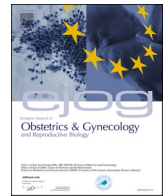




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Full length article

Experience of breastfeeding during hospitalization after birth: a qualitative study

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ABSTRACT

Aim: Hospital admission after childbirth is a crucial period for establishing breastfeeding. The aim of this study is to explore mothers' experiences regarding feeding their children during the first 48 h of hospital admission.

Design: A qualitative study design was used.

Methodology: A phenomenological approach was employed through thematic analysis, conducted via interviews with 14 postpartum, aged 25–41 with diverse parities and cultural backgrounds, women during their hospital admission.

Results: Common factors were identified among mothers, such as the influence of health professionals on their perceptions and feelings about breastfeeding. Maternal origin and culture were found to influence how mothers approach infant feeding. Family support could be both positive and negative, and its absence could lead to the early abandonment of breastfeeding. Feelings of guilt and shame were reported by participants, especially when they did not meet societal expectations regarding breastfeeding. **Conclusion:** Breastfeeding is influenced by social and cultural factors as well as the quality of professional support. External opinions and a lack of support can hinder its successful establishment. New mothers face physical (pain, fatigue, body changes) and emotional challenges, including the shame and guilt associated with the standards of being a "good mother."

Impact: In a world where motherhood is often idealized, insufficient support can exacerbate maternal insecurity. This highlights the need for an approach where the humanization of care takes precedence over a strictly biomedical model.

Patient or Public Contribution: The findings are based on interviews conducted with mothers.

Introduction

Breastfeeding (BF) plays a major role in parenting because breast milk has evolved into a food that is fully adapted to the changing needs of infants at different stages of development. Thus, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) [22,36] recommend exclusive breastfeeding (EBF) of infants until 6 months of age, along with adequate complementary feeding until at least 24 months of age. These recommendations are due to the health benefits observed both in the short and long term for the BF dyad [34]. Therefore, it is not so important to talk about the benefits, but rather that the alteration of this

physiological process is associated with adverse outcomes for both the child and the mother. The 48-hour hospital-based approach is particularly relevant compared to other key breastfeeding milestones (e.g., at 6 weeks or 3 months) because it represents a critical window for establishing breastfeeding success, providing immediate support, addressing early challenges, and reinforcing maternal confidence when guidance is most needed.

In mothers who choose to breastfeed, a later resumption of menstruation is observed in the short term and, therefore, a greater spacing between pregnancies and a faster loss of the extra weight acquired during pregnancy [17]. On the other hand, a review study states that this weight loss could not be related EBF, since there are many associated factors [23]. Among the long-term outcomes in mothers, BF is

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associated with a lower risk of premenopausal breast cancer, [12,34] ovarian cancer [31,34], lower arterial hypertension [11,27] and type II mellitus diabetes, especially in women without a history of gestational diabetes.

In children, breastfeeding is associated with a lower risk of infectious morbidity in the short term, especially gastrointestinal infections and acute otitis media [2,17,34]. A lower risk of death from infectious causes is also observed in children who are breastfed, and this risk is lower the higher the percentage of breast milk in the diet. As long-term results in children, it was found that BF acts as a protective factor against obesity and is related to lower mean arterial pressure and total cholesterol levels in adulthood. Likewise, BF seems to have a protective effect against epilepsy, an effect that increases according to the duration of BF. This data is especially noticeable when there is EBF. BF for at least 4 months (with better outcomes if continued until at least 6 months) is associated with improved lung parameters [9], forced vital capacity, expiratory volume in the first second, and peak expiratory flow at 10 years of age [24]. A decreased risk of acute lymphoblastic leukemia has also been observed [16].

Different studies indicate that, among the predisposing factors to encourage the initiation and maintenance of breastfeeding, there is the educational support of health professionals, as well as hospital practices at the beginning of life that encourage and protect BF. However, when the experience of mothers regarding the feeding of their infant is studied in depth, other influences are discovered in the choices they make. Thus, it is observed that the greater the cultural roots of the mother, the more the social norms of her culture influence maternal decisions [6]. Thus, there are ethnic groups with a greater predisposition to feed their children through BF [18]. Women often report feeling pressured by family and friends to feed their children according to their preferences [29]. However, the family is also often a source of support for women [15]. Family influence is positive if the family members believe that breast milk is good, necessary, and protects against disease. Also, if there is a history of successful BF in the family [35].

On the other hand, the influence of healthcare personnel is clear, but it does not always achieve the desired objective. It is important to bear in mind that the educational support of healthcare professionals is highly influenced by their previous experiences and beliefs [28]. In addition, their attitude will mark the mothers' response, as they can facilitate the emotional process of women by validating their motherhood. These attitudes will facilitate adaptation to the difficulties of BF or, on the other hand, they can undermine maternal confidence by fostering feelings of shame, guilt or humiliation [19].

The impact of healthcare support on maternal self-efficacy must be taken into account. Mothers who feel little emotional support during the first days after birth, due to the heavy workloads of healthcare professionals, report decreased self-efficacy and feelings of low worth, which distanced them from their goal of BF their children. In contrast, mothers with adequate professional support, despite the difficulties, do not suffer a decrease in confidence in their ability [32].

On the other hand, the biological changes that prepare a woman's body for BF influence her body image. These changes in body image can be perceived negatively, making a woman feel uncomfortable with her image and what she shows to others, causing feelings of dissatisfaction and shame [26]. Other women, on the other hand, have a positive perception of these changes, as they provide positive reinforcement of successful BF, a feeling of deep connection with their child, and a sense of fulfillment as a woman and mother [26]. There may also be concern about the direct physical effects related to the act of BF: pain, exhaustion, and lack of sleep [30].

Besides, maternal emotions play a key role in maternal decisions about infant feeding. When BF is associated with positive emotions, and the choice is made by one's own decision, and not influenced by social norms or the opinion of reference persons, the relationship with their baby is at the center of their infant feeding decisions. Consequently, the emotional bond between mother and baby is the main reason for

intending to breastfeed. These emotions are associated with a longer duration of BF. The gap between expectations and reality in relation to BF is observed by many studies [14,15,19]. Prenatal educational support does not sufficiently prepare them for the challenges of the postpartum period, especially those associated with infant feeding [14]. The feelings that mothers most frequently associate with BF include negative aspects such as guilt, shame, and fear of failure and positive aspects such as bonding with their child [14,19].

Given the importance of this area, the present work aims to explore the physical and emotional experience of mothers in their relationship with the feeding of their children during 48 h hospital admission after birth, including feelings, motivations, expectations, relationships with health personnel and family dynamics regarding breastfeeding. This study expands on previous literature by providing a focused exploration of mothers' physical and emotional experiences with infant feeding during the first 48 h postpartum, a critical but often underexamined period. Unlike prior research that primarily addresses long-term breastfeeding outcomes and influencing factors, this study highlights the immediate postpartum challenges, the role of healthcare professionals, and the emotional dynamics that shape early breastfeeding decisions.

Methodology

Ethical considerations

This project has the approval of the Health Research Ethics Committee of the Hospital Clínico San Carlo, where the study was carried out (ID 23/780-E). All women who met the inclusion criteria were provided with a participant information sheet and received a verbal explanation of the study's objectives and procedures from the primary researcher. It was emphasized that participation was voluntary and that they could withdraw at any time without consequence. All participants provided written informed consent before the interviews commenced. To ensure confidentiality, interviews were conducted in a private room, and all transcripts were anonymized using alphanumeric codes to protect the identity of the participants.

Research design

A qualitative study using a thematic analysis, aiming to understand and describe in detail the perception of breastfeeding (BF) during the first 48 h of a newborn's life through in-depth interviews with mothers who have given birth vaginally or via cesarean section without complications.

Setting and relevant context

This study was conducted at Hospital XXXX, a public tertiary hospital in Madrid, Spain, between October 7 and December 5, 2023. The hospital serves a diverse urban population, reflecting Spain's multicultural context, with a significant proportion of immigrant families from Latin America alongside native Spanish residents. The maternity ward provides standard postpartum care, typically involving a 48-hour hospital stay for uncomplicated vaginal or cesarean deliveries, during which breastfeeding initiation is supported by healthcare professionals, including nurses and midwives. This setting is shaped by Spain's public healthcare system, which promotes breastfeeding in line with WHO and UNICEF guidelines, though resource constraints and varying staff training may influence the quality of support. The immediate postpartum period was chosen as it represents a critical phase for establishing breastfeeding, influenced by hospital routines, professional interactions, and family presence, all of which impact maternal experiences in this context.

Sample

To achieve a maximum variation sample, the research team actively monitored the characteristics of the recruited participants. This ensured the inclusion of women with different parity levels (first-time and experienced mothers), a diverse age range, and various cultural backgrounds to capture a wide spectrum of perspectives on the breastfeeding experience. The sample size calculation took into account the criterion of information saturation.

The inclusion criteria were as follows: women who have been assisted at the birth of their child at the Hospital; single birth; date of birth between October 7 and December 5, 2023. The following exclusion criteria were applied: clinical complications during delivery or cesarean section and/or after birth; admission of the newborn during the first 48 h of life; admission of the mother to the Intensive Care Unit during the hospital stay; early discharge within 24 h of birth; not fluent in Spanish; mother under 18 years of age; mothers who do not choose to breastfeed.

Data collection

Sociodemographic data were collected through electronic medical records. Information on BF experiences was obtained through open, unstructured interviews, which were guided by active listening. Interviews were conducted by a nurse (female) with experience in women's health and breastfeeding in particular. Participants were invited to individual interviews at a time and place convenient to them, taking into account the criteria of the study. Participants were asked about demographic variables such as age, profession and educational level before starting the interviews. These interviews were conducted 48 h after birth and were recorded using an audio recorder, and subsequently transcribed using the *O Transcribe computer tool*. The initial contact with participants was made at the maternal-fetal health consultation. During this first meeting, the interviewer, who had no pre-existing relationship with the women, introduced the study in order to establish rapport. At this consultation, the principal investigator introduced himself and explained the characteristics of the study. Once the woman was admitted to the delivery room, she was contacted again to have an informal conversation. After delivery, and once it was verified that she met the inclusion requirements and did not present any exclusion requirements, she was asked on the first day of admission if she wanted to participate in the study. If the answer was affirmative, the informed consent document was given and another informal conversation was held.

Data analysis

A deductive content thematic analysis was applied in which categories emerged from the text [7]. For data analysis, firstly, the interviews were transcribed from audio recordings using the *O Transcribe computer tool*. Secondly, a general reading of the transcribed interviews was carried out, as well as the organization of the information and understanding of the data. A five-phase approach to thematic analysis was followed, including: familiarizing with the data; generating initial codes; generation of themes from the codes; review of potential themes and definition of themes for the final report. Initially, the principal investigator reviewed the transcripts and the responses to each question, and the analysis of the themes was carried out by two researchers with experience in qualitative analysis, through a discussion group until reaching an agreement. Data saturation was determined to have been reached after 14 interviews, as no new relevant themes were identified during the analysis of the final participants.

Rigor of the study

According to Lincoln and Guba [20] the following criteria were applied to ensure the quality and rigor of the analysis of the interviews:

a) Credibility. For this purpose, a sufficient number of interviews will be carried out to obtain all possible information, until data saturation is achieved; b) Transferability. To facilitate transferability, a detailed description of the context in which the research is carried out will be made, as well as the sociodemographic description of the participants; c) Dependency. In order for the research to be replicable, an exhaustive description of the process followed in the development of the research will be made, especially, the data analysis; d) Confirmation. For this purpose, the complete transcribed interviews of the participants can be requested, as well as the analytical memos prepared; e) Authenticity. The research will serve to improve the care of mothers and children during their admission after birth; f) Justice. For this purpose, women from minority and/or vulnerable groups will be included.

Results

Sociodemographic results

The sample consisted of 14 women who had given birth to their child in a public hospital in the last 48 h and who chose to breastfeed (Table 1). The average age was 30 years old, 57.1 % of participants were Spanish, 35.7 % do not work unemployed, 50 % do not have more children were primiparous. Of the total, 57.1 % had normal delivery and 64.2 % do not present pain.

Below are the different themes that emerged during the interviews conducted, as well as a detailed description of them.

Educational support for healthcare professionals

The perception of educational assistance provided by health professionals shows notable disparities linked to family particularities and social environment. In the case of those mothers with previous breastfeeding experiences, it is observed that the expectations of these mothers are not met, in relation to the training acquired by health professionals or their guidance regarding breastfeeding. Notably, these women repeatedly emphasize having received contradictory information from different health professionals. This causes a decrease in their confidence regarding breastfeeding, as well as the spheres of their postpartum experience. Likewise, they perceived the information provided as inappropriate or incorrect. However, mothers without previous training in breastfeeding and mainly of Latin American origin, find gratitude for all the information received from health professionals.

"...the nurse who came clearly lacked proper training and wasn't very helpful. Perhaps someone more specialized in breastfeeding would have been more helpful and would have been more appreciated."

In all cases where prenatal preparation was carried out, breastfeeding training was considered beneficial and useful in many aspects. However, many mothers expressed that it would have been appropriate and beneficial to have more knowledge about the experience that mothers have during the postpartum period. Being able to understand how the recovery process develops in the postpartum period, and especially, what the first stages of breastfeeding are like, could dispel many doubts and allow mothers to prepare for the process.

Relationship between health professionals and mothers

The relationship between healthcare professionals and mothers is characterized by several dynamics that influence women's perception of the care received during the postpartum process. First, the lack of time on the part of healthcare personnel is a significant barrier that impacts the quality of interaction and the time they can dedicate to supporting mothers in the initiation of breastfeeding. This time deficit, often evidenced in brief and hurried consultations, can hinder the ability of professionals to comprehensively address the needs and concerns of mothers. Furthermore, disagreement with the information provided by

Table 1

Sociodemographic data and obstetric history.

SUBJECT	AGE	NATIONALITY	JOB	PREVIOUS CHILDREN	TYPE OF BIRTH	PAIN
1st	38	ITALIAN	YES	YES – 2	EUTOTICEUTOTIC	NO
2nd	28	HONDURAS	YES	NO	EUTOTIC	NO
3rd	39	SPANISH	YES	NO	INSTRUMENTAL	YES
4th	39	SPANISH	NO	YES – 2	INSTRUMENTAL	NO
5th	26	BOLIVIA	NO	YES – 1	EUTOTIC	NO
6th	25	BOLIVIA	YES	NO	CESAREA	YES
7th	27	BOLIVIA	YES	NO	INSTRUMENTAL	YES
8th	20	SPANISH	NO	NO	INSTRUMENTAL	YES
9th	31	SPANISH	NO	YES – 1	INSTRUMENTAL	YES
10th	41	SPANISH	YES	YES – 3	EUTOTIC	NO
11th	19	HONDURAS	NO	NO	EUTOTIC	NO
12th	26	SPANISH	YES	YES – 1	EUTOTIC	NO
13th	29	SPANISH	YES	NO	EUTOTIC	NO
14th	32	SPANISH	YES	YES – 3	EUTOTIC	NO

healthcare professionals constitutes another relevant element in this relationship. The discrepancy of perspectives generates uncertainty and decreases mothers' confidence in the recommendations received. Likewise, the lack of consideration of cultural or ideological characteristics in the planning of care adds a layer of complexity to the relationship, since mothers may perceive care as insensitive to their values and cultural context. Women who culturally perform care that is characteristic of their social group are often subject to correction and lack of understanding. The feeling of being evaluated during interactions with healthcare personnel adds an emotional dimension, generating anxiety, feelings of inadequacy, and affecting the quality of communication.

“ Well... sometimes some nurses or assistants—I don't know how to differentiate them a lot—make you feel a little silly. It's true that I've asked a lot of questions, and I'm sure I've also called a lot, but often I don't know if she's hungry or what's going on, because I put her to my breast and she doesn't eat, or she eats but keeps crying. You have a lot of doubts and you don't know what to do. You feel bad, and you think someone can help you, but they don't. I don't know, maybe they don't know either. Then, each one tells you different things.”

Finally, unassertive communication by healthcare professionals represents a challenge. Clear and respectful interaction is essential to establish a supportive environment. Lack of assertiveness can lead to confusion and misunderstanding, negatively affecting the experience of mothers during this crucial postpartum period. On the other hand, some mothers report excessive pressure placed on those who choose not to exclusively breastfeed. In this situation, negative judgment is made by some professionals, making it difficult to express preferences and doubts.

“They make you feel bad. Here too, every time I've asked for milk, they don't like it. I don't want them to scold me, or look at me as if I've done everything wrong. I don't know why they can judge you; it's not right for them to do that. It's not right.”

External influences on the initiation and development of breastfeeding

External influences affecting the initiation and development of breastfeeding reveal complex dynamics that shape mothers' experience during this crucial period. The expression of greater trust in people outside the health care staff highlights the importance of social and family support networks in breastfeeding decision-making. However, this is sometimes due to the fact that, in many cases, health care personnel do not achieve adequate trust to establish adequate and useful communication. This preference for advice from close individuals may suggest a significant degree of interpersonal influence in the formation of breastfeeding attitudes and practices that are sometimes based on myths or erroneous knowledge. Likewise, seeking support from health care professionals outside the National Health System and from support

groups underlines the diversity of sources to which mothers turn for guidance. The willingness to explore options beyond traditional health care structures suggests an adaptive strategy on the part of mothers to obtain a more complete and personalized perspective, trying to compensate for the feeling of lack of support and lack of information.

“I have help. My partner and my mother are a great support to me. I can count on them for everything. That's a point in my favor, clearly.”

“Breastfeeding is very healthy, but it is not designed for the mother to work at the same time.”

“It's exhausting all the time, with no sleep at all. My family helps me. Being alone on those days when everything hurts and you can't sleep would be worse.”

Identifying the benefit of support groups as a positive influence highlights the importance of peer interaction and validation of shared experiences. Participation in these groups not only provides valuable information, but also creates a space conducive to the expression of emotions and the construction of emotional connections, thus contributing to the strengthening of social support during the breastfeeding process. Together, these external influences outline a landscape in which breastfeeding decision-making and development are intrinsically intertwined with the social and community fabric surrounding mothers.

Maternal motivation

Maternal motivation to breastfeed is shaped by a number of factors that reflect the complexity of this process. First, the perception that breastfeeding creates a meaningful bond with the child emerges as a central motivator. This suggests that the emotional connection and sense of intimacy resulting from breastfeeding contribute substantially to mothers' decision to opt for this practice. The generation of happiness in the mother as a result of breastfeeding is another influential element in maternal motivation. This positive emotional connection reinforces the individual experience of motherhood, contributing to a sense of personal fulfillment and satisfaction. The perception of breastfeeding as a simpler and cheaper option compared to formula feeding also plays an influential role in families with fewer economic resources. The simplicity and affordability of breastfeeding are considered practical advantages that may influence mothers' choice. However, it is noteworthy that consideration of the benefits to the mother's health is not perceived as a determining factor in motivation.

“And I'm very happy. Breastfeeding is important. It's important to breastfeed for babies. It makes them healthy.”

“ It's the most appropriate way to feed a baby, the one that reduces many health risks. Everywhere, they tell you it's the right thing to do for the child's sake.”

“... when my oldest son was born, everything was relatively easy.... I found it easy and comfortable”

Social and cultural influence

Social and cultural influences on the experience of BF are a rich and multifaceted dimension that shapes mothers' attitudes and behaviors during this process. First, the perception that the needs of children come first reflects an ingrained cultural norm that places the well-being of children as the highest priority.

This perspective drives mothers to view breastfeeding as a practice in line with optimal child care, thereby positively influencing their decisions. The importance of being a good mother is highlighted as a central element in social and cultural influence. Perceived pressure to meet social and cultural expectations of motherhood may influence the choice of breastfeeding as a key component of maternal identity. The perception of a moral obligation to provide the best for children reinforces this commitment, suggesting that mothers internalize cultural norms that dictate maximum dedication to parenting.

"Besides, everyone in my family and my husband's has been breastfed. "I have to reveal myself to people I don't know. The first few months are spent being home with the baby."

The shame associated with exposing the body during breastfeeding and the obligation to cover up while breastfeeding indicates the cultural pressure that dictates norms of modesty and privacy. These elements reveal how social norms can affect mothers' experience during breastfeeding, generating emotional and logistical complexities. Views about maternal diet constitute another cultural dimension that influences breastfeeding practices. Culturally embedded perceptions regarding what is considered healthy and appropriate for the breastfeeding mother can affect her dietary choices and, consequently, the quality of her breast milk.

Previous breastfeeding history

The identifying characteristics related to the previous breastfeeding history reveal a crucial influence on the development and current experiences of mothers during the breastfeeding process. First, it is observed that the previous breastfeeding history exerts a notable influence on the configuration of current breastfeeding. Previous experiences, whether positive or negative, are determinants that shape mothers' attitudes and expectations towards breastfeeding in the present. Clearly, successful breastfeeding is a protective factor in the development of breastfeeding. Tandem breastfeeding, characterized by the simultaneous breastfeeding of a newborn and an older sibling, stands out as a dynamic that facilitates the successful initiation of breastfeeding of the newborn. In cases where tandem breastfeeding occurs, it is common to receive negative messages about this practice from family, reference persons or health professionals. This finding suggests that the cumulative experience of previous breastfeeding can provide beneficial resources and skills in the initiation of breastfeeding with a new child. Likewise, the presence of previous successful breastfeeding is a positive factor that influences the current breastfeeding process. These previous successful experiences can give mothers confidence and competence, thus contributing to the successful development of current breastfeeding. However, when difficulties and complications are encountered in the breastfeeding history, it is a barrier to the development of current breastfeeding.

"Breastfeeding our first child went poorly, and in the end, we couldn't make it work. But the other two were breastfed."

"Well, I already have two other children that I have breastfed."

"I can't complain; breastfeeding my other two children was quite comfortable. So, I feel pretty confident"

Maternal feelings in relation to the development of breastfeeding

Maternal feelings in relation to the development of breastfeeding

reveal a rich and complex range of emotions that significantly impact the experience of mothers during this period. The experience of feelings of guilt for devoting excessive time to breastfeeding and, consequently, neglecting other children, constitutes an emotional dimension that reflects the challenges and tensions that can arise in the management of time and maternal care. This internal conflict between attending to the needs of newborns and older children can generate a host of complex emotions. Likewise, the feeling of guilt for the perception of lack of success in breastfeeding manifests itself in various ways, but it is usually an intense and long-lasting feeling. The statement of a mother about the feeling of guilt, which she maintains years after the failure of breastfeeding her first child, stands out.

The insecurity related to the fear of not doing it well, of not having enough milk, or that breastfeeding may cause health problems for the newborn highlights the emotional burden that can accompany this process, which is combined with the emotional situation related to postpartum hormonal changes.

"But I'm trying. Everything hurts, and I can't sleep. I need to rest. I can't take it anymore. It seems like everything I do is bad for the baby."

"Between the stitches, the nipples, and not sleeping, I don't think I've ever felt this bad.. It would be nice to know. It would be nice to know a lot of things."

"Tired, breastfeeding is very difficult at first. Very boring for mothers. You can't do anything else."

Identifying breastfeeding success as an indicator of being a good mother underlines how mothers link their breastfeeding achievements to their self-concept as parents. However, it also highlights the need to maintain an optimistic outlook, as an emotional strategy to cope with the challenges and pressures associated with breastfeeding. Pride in effort reveals a positive dimension in which mothers recognize and value their commitment to breastfeeding, even in the midst of difficulties, especially once difficulties and difficult times are overcome. The desire to have time for themselves and to provide the best for their children reflects personal aspirations and the desired balance between self-care and family care. Insecurity caused by lack of experience, absence of relationships with women who have breastfed, and lack of knowledge underlines the importance of external factors in building maternal confidence in relation to breastfeeding. Today, it is rare for mothers to have had contact with other mothers, prior to the birth of their own child. In cases where this has occurred, mothers say they trust more in the learning acquired from that experience than in the learning received from health services. These elements reveal the emotional and psychological complexity that drives the experience of breastfeeding, highlighting the need for comprehensive support to address these emotional aspects.

"In our case, breastfeeding has been very comfortable, I'd even say very beautiful. It's helped us bond a lot with the children."

"I would say it gives me peace. It gives me a feeling of so much love, and so much happiness."

"We can't hold our children all day. We have other things to do. I need to sleep and rest."

"I'm lucky at that; I'm good at it. Then I feel sad when I have to stop, because the time spent breastfeeding them is quite pleasant. And comfortable."

Family relationships

Family relationships play a key role in the experience of breastfeeding, and various dynamics influence mothers' experiences during this process. The beneficial influence of partner support is a positive factor that can strengthen mothers' confidence and emotional comfort during breastfeeding. It is an invaluable aid for mothers in adapting to the new role. However, when there is a paternal concern to ensure that the baby does not go hungry, it is an influence towards not opting for

exclusive breastfeeding. When there is a lack of family support for breastfeeding, it creates a significant emotional challenge for the mother, as well as a lack of confidence in the help that they can provide.

"My husband just wants the kids and me to be okay. And my mom isn't too keen on breast milk."

"My mother didn't breastfeed us; she says there's no milk in the family. My sister didn't give it to her son either."

"Neither my family nor my friends seem to understand what's happening to me. They think I worry more than necessary. And I don't feel like arguing or trying to convince anyone."

Lack of support can generate emotional tensions and make it difficult to continue breastfeeding. In addition, negative opinions of family and friends regarding the development of breastfeeding add external pressures that can affect the emotional well-being of mothers. Support from the maternal family, although beneficial, is usually observed in families where male involvement in child rearing is less. This dynamic may reflect traditional attitudes toward gender roles and their implications for child rearing.

Mother's wishes regarding infant feeding

When mothers ask for formula milk, or express their desire to choose another way of feeding, they may feel judged and labelled as bad mothers. On several occasions, they have said they lie to health professionals to avoid being treated that way. On the other hand, they claim that the children they know who are fed with mixed or formula milk are also in good health, which indicates that information related to the health benefits for babies is not adequately understood.

"I want to raise my baby, but I also have to think about what's best for me. I'm not well right now, so I think being able to give him a bottle will help make it easier."

"I'm looking forward to getting through this first part, because at first it hurts, but then when he picks it up and eats, no, then I feel happy, because I'm being fed."

"Breastfeeding is very important to me."

Lack of privacy

The constant presence of healthcare professionals continually entering the room represents an intrusion into the mother's personal space, affecting her sense of privacy and autonomy. This continued situation can generate emotional and physical discomfort, affecting the quality of the breastfeeding experience. Added to this is the excessive number of visitors during admission, which further aggravates the lack of privacy, creating an environment in which mothers may feel exposed and disadvantaged in their attempt to establish an intimate connection with the newborn.

"I'm content with not having visitors. It's been crazy, these visits.. You're a mess, putting up with people. In your nightgown, bleeding, your breasts swollen and sore, you feel terrible, your daughter won't stop crying... what a horrible situation."

Duration of breastfeeding

Maternal considerations regarding breastfeeding duration reflect the complexities and time considerations that mothers face in breastfeeding progress. Doubts about breastfeeding duration point to the uncertainty that some mothers experience about how long to continue breastfeeding. This aspect may be influenced by various factors, such as information received, personal experience and cultural expectations, but also by a lack of confidence in their own ability to continue breastfeeding for as long as they wish. This last reason causes them to be unable to set a goal by their own decision, as they consider it to depend on external factors.

The desire to continue breastfeeding for as long as possible highlights a positive and committed aspiration on the part of mothers. This desire may be linked to the long-term health benefits for the baby, as well as the emotional connection that breastfeeding provides. The intention to continue breastfeeding until returning to work indicates planning and time management in the breastfeeding process. The difficulties involved in combining work and breastfeeding must be considered, due in part to the impossibility of expressing milk in many jobs. Reconciling motherhood and career is a challenge for many mothers.

"I don't want to have the baby hanging on my breast all day. She's very small now and that's fine, but in a couple of months."

"I tried to breastfeed the other children as much as possible. I had to give up on work; I couldn't continue. My mom doesn't like it, but what can I do? I'd like other things.."

"When I have to start working, I can't keep going; it's impossible. Work and children are enough."

Future expectations regarding breastfeeding

Mothers' expectations of the future regarding breastfeeding reveal the projections and concerns they have about this process as they move through their experience. The desire to return home with their partner and reorganize their life suggests the importance of the transition from the hospital environment to a more familiar and comfortable environment. However, this perspective carries with it the inherent concern about family organization after returning home. Mothers anticipate logistical challenges and adjustments in family dynamics that may arise in this transition period, highlighting the need for support and adaptation during this critical phase. These challenges are especially worrying for women who already have other children, and for those without a support network. It is also notable for mothers with positive previous experiences with breastfeeding, who describe physical and logistical complications as temporary, stating that they usually last only a few weeks. This perspective acknowledges the possibility of facing initial challenges, but at the same time suggests the belief that with time, breastfeeding will become smoother and less complicated. Very different concerns and expectations are observed between mothers with previous breastfeeding experience and those facing the process for the first time.

"So, I hope everything works out. It's something I want. Throughout my pregnancy, I've been very clear that I wanted to breastfeed. I didn't expect it to be so hard, but I have to keep trying.."

"That's why I feel pretty confident that this breastfeeding is going to go well. Yesterday she lost a little more weight than usual, but I'm sure it'll just be a one-time thing."

Adaptation to the role of mother and breastfeeding

The significant category of adaptation to the mother role includes adaptation to the breastfeeding process. This period is fraught with great emotional and physical complexities that mothers face. The first days postpartum are perceived as difficult, exhausting and emotionally unstable, due to the intense feelings caused by hormonal changes. This intense emotional experience can contribute to the emotional vulnerability of mothers in this initial phase of motherhood and breastfeeding. In addition, the mismatch between expectations and reality about breastfeeding constitutes a common challenge. Therefore, the difference between expectations and reality constitutes one of the main problems in achieving adaptation to the new role. Mothers may face surprises and frustrations when the reality of breastfeeding does not match their previous expectations, generating feelings of uncertainty and adaptation.

"I don't feel as scared as I did with my first baby, but I guess you always have fear."

"I think the three of us—my partner, the kid, and I—will be better off at home. I don't see myself alone with all this. I don't feel strong enough."

"I just want to do it right. I'm happy with him. But there's a lot going on. I'm not feeling well at all, and then everything is so complicated. I want to rest and not have to listen to everyone all the time."

Postpartum recovery, which encompasses both physical and emotional aspects, highlights the social and cultural pressures that can contribute to feelings of exhaustion and stress. Finally, the presence of new family models highlights the diversity and evolution of family structures, which can influence the perception and execution of the mother's role and breastfeeding. These new models require new ways of assessing and supporting the postpartum period and breastfeeding.

Feelings and thoughts about body changes

Feelings and thoughts about bodily changes reveal the complex experiences that mothers have in relation to the transformation of their bodies during pregnancy and breastfeeding. It is difficult to reconcile the image of mother and the image of woman, with the aesthetic implications that this has. The feeling of not recognizing one's own body is a prominent emotional phenomenon since it implies a rejection of the changes that have occurred. These physical changes can have a profound impact on the perception of body identity. This feeling can be linked to significant alterations in body appearance and function during the process of pregnancy and breastfeeding.

"These days you don't even know how to dress, everything feels wrong. Your body feels weird, right? Your belly won't go down, your breasts get bigger and sag, your body swells, you bleed, and the stitches make you feel like part of your body isn't yours. It's weird. It's the hardest thing for me."

Weight loss is presented as a major concern, closely related to current beauty standards. It reflects the complexity of adjusting to the new demands of the mothering role and breastfeeding, combined with maintaining one's former female self. The exhausting experience of breastfeeding highlights the physical and emotional demands that this practice can place on mothers, underlining the need for support and self-care. Here again lies the importance of having a support network. Weight loss can generate a mix of emotions, either as a positive outcome or as a source of anxiety in relation to health and well-being.

"Not long ago, I wore beautiful dresses to go to parties. Everything changes so much. My stomach, my breasts, my legs. I don't recognize myself."

Postpartum recovery addresses both physical and emotional aspects, highlighting the importance of a comprehensive process of restoration and adaptation to changes, all of this closely related to the adaptation to the new maternal role. Concerns about body modifications due to pregnancy and breastfeeding reflect the concerns mothers may have about how these experiences will permanently affect their body, and their future selves. This fear may be related to social and cultural pressures around beauty standards and self-acceptance.

Effects of pain

Pain and nipple injury are physical aspects that can significantly affect the comfort and continuity of breastfeeding. These adverse effects can be caused by various reasons: inadequate sucking by the baby, problems with position or incorrect latching, among other factors, generating discomfort and difficulties, as well as insecurity in the development of breastfeeding. The presence of nipple pain can influence the perception and general experience of breastfeeding for mothers, and is a common cause of rejection towards continuing breastfeeding of the baby. In addition, it is highlighted that labor pain can have additional

implications, as it can make the initiation of breastfeeding even more complicated. Pain associated with childbirth can affect the emotional and physical disposition of the mother, impacting her ability to establish and maintain successful breastfeeding, as it prevents the mother from acquiring adequate postures at the time of breastfeeding. This aspect underlines the interconnection between perinatal events and breastfeeding, highlighting the importance of a comprehensive approach that addresses both physical pain and the associated emotional ramifications.

"With all the pain, it's torture. It hurts so much. I put on the cream they told me to, and it doesn't do anything. Now he's latching on worse, it's getting harder and harder for him. I'm really looking forward to breastfeeding him. I didn't think he'd have such a bad time. I'm having a terrible time. I'm going to keep going, but I'm having a terrible time."

"When he latches on to the breast that hurts the most, you hold on, whether it hurts a lot or a little, and you hold on. The truth is, even though the cracks seem small, they hurt like skin is coming off. When you know he's going to latch on to the breast that hurts the most and you hear him cry, you get a little nervous. It's better not to think about it."

"My nipples are raw, they hurt when I shower, it hurts to get dressed, and when the baby eats, it's horrible. They say she eats well, but it kills me. Now, my breasts have hardened, and they hurt even more."

Discussion

Breastfeeding is globally recognized as a fundamental practice for the health and well-being of both mothers and children, supported by international organizations such as WHO and UNICEF. However, its implementation faces multiple challenges related to biological, cultural, emotional, and social factors. In this context, the immediate postpartum period becomes a critical window for establishing breastfeeding, where the hospital environment and interactions with healthcare professionals play a decisive role. This study provides an essential qualitative perspective to understand mothers' experiences during the first 48 h after birth, identifying barriers and opportunities to enhance support during this key period.

After analyzing the interviews, they confirm much of the literature on the topic consulted. Even though studies are carried out in different countries with different cultures, much of the experience of breastfeeding is similar. Regarding social and cultural influence, two different branches must be established. On the one hand, we find the great influence produced by the customs and beliefs of the group, which is especially seen in those women with deep cultural roots [6]. There is a high percentage of women from South America among the population evaluated (45.2 %; among these mothers, those who had a greater rooting with their reference culture, the influence of beliefs from their culture of origin was greater. In most of these women, there is an important cultural and social history of breastfeeding the children of the family. However, in those women in whom there is less connection with their culture of origin, it is more common to find the need for more educational support due to lack of references.

On the other hand, being supported by deep cultural beliefs creates a barrier in communication with health professionals, and therefore it is more complicated to change myths or misconceptions. As a great advantage, there is a greater predisposition to choose breast milk as a newborn's diet, when there is a history of breastfeeding among the reference people [18] and, even more so, if what the woman has observed are successful breastfeeding in her environment [35].

As another branch of social and cultural influence, the influence of beliefs about the difficulty for a mother to develop successful breastfeeding, which are very common in our Western culture, must also be considered. These ideas and myths about breastfeeding make it easier to abandon or choose another type of feeding [35]. Support is generated to abandon breastfeeding, contrary to health education messages. Likewise, in mothers with traditional beliefs, and in some cases related to belonging to religious groups, the exposure of the female body during

breastfeeding is considered something negative or indecent [19], although a change in the paradigm is observed, especially in European women, where it is not only not considered a negative factor, but a right.

Likewise, in some social circles, the exposure of the female body is considered indecorous and can lead to not maintaining exclusive breastfeeding, or to generating negative feelings related to it. The negative view of breastfeeding in public can be found in the morals of the mother, the environment or society [19].

The cultural differences observed in mothers' experiences align with broader literature on the impact of migration and acculturation on breastfeeding practices. Research consistently shows that while immigrant women often have higher rates of breastfeeding initiation rooted in their cultural traditions, these practices are vulnerable to the process of acculturation [5]. As mothers adapt to the host country's norm, which may include higher rates of formula feeding and a medicalized approach to childbirth, their breastfeeding duration and exclusivity can decline. Furthermore, the migration process itself often dismantles the traditional social support networks (e.g., grandparents, extended family) that are instrumental in providing practical and emotional breastfeeding support in their countries of origin [13]. Consequently, immigrant mothers may find themselves isolated and solely dependent on a healthcare system that is not always equipped to provide culturally competent lactation support. Our findings underscore the need for healthcare professionals to be aware of these dynamics, moving beyond simple advice to offer support that acknowledges and respects the mother's cultural background while helping her navigate the challenges of breastfeeding in a new sociocultural environment.

If we look closer to the mother-child dyad circle, we find the influences of the family and reference people. These influences are usually related to previous experiences and persistent myths in these people from the closest environment. The influence that these can cause is closely related to the bond and dependence that mothers have on this group of individuals. What is frequently observed is the pressure from family and friends regarding the method of raising the newborn, especially regarding the feeding method. This pressure is related to previous experiences and existing myths in those members of the mother's closest circle. In a high percentage, women report pressure from these members of their close circle, when they do not coincide in their expectations [29]. However, even when ideas about breastfeeding between new mothers and their family coincide, the family continues to be a reference for support in parenting [15]. When such support is impossible due to distance or the great gap between ideas about parenting, it generates a great void and instability for the mother.

Mothers' experience of feeding their newborns directly affects their emotional state. A wide range of emotions are observed: from fear, guilt, shame to joy and satisfaction. Mothers who do not choose to breastfeed or who face difficulties at the beginning and are forced to abandon their goal of exclusive breastfeeding frequently feel guilty about not starting, abandoning or failing to establish and maintain breastfeeding [14,19]. Shame, on the other hand, is more related to interaction with others (reference persons or health professionals) when there are difficulties or when mothers are subject to evaluation by others.

As a common factor for many puerperal women in the first days postpartum, the influence of health professionals from different perspectives and with different results stands out. The attitude of health professionals influences the emotional process that allows women to validate their motherhood, in many cases, through their intervention in maternal performance in feeding newborns [19]. Regarding the performance of health professionals, the feeling of mothers that these health professionals do not have adequate training is important, in addition to not having enough time to provide effective educational and logistical support. Both components contribute to not supporting the development of breastfeeding in new mothers and decrease the feeling of self-efficacy experienced by mothers [32]. In general, it is observed that most mothers do not feel adequately supported by the health care received. And they feel judged when their choice is not breastfeeding

[4], to the point that they prefer to lie to health professionals, so as not to feel judged. It is identified that the care at the beginning of breastfeeding is focused on a biomedical approach [32] in which mothers feel that health professionals examine, judge and do not respect the autonomy of patients. The three elements of the biomedical model in breastfeeding care generate less self-confidence in the mother, less effectiveness in the initiation of breastfeeding, long-term effects on maternal emotional well-being and create barriers in communication. On the other hand, and it has not been found in the consulted bibliography, they positively value the educational support received from primary care prior to birth. Although they also value the preparation for breastfeeding prior to birth as insufficient.

It must be considered that sometimes there is a great distance between the expectations created in relation to parenting and reality [3,14,15,19]. When there are positive feelings in relation to infant feeding, a feeling of greater bonding with the child is generated. In this sense, perhaps due to the early nature of the study in the evolution of breastfeeding, no difficulty has been observed in the bond with the child when breastfeeding develops with difficulty [25,33]. This would be an interesting point to evaluate at the next level of the study.

Regarding the bodily changes related to childbirth and breastfeeding, concern and dissatisfaction are mainly observed. On the contrary, it is observed that these changes create an imaginary distance between the woman before pregnancy and the woman after childbirth [26].

The challenges mothers faced can be analyzed through the lens of social support frameworks, which categorize support into distinct types: emotional, informational, instrumental, and appraisal [21]. Our findings indicate that while mothers received instrumental support, the provision of informational and emotional support was often fragmented and inconsistent. The conflicting advice described by participants highlights a critical failure in providing coherent informational support, which is known to increase anxiety and undermine maternal confidence [28]. Moreover, the mothers' narratives underscore the profound impact of emotional support; the way advice was delivered was often more significant than the advice itself. A perceived lack of empathy or patience from staff acted as a significant barrier, whereas moments of genuine encouragement constituted powerful acts of appraisal support, validating the mother's efforts. Therefore, our study suggests that for effective breastfeeding promotion in the immediate postpartum period, it is not enough for support to be merely available; it must be holistically integrated. Professionals should be trained not only to provide technical help but also to deliver consistent information and sensitive emotional support, thereby creating a robust supportive environment that empowers mothers during this vulnerable transition.

Our findings resonate deeply with Bandura's theory of self-efficacy, which posits that an individual's belief in their capacity to succeed is a key determinant of their performance [1]. In the context of breastfeeding, maternal self-efficacy is a powerful predictor of initiation and duration, as extensively documented by researchers like Dennis and [10]. The experiences of uncertainty and frustration reported by mothers in our study can be interpreted as a reflection of low initial self-efficacy, shaped by the four main sources proposed by Bandura. The difficulties with latching and the pain experienced represent challenging 'mastery experiences' that, instead of building confidence, undermined it in this critical early phase. Furthermore, the inconsistent advice from professionals deprived mothers of positive verbal persuasion, a crucial element for building confidence. Our results suggest that the 48-hour hospital stay is a formative period where healthcare professionals' actions such as providing hands-on assistance or offering consistent encouragement are not merely supportive gestures, but critical interventions that directly shape a mother's breastfeeding self-efficacy. When a midwife successfully helps a mother and baby achieve a painless latch, she is providing a powerful vicarious and mastery experience that can significantly bolster the mother's belief in her own ability to continue breastfeeding after discharge [8].

Our findings reflect the complexity of breastfeeding, with cultural

and emotional nuances reported in previous studies, while also highlighting specific critical areas for improvement in the hospital context. In line with research conducted in other countries, the educational support received by mothers was found to be inconsistent, with contradictory messages from healthcare professionals undermining women's confidence in their ability to breastfeed. Taylor et al. also identified that mothers often perceive an overly biomedical approach in care, leading to feelings of judgment and diminished autonomy [32].

Furthermore, the emotional experiences associated with breastfeeding, such as fear of failure, guilt, and insecurity, are common among the interviewed mothers. These emotions are deeply influenced by social and cultural norms, aligning with the findings of Leeming et al. [19], who highlighted the impact of self-conscious emotions on infant feeding decisions. This aspect underscores the need for a more humanized approach to care, characterized by empathetic, respectful, and culturally sensitive interactions.

A critical issue identified was the lack of time and training among healthcare staff, a barrier also described in other studies [30]. Addressing this issue could involve implementing continuous training programs for professionals, focusing not only on technical skills but also on communication and cultural competence. Additionally, ensuring an adequate staff-to-patient ratio is essential to enable meaningful interactions during this crucial period.

Limitations

Despite the efforts made to ensure the validity and reliability of this qualitative study on mothers' experience of breastfeeding during hospital admission after birth, it is important to recognize the limitations that may have influenced the results and the interpretation of the findings. These limitations include the sample size, which consisted of 14 mothers who voluntarily participated in the interviews. Although diversity was sought in the selection of participants, the relatively small sample size prevents generalization of the results to a broader population of breastfeeding mothers in similar hospital settings. Having found very similar results in the consulted literature, reinforces the conclusions reached. Interviewer bias must also be considered, since the interpretation of interview responses may have been influenced by the interviewer's prejudices or expectations. In this sense, it is impossible to completely eliminate subjectivity in interpretation. Furthermore, this study was conducted in a specific context, which could limit the applicability of the findings to other cultures or social contexts, which are increasingly common in our environment. Mothers' perceptions and experiences of breastfeeding may vary according to cultural, social and economic factors, which were not fully addressed in this study. Since large differences have been observed depending on maternal origin, it is considered necessary to delve deeper into the cultural influence on choices regarding infant feeding.

Likewise, during the data collection period, participants may have experienced external events or situations that influenced their experiences and perceptions about breastfeeding. These external factors were not controlled in the study and could have affected the results in unexpected ways. Finally, the analysis is focused on first-time mothers, which leads to assessing a new experience that is just beginning, which may create opinions that are not settled or based on a deep knowledge of the process. For this reason, it is considered necessary to repeat the interviews after a few weeks, expanding the study to the analysis of the maternal experience of breastfeeding at 3 months after delivery.

Implications for policy and practice

Taking these limitations into consideration, this study provides a meaningful and enriching insight into mothers' experiences of breastfeeding during hospital admission after birth, which may contribute to the development of more effective interventions and policies to support breastfeeding mothers in hospital settings. However, caution is advised

when interpreting the results and their applicability to other contexts.

Following the analysis carried out, the need to delve deeper into the evolution of the experiences of these mothers is raised, with interviews a few months after the birth. However, the need to identify the influence of the mothers' cultural origin has also been identified, since in an increasingly multicultural society, humanized care for mother and child requires understanding their social context. In general, we could say that, in a world where motherhood is idealized, with the obligation for all mothers to do everything well, many mothers do not find the support they need for their new life, neither from health professionals nor in the family and social environment.

Breastfeeding, as a health-promoting practice for both mother and child, is shaped by diverse factors that interact during the early postpartum period. Educational support from healthcare professionals emerges as a critical element, yet it is often hindered by barriers such as limited time, inconsistent information, and insufficient cultural sensitivity. These gaps in professional care exacerbate the challenges mothers face, especially when their beliefs about infant feeding differ from those of their surrounding environment, leading to communication barriers with reference persons.

External influences, such as social support and family opinions, significantly impact breastfeeding decisions. Supportive family dynamics can encourage initiation and continuation, while conflicting beliefs may create additional pressure or doubts for mothers. Many women report experiencing pain, fatigue, and lack of sleep in the initial days, challenges that are not adequately addressed in hospital settings. The rigidity of hospital routines further limits opportunities for mothers to adjust to their new roles.

Lastly, societal expectations around the idealized concept of a "good mother" add emotional strain. This is particularly harmful for women without prior breastfeeding examples in their environment, as it magnifies feelings of insecurity and inadequacy. Addressing these issues requires a humanized approach to care, fostering empathy and tailored support for each mother's unique experience.

CRediT authorship contribution statement

Cristina Nieto: Writing – review & editing, Writing – original draft, Resources, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Patricia Lopez-Mases:** Writing – review & editing, Validation, Supervision, Resources, Methodology, Investigation, Conceptualization. **Rafael Vila-Candel:** Writing – review & editing, Resources. **Esther Lazaro:** Writing – review & editing, Validation, Supervision, Resources.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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