seeing my husband having to do my job. The idea of men working at home is not acceptable in my culture. He could help when I am sick, but that is not even part of his duties. We are not used to the idea of a woman being sick. In my culture, I am supposed to be strong and healthy all the time. . . I would only ask for him to do simple things or things that I cannot do because I am either sick or pregnant. I do my best not to ask him for anything much. That is what I have been taught when I was little.

A spouse's stress and financial pressure can also affect the level of support, which a husband provides to the mother, which, in turn, influences breastfeeding. Raina stated: "If the family is not financially stable, they will be under a lot of pressure . . . my husband is busy with work, and he cannot help. . . if the husband cannot support and no family members to help for sure, it would be hard to continue breastfeeding." Nadia's husband helped her when he was at home, but she had no support when he went to work. Therefore, she did not get time to rest and breastfeed.

Despite acknowledging the presence of other relatives such as the mother-in-law and sisters, extended family members did not seem to directly influence the mothers' breastfeeding practices. Perhaps this was because these family members were not in Canada and therefore less accessible to help these women. Additionally, although not a family member, one of the mothers had the support of a housekeeper, which allowed her to focus on caring for her baby and herself. However, given the income level and occupation of the participants and their spouses, not all of them could afford to pay someone to help them.

2.4 Religion

Religious beliefs and values strongly influenced breastfeeding practice by the participants, all of whom were Muslim. A verse in the Qur'an, the Holy Book of Islam, encourages breastfeeding for two years after the baby's birth. It is based upon the act of mercy as dictated by the Qur'an, an act that

is demonstrated by the mothers' provision of food or nourishment to their babies, who depend entirely on them. This explains why Muslims believe in the practice of breastfeeding since it is enshrined in the Qur'an.

The strength of Shaima's religious beliefs was enough to ensure that she decided to breastfeed. She said: "Since it is mentioned in the Qur'an, then it is the best for the baby." Lena echoed Shaima's sentiments: "If it has been mentioned in the Qur'an, it must be the best for both the mother and the baby." Participants mentioned that in many Arab societies, breastfeeding is a strict religious practice, and mothers breastfeed their children to follow the Qur'an. Maya said: "Some people are strictly following the religion. For them, it is mandatory to breastfeed for two years. It is more religious and cultural rather than a personal opinion." Haneen also linked breastfeeding with culture. She stated that breastfeeding is not only a religious matter. It is also one of the cultural beliefs. She said, "It is not about religion at all. People from different religions can support breastfeeding as well. It is more of cultural and personal beliefs and values."

Another participant stated that Islam encouraged but did not force a mother to breastfeed her child. For example, Eman explained: "In the Qur'an, it encourages breastfeeding for two years. It is not a must, but to whoever can breastfeed." She emphasized that, in her religion, it is a choice rather than a rule.

The findings from this study revealed that some religious beliefs and values impeded breastfeeding practice. Given that exposing intimate body parts is strongly condemned for Muslim women, some participants were discouraged from breastfeeding in front of others. Maya reported ". . . in Islam; women should not expose her body to men other than a family. My mother-in-law and other women advised me not to breastfeed in front of others." Consequently, some participants avoided socializing while breastfeeding their children. As Maya described: "I was invited to three different parties, and I attended none of them because I am too shy to breastfeed in front of others." As a result, to avoid social isolation, some Muslim women opt to feed their baby with infant formula, thus further hindering breastfeeding.

Another practice that inhibits or reduces the longevity of breastfeeding among Muslim Arab women is the religious practice of using foods other than breastmilk for some duration after birth. One practice, known as Tahneek, arises from a Sunnah, which involves sayings, practices, and teaching of Muhammad, the prophet of Islam. Lena described the practice as: ". . . basically softening a date, and then rubbing it onto the palate of the baby's mouth just after birth. We do it for about seven days or more." The practice has con-

tinued to sustained in Canada. Sara said, "I have practised Tahneek on all my children here in Canada. I believe people should practise this because it is a cultural tradition, and it is healthy for the infant." Although these customs are practised to maintain the baby's health, they might disrupt exclusive breastfeeding practice.

3. DISCUSSION AND IMPLICATIONS

The complexities of the mothers' family context and religious observances, their experiential effects, and subsequent implications for practice, nursing education, and research are presented in this section.

3.1 Family

The family is an integral part of Arab culture and has a profound influence on breastfeeding practices.^[26] The participants in this study spoke of how influential their family's support or, sometimes lack thereof, was towards their success in breastfeeding their infants. All participants looked to their mothers for advice, trusting them with knowledge of and experience of breastfeeding techniques, ways to enhance milk production, maternal nutrition, and breastfeeding complications. A study by Prates, Schmalfluss, and Lipinski showed that this reliance is universal, and grandmothers, mothers, and mothers-in-law are perceived to be individuals with experience and considered an essential source of information on issues relating to lactation and breastfeeding processes.^[27] The study also suggested that mothers were often more sensitive and vulnerable to pressures and advice from family members or friends during breastfeeding. However, their advice could either enhance or hinder exclusive breastfeeding practices^[27] since such advice conventionally lacked scientific evidence and differed from professional recommendations in some respects.^[28]

During the initial stages after giving birth, one significant challenge to women was balancing household responsibilities and childcare. As a result, mothers who received their family's support were more successful in coping with challenges associated with breastfeeding and handling household chores and demonstrated a better experience than those who lacked any support. Furthermore, most of the mothers interviewed believed that relying on family members' experiences helped them build confidence and better manage themselves during the breastfeeding period.

Immigrant women may not always have the support of their husbands to lessen their burden of caring for themselves and their babies due to traditional gender roles. As pointed out by Bich et al.,^[29] with the active support of the fathers before, during, and after birth, mothers were less likely to give prelacteal food and more likely to breastfeed exclu-

sively. If fathers were to understand better the extent of support their partners need and the impact they could make, it might motivate them to participate more actively in breastfeeding decision-making. One means of gaining a better understanding is attending breastfeeding education classes. Gender-appropriate prenatal classes that include both parents would reinforce the father's role and the significance of exclusive breastfeeding.

Breastfeeding mothers can be confused about how to breastfeed, especially if they have little knowledge regarding breastfeeding or have geographical barriers with their family members. In the present study, eight mothers could not access direct support from their mothers after delivery. After birth, most women experience a major challenge juggling domestic chores and child-rearing.^[30] Consequently, at this vulnerable time, the two Arab mothers who received physical support from their mothers were positively influenced by it and leveraged on the experience of their mothers. This implies a need for a support system within Canadian society for sharing and addressing cultural and religious concerns among conservative Arab mothers. Telephone-based breastfeeding peer support can, for instance, be developed to address these concerns.

In alignment with Jessri, Farmer, and Olson,^[31] the findings from this study suggested that immigrant families often maintain close ties with relatives back home through telephonic communication (e.g., Skype, WhatsApp), resulting in the acquisition of cultural knowledge relating to breastfeeding. Similar to Alzaheb's study,^[32] this study found that some parents encouraged their children to uphold cultural practices such as Tahneek, which inhibit exclusive breastfeeding. Consequently, despite the commitment to breastfeed, some belief systems ingrained in the Arab family culture about prelacteal feeding contributed to the cessation of the practice. The Arab mothers shared that they received advice that encouraged pre-lacteals as this was considered part of appropriate religious practice. As a result, the cessation of exclusive breastfeeding occurred inadvertently in some cases. It was further worsened by the desire to meet religious requirements while oblivious to their impact on the infant's health.

The participants, who had no close family members, turned to HCPs as the primary source of information. They also relied on HCPs as a source of essential breastfeeding support to deal with common breastfeeding problems. Despite providing advice on breastfeeding, Canadian HCPs focus primarily on promoting health outcomes such as weight, sleeping patterns, etc., of both the mother and the infant.^[33] There is still inadequate attention on culture-specific knowledge and culturally sensitive solutions to common breastfeeding problems

in contrast to scientific information, which may inadvertently contribute towards a higher supplementation rate among the Arab immigrant mothers interviewed in this study. Moreover, some Arab mothers were influenced by the opinions of their maternal parents about decisions to comply with Canadian doctors' instructions. It was observed that Arab mothers demonstrated varied views regarding following doctors' orders relating to breastfeeding practices. However, the extent to which they consider the information they receive is contingent on how it resonates or differs from the information they access within the family contexts. Although some mothers were advised to ignore recommendations by doctors that encouraged giving formula milk, several participants were supported by their mothers to follow doctors' advice to practice both breastfeeding and formula feeding.

3.2 Religion

Muslims believe that breastfeeding is a holy act enshrined in the Qur'an where it is considered to be an act of mercy. Some of the participants practiced breastfeeding as they thought it to be a religious and cultural obligation, while for others, it was a personal preference. Some religious beliefs can inhibit breastfeeding. As already mentioned, Muslim women are expected to uphold a high standard of dignity in public spaces by avoiding indecent exposure of their intimate parts. Participants in this study explained that women who have violated these socially accepted norms receive a judgment or are ostracized by the family. They also explained that although both religious institutions and family members have advised them to breastfeed, they had to avoid breastfeeding in public because it would make them feel extremely uncomfortable. To these mothers, privacy is paramount. They are very particular about protecting their modesty to the point that they declined invitations to social gatherings knowing that they could not preserve modesty by breastfeeding at these events.

Consequently, they were restricted to their home environment, thus increasing social isolation and limiting their opportunities to interact with and integrate into Canadian culture. Also, when male visitors come to their homes, they go into their bedroom to breastfeed. Consequently, these forms of restriction contribute significantly to inhibiting breastfeeding among Arab mothers. Similarly, it highlights how some religious doctrines and cultural expectations can create social barriers for women in receiving support from their husbands and community. By regulating public behavior, the extent to which women can express themselves or reach out to other women for support is limited.

The results highlight the relationship between men and women, primarily defined by gender roles and expectations.

The prevailing cultural construct is informed by the principles of Islam, which places more emphasis on patriarchy.^[34] Based on the perspectives highlighted by Vandenberg and Hall,^[34] the dynamics of power and control among men and women shaped their approach to breastfeeding practices. The immigrant Arab mothers lived within a male-dominated society, which gained patriarchal authority based on the Islamic doctrine. Consequently, there was a lower degree of involvement among men regarding breastfeeding due to the religious doctrine's explicit role definitions. This implied that women were allocated responsibilities including childbearing, child-rearing, and domestic chores.

Additionally, the system of patriarchy prescribed some of the activities that were prohibited for women, such as public breastfeeding or exposure of intimate parts of the body. As a result, these forms of structural barriers in power relations defined the ways through which Arab mothers could breastfeed. In areas where there was a lack of public facilities, the conditions influenced the potential decision of supplementation.

The interplay between culture, environment, religion, and family contributes significantly to breastfeeding decision-making processes. Islam encourages breastfeeding but ironically does not explicitly promote exclusive breastfeeding due to the prescribed prelacteal practices. Two of the participants spoke of practicing the prelacteal feeding custom of Tahneek. These mothers indicated that this religious practice is considered a healthy Sunnah, and offers an incentive for mothers to participate. However, engaging in such practices technically might inhibit exclusive breastfeeding, as described by Alzaheb.^[17]

Communication between the mothers and the HCPs regarding the religious and cultural intentions for prelacteal feeding is crucial to support the timely initiation of breastfeeding and ensure the health of the infant (Shariff & Sharma, 2018). More particularly, in foreign nations, there is a need to promote a more inclusive outlook to maternal care, accommodating cultural variations in the interest of the infant's health. The implication of this solution is the delay of prelacteal feeding until after the recommended time of six months for breastfeeding as promoted by the World Health Organization^[3] and Health Canada.^[2] Regular communication between the mothers and HCPs would ensure that breastfeeding mothers continue to breastfeed their babies as they would stay motivated and informed regarding the benefits of exclusive breastfeeding. Mothers that are unable to breastfeed claim that they have little breastmilk or those working might also benefit when they receive the information regarding how best to feed their children. This would be of great help to

Arab mothers who have little knowledge regarding exclusive breastfeeding and cannot communicate with their mothers or other family members. Furthermore, Arabic mothers might receive the encouragement of breastfeeding very positively because it resonates with their religious beliefs and traditions.

4. CONCLUSION

Breastfeeding initiation by Arab mothers in Canada is high, but by six-months after birth, breastfeeding duration rates quickly drop below the desired international rates. Lack of familial support available to immigrant Arab mothers and religiously informed breastfeeding traditions contribute to the lack of successful breastfeeding, leading them to wean their infants prematurely. This critical ethnography study has provided insight into the breastfeeding experiences of Arab mothers and the sociocultural factors that serve to facilitate or inhibit their experiences.

The findings show that women's lack of family support networks and their tendency to carry out the religiously endorsed traditional customs which may conflict with the recommendations of the HCPs, can influence the frequency and duration of exclusive breastfeeding. Immigrant Arab mothers in Canada who no longer have traditional support systems struggled with the challenges of breastfeeding. Without the

immediate family's support, mothers are overburdened with household chores and struggle with inexperience and low confidence. These problems are further exacerbated due to traditional gender roles and financial pressures, limiting the husbands' ability to support their wives in child-rearing. Since mothers voiced isolation and a need for support, it is crucial for researchers to involve mothers in program planning and evaluate the outcomes of their participation. Further research is needed to evaluate the best ways to involve male Arab partners in supporting exclusive breastfeeding.

The religious principles can inform cultural practices regarding prelacteal feeds and breastfeeding of an infant in public. Religiously informed practices can also engender conflict between acceptable cultural practices and recommendations of the HCPs. A more precise understanding of the sociocultural contexts that support and encourage exclusive breastfeeding is an important consideration by HCPs caring for Arab immigrant mothers in Canada. Culturally sensitive interventions tailored to the specific Arab mothers' breastfeeding concerns and needs are needed to have exclusive breastfeeding become the norm among this population in Canada.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare no conflicts of interest.

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