

**“Breastfeeding is natural, but it’s not the norm in  
Ireland”.**

**An assessment of the barriers to breastfeeding and the  
service needs of families and communities in Ireland  
with low breastfeeding rates**

**A report prepared by the UCD School of Public Health and Population  
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## List of abbreviations

BFHI	Baby Friendly Hospital Initiative
DOHC	Department of Health and Children
ESRI	Economic and Social Research Institute
FSAI	Food Safety Authority of Ireland
GP	General Practitioner
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
LLL	La Leche League
MCS	Millennium Cohort Study
OLS	Ordinary least squares
OR	Odds ratio
ROI	Republic of Ireland
SE	Standard error
SES	Socio-economic status
SLAN	Survey of lifestyle, attitudes and nutrition in Ireland
UNICEF	United Nations Children's Fund
WHO	World Health organisation

## List of definitions<sup>1</sup>

**Infant formula:** artificial breast milk substitute, usually casein based or soy based, which is recommended for use in women where breastfeeding is not possible.

**Breastfeeding initiation:** the mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, she either puts the baby to the breast, or the baby is given any of the mother's breast milk

**Exclusive breastfeeding:** the practice of feeding only breastmilk (including expressed breastmilk) to infants. No other substances are permitted, aside from vitamins, minerals or medicine.

**Non-exclusive breastfeeding:** the practice of feeding breastmilk in conjunction with other foodstuffs such as breastmilk substitutes

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<sup>1</sup> Definitions derived from the Who Baby Friendly Hospital Initiative teaching materials, accessed on 19th November 2009 at [http://www.who.int/nutrition/publications/infantfeeding/9789241595018\\_s2.1.pdf](http://www.who.int/nutrition/publications/infantfeeding/9789241595018_s2.1.pdf). except for the definition of Breastfeeding initiation which was derived from UK NHS definitions from [http://www.bristolpct.nhs.uk/PublicHealth/healthofbristol/improving\\_health/breastfeeding\\_initiation.asp](http://www.bristolpct.nhs.uk/PublicHealth/healthofbristol/improving_health/breastfeeding_initiation.asp)

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## **1 EXECUTIVE SUMMARY**

### **1.1 Background and context**

Breastfeeding is widely recognised as the optimal way to feed an infant, with multiple health benefits for both the baby and the breastfeeding mother. Despite this, breastfeeding initiation rates in Ireland are low in comparison with other industrialised nations, and persistence in breastfeeding up to six months of age is rare amongst Irish mothers. Particular subgroups of the population are at most risk of never initiating or prematurely discontinuing breastfeeding, namely those mothers who are younger, have less formal education, and who are more likely to be economically deprived.

International studies by such bodies as the WHO have shown that maternity unit factors such as separation from the infant at birth and promotion of artificial breast milk substitutes, and maternal factors such as low educational achievement, are recognised barriers to breastfeeding initiation and continuation. However, given the problem that clearly exists with establishing a culture of breastfeeding in Ireland, there is a need also to address the barriers specific to the Irish population, and indeed, to those mothers at highest risk of never breastfeeding. In the current situation, the economically disadvantaged mother is the least likely to benefit from the economic advantages of breastfeeding. The same mother, who may not have consistent access to healthcare, is also not providing her baby with the health benefits of breastfeeding, which has been shown to be robustly associated with lower rates of infections such as otitis media (inner ear infections). Multiple public health nurse clinics and community organisations exist to support breastfeeding mothers, but it is unclear whether this disenfranchised group avail of these services.

A key objective proposed by the 2005 Report of the National Committee on Breastfeeding is to identify the needs of families in society in Ireland which do not breastfeed (Objective 1.1 (5), DOHC, 2005). In response to this action point, and commissioned by the HSE, we undertook this study of the factors, both previously



identified and new, that may be contributing to the low breastfeeding rates in vulnerable and socio-economically disadvantaged mothers. This executive summary will summarise the findings from the extended report.

## **1.2 Study design**

This study has five aspects. First, there is a literature review, undertaken to establish the international and national evidence about breastfeeding rates and gaps in service amongst socio-economically disadvantaged mothers. Second, a quantitative study with analysis of four data sources (cohort studies and cross sectional surveys) from the UK and Ireland, to frame the question of maternal disadvantage and breastfeeding rates in contemporary data. Third, a description of the current breastfeeding support services in Ireland, with an audit of the breastfeeding policies of the Irish maternity hospitals. Fourth, a qualitative study using focus groups and semi-structured interviews on the perceived barriers to breastfeeding from the perspective of the women themselves, some who have breastfed and some who have not, from different settings and degrees of socio economic disadvantage.. Fifth and finally, a qualitative study using semi-structured interviews, of the barriers as perceived by breastfeeding support service providers, from within the HSE and from external groups. Both qualitative studies were undertaken to gain new insights into the issues and barriers that women are currently facing.

## **1.3 Literature review**

A literature search was undertaken to describe available Irish breastfeeding data, to contextualise in relation to other westernised countries, and to describe the existing research on barriers to breastfeeding both in the quantitative and qualitative fields of research. Ireland compares very poorly with the rates of breastfeeding initiation and duration as described by such countries as the UK, Australia, USA and Canada and the northern European countries. In Ireland, the mothers who are more likely to breastfeed are non-Irish nationals and those with higher status jobs. Mothers who are less likely to breastfeed are those in routine or low status jobs, younger

mothers and those of low socioeconomic status. Internationally, this correlation between social position and breastfeeding is present even in countries with high breastfeeding rates and established breastfeeding support structures.

The review of the qualitative research is considered in terms of the mothers' antenatal intentions and beliefs, their post partum experience, the support received from health professionals, their social supports and the effects of the prevailing culture and embarrassment. It has been shown that mothers in the low socioeconomic groups may have an antenatal expectation that breastfeeding will be difficult, and that they will not succeed at it. Conversely, there is a perception that breastfeeding is natural, and therefore if problems do arise, mothers have not anticipated and are not prepared for this period of learning a new skill. Previous exposure to newborn infants builds confidence in parenting skills, and similarly exposure to breastfeeding is an important contributor to confidence in breastfeeding. A need for practical skills training, as opposed to written information only, is expressed. Health professionals are seen to "do, rather than teach", and mothers prefer a more hands-off method of instruction on the skills needed for caring and feeding their infants. There is also a finding that some low income mothers fear antenatally that their breastmilk would be insufficient for the needs of their baby. This has been found also to be a significant cause of women prematurely stopping breastfeeding.

The role of social supports is an important one, with a supportive mother, friend and/or partner having a substantial positive impact on breastfeeding. Among groups of middle class women, support networks such as breastfeeding groups can be extremely helpful in promoting continuation of breastfeeding. This socialization is a positive experience for the mothers and is an important mode of transmission of feeding practices and beliefs. Embarrassment and shame of personal exposure of one's breasts in public is a commonly cited fear among women in low socioeconomic groups.

Within the Irish context specifically, qualitative studies have found similar concerns as those found in the international literature. Barriers identified include possible negative attitudes of others, and the idea that breastfeeding is inconvenient and hampers your ability to get out and about. Bottle feeding is seen as a “natural” part of the culture and of child rearing, with the minority of women who did breastfeed expressing a strong level of self determination regarding their choices. Social embarrassment relating to breastfeeding is a consistent theme identified in the Irish studies. One study of Traveller women discussed the potential embarrassment that Traveller women might feel in relation to breastfeeding, particularly in light of the lack of privacy which may affect them in their homes. Traveller mothers have particularly low rates of breastfeeding initiation. This is in the context of high rates of galactosaemia within the Travelling community, and recommendations to hospital staff to discourage galactose-containing feeds including breastmilk for all Traveller infants, until the results of the diagnostic Buetler test for galactosaemia are available. A scheme in certain HSE areas also provides free formula milk to low-income mothers until their infant is 6 months old, with no reciprocal benefit for those mothers who are breastfeeding.

#### **1.4 Quantitative study results**

A review and quantitative analysis of secondary data sources was undertaken, with the aim of describing current breastfeeding practices as identified in these data sources, and using the data to identify predictors of breastfeeding initiation and duration in an Irish context. Three Irish data sets were analysed: SLAN (Kelleher et al, 1999; Kelleher et al, 2003; Morgan et al, 2008), Lifeways (O’Mahony et al, 2007), and the All Ireland Traveller Health Study or AITHS, with a further cohort from the UK included to make comparisons with the breastfeeding practice in our geographical neighbour.

As established previously in the literature, the Irish breastfeeding initiation rates are lower than those in the UK (54.1% in the 2007 Irish Lifeways survey vs 65.6% in the 2001 UK Millennium Cohort Study (MCS: Dex & Joshi, 2005) and 78% in the 2005 UK Infant Feeding survey (Bolling at al., 2007), although it should be noted

that breastfeeding rates in Northern Ireland (47.8% in the 2001 UK Millennium Cohort Study and 63% in the 2005 UK Infant Feeding Survey) are lower than the rates reported for the whole of the UK. Furthermore, breastfeeding initiation rates amongst Traveller women are particularly low.

Despite this poor initiation rate, of the mothers who do breastfeed, the average duration of exclusive breastfeeding in Republic of Ireland (ROI) women is longer than for the whole UK sample (ROI mean duration 11 to 17 weeks, compared with 8 weeks in the UK MCS). From the Lifeways cohort study, mother having a third-level educational degree was an independent positive predictor of breastfeeding initiation (Odds ratio or OR 5.50, standard error or SE 1.86,  $p < 0.01$ ). From SLAN 2007, mother's education was also an independent predictor of breastfeeding initiation, with a clear gradient of the effect size (OR 2.24, SE 0.67 for completing secondary education, OR 3.45, SE 1.0 for undertaking some third level education, and OR 5.89, SE 1.77 for completing third level education,  $p < 0.01$  for all point estimates). Other positive predictors which were statistically significant were increasing maternal age, increasing size of family, and maternal employment. Maternal smoking was a negative predictor. Similar patterns were observed in the UK data, although here maternal employment was a negative predictor for breastfeeding initiation.

Associations with duration of breastfeeding were examined. From the Lifeways cohorts, mother having completed third level education and larger family sizes were positively associated with an increased duration of breastfeeding. There was also a positive association with mother's age when non exclusive breastfeeding was used as the outcome variable. The positive association between breastfeeding duration and education status persisted in the SLAN studies, as did the association with larger family size and increasing maternal age. Maternal smoking was associated with lower non-exclusive breastfeeding duration in the SLAN 2007 data. The associations with exclusive and non exclusive breastfeeding duration in the UK MCS data are broadly similar to those seen in the Irish data: however, maternal

employment is again a negative factor in the UK, with a negative association with both exclusive and non-exclusive breastfeeding.

To summarize: breastfeeding rates in Ireland are below the WHO recommendations in terms of both exclusive and non-exclusive breastfeeding. Based on all available national datasets for the last ten years, the Irish breastfeeding initiation rate ranges from 38% to 55%, and remains below the UK's initiation rate of 66%. In the 2005 UK Infant Feeding survey (Bolling at al., 2007), rates of breastfeeding at 6 weeks in 2005 were 21%. At 6 months, only very few Irish and UK mothers are breastfeeding exclusively (2.1% vs <1% respectively). Clearly, breastfeeding duration rates are still well below the WHO guidelines recommendation of 6 months of exclusive breastfeeding and up to 2 years of non-exclusive breastfeeding. The primary factor influencing the incidence of breastfeeding in the UK and Ireland is maternal education. Marital status, maternal age and smoking also play a role in breastfeeding decision across all samples. The factors influencing the initiation and length of breastfeeding differ somewhat across the samples. While maternal education and the number of children play a consistent role in breastfeeding duration, few other factors are statistically significant across all samples. This may reflect differing questionnaire items used to ascertain breastfeeding initiation and duration in the studies. Furthermore, the sampling frames and methods across the study datasets differed, rendering a direct comparison of the datasets challenging.

Despite these considerations, a clear picture of Ireland's challenges with regards to meeting national and international breastfeeding targets and recommendations has been presented, and the link between maternal educational status, maternal age, and maternal smoking has been again verified in the Irish population.

### **1.5 Results of the audit of services for mothers wishing to breastfeed or currently breastfeeding**

Although breastfeeding is thought of by mothers as a natural process, it is in fact a skill which must be learnt by new mothers. How to latch the baby on to the breast, understanding the baby's signals and needs, knowing when the baby is feeding

enough and thriving, and understanding the potential problems in breastfeeding and knowing where to go to get help, are vitally important skills and lessons. However, with breastfeeding so uncommon in Ireland, these lessons and skills are no longer being passed on from mother to daughter, and support must be sought from outside persons or agencies. This substudy investigated the current services available in the community for support and education about breastfeeding, and the current services and policies regarding breastfeeding promotion and support within the public maternity units in the Republic of Ireland.

The community services relating to breastfeeding were identified through the World Wide Web (via the HSE's [www.breastfeeding.ie](http://www.breastfeeding.ie) links), through services known to us, and services mentioned during the qualitative interviews. With respect to services provided by the HSE: these included breastfeeding clinics run by the maternity hospitals and sited within the maternity hospitals, breastfeeding clinics run by public health nurses, services provided by general practitioners, information available through [www.breastfeeding.ie](http://www.breastfeeding.ie), and services available through the community mothers' scheme. With respect to services provided by voluntary and charitable organisations, these included services provided by Cuidiu (the Irish Childbirth Trust), La Leche League of Ireland, and the website [www.thebreastway.com](http://www.thebreastway.com). With respect to services provided on a private fee-for-service basis, these included private lactation counsellors and maternity nurses. It was clear from this overview of services that there are a number of committed health professionals and interested mothers, both in private practice and in the community, providing expert advice and support and facilitating vital group meetings. However, these services are not uniformly available across the country, and access to such services as Cuidiu and La Leche League meetings is variable. Nevertheless, the persons who run these services express a great commitment to the promotion breastfeeding, and will offer telephone counselling to mothers with difficulties.

The activities of the maternity units in promoting breastfeeding were assessed by evaluation of the hospitals' written policies. These were requested from all public

maternity units in the Republic of Ireland, and of the 19 units contacted, all provided a written policy (15 policies from 19 units, with one policy covering two units and one policy covering four units). The policies were assessed by whether they adhered to the WHO's "Ten Steps to successful breastfeeding" (WHO, 1998) and the International Code (the "Code") of marketing of breastmilk substitutes (WHO, 1981). The "Ten Steps" are also routinely assessed by both policy review and site visits and interviews with key personnel by the Baby-Friendly Hospital Initiative (BFHI) team. The BFHI is a UNICEF-guided global campaign which was instigated in 1991. Over 300 European hospitals have achieved Baby-Friendly status, and the Irish BFHI was initiated in 1998. As of September 2009, 19 of the 20 Irish maternity hospitals were participating in the BFHI.

Of the 15 hospital breastfeeding policies reviewed, there was a consistent commitment seen to the principles of the Ten Steps, with all or nearly all of the policies endorsing the practices of early post delivery skin to skin contact and "rooming in", as well as ensuring that information regarding the benefits of breastfeeding is delivered to mothers, training all maternity staff in breastfeeding practices, prohibiting the promotion of bottle feeding at antenatal classes and encouraging new mothers to attend breastfeeding support services. However, it was notable that much fewer policies explicitly stated that mothers should aim to breastfeed exclusively to 6 months (8/15 policies, 53.3%), and to continue to breastfeed to 2 years (7/15, 46.7%).

With regards to adherence to the Code, fewer policies explicitly stated principles in keeping with the Code's aims. In particular, only one policy stated that no free infant formula would be provided to mothers on discharge from hospital (6.7%), with three policies stating that the sale of formula was prohibited on the hospital premises (20.0%) and two stating that the sale of bottle feeding paraphernalia was prohibited on hospital premises (13.3%). Given the widespread bottle- and formula-feeding culture in Ireland, we might speculate that at least some of the other maternity units are indeed providing these services to mothers, contrary to the premises of the Code, but perhaps done with the intention of facilitating all

mothers and ensuring that infants will be given adequate nutrition on discharge home, albeit infant formula. However, it could be argued that if adequate prenatal education, in-hospital breastfeeding assistance and post discharge support were in place, such safeguards should not be needed.

In summary, an audit of hospital and community breastfeeding services and practices has shown the multiplicity of services available to mothers intending to breastfeed and those who are currently breastfeeding. Consistent provision of these services, and consistent reinforcement of the WHO "Ten Steps for successful breastfeeding" and the "Code" within the maternity services through such initiatives as the BFHI, are key to supporting women in initiating and maintaining breastfeeding.

### **1.6 Qualitative study results**

To identify the true base causes of the poor levels of breastfeeding in Ireland and in particular, in the most vulnerable populations, qualitative interviews were undertaken. These were performed with mothers themselves, with a mixture of focus group sessions and individual interviews used. Mothers from four groups were recruited: urban mothers at socio economic disadvantage, rural mothers at socio economic disadvantage, Traveller mothers and mothers who were part of the *Preparing for Life* study of parenting in settings of severe socio economic disadvantage. Secondly, individual interviews using topic guides were used to gather data from 40 breastfeeding service providers, both from the hospital and paramedical settings, but also from community groups and services.

From the mothers' interviews, it is clear that the mothers are not unaware of the benefits of breastfeeding, and indeed some express guilt that they were unable to provide these benefits for their children. They however describe that breastfeeding is not the norm amongst their friends or family. Whilst they would support another mother who breastfed, they themselves would experience shame or embarrassment if they were to be seen to breastfeed, or to breastfeed in public. The family, in particular the woman's mother, has a significant influence on infant feeding.



Mothers describe mixed experiences in the maternity services. It is suggested that more practical breastfeeding information in the antenatal period would be helpful. Whilst some mothers describe receiving advice and support from health care workers in the maternity hospitals and from their public health nurse (PHN), others describe receiving inconsistent advice, and encountering health professionals who were under too much time and work pressure to help them. Traveller mothers describe feeling isolated on the maternity wards, and feeling unable to ask any questions.

Service providers also highlight the lack of consistent information as a key issue, both information that they can access to inform their breastfeeding practice, and the information which mothers are given by different service providers. Mothers in the socio-economically disadvantaged groups are infrequent attendees at antenatal classes, and are hard to access to educate regarding breastfeeding.

Within the maternity unit setting, staff are felt to have insufficient time to adequately support breastfeeding mothers. "Top ups" of formula are thought to be over-used, and act as a deterrent to breastfeeding. The free formula milk scheme is also a potential deterrent. There is a problem of continuity of care when a breastfeeding mother moves from the hospital milieu to the community framework, and there can be a drop-off of breastfeeding at this time.

In summary, both mothers and service providers identify a number of key issues in common: the appropriate and timely provision of information both to service providers and to mothers; the pressure on health workers in the maternity units; the positive effect that breastfeeding role models and support from key family members can have; and the continued culture of "embarrassment" that surrounds breastfeeding in Ireland.

## **1.7 Conclusions and Recommendations**

It is clear that there are multiple barriers to increasing the breastfeeding rates in Ireland's most vulnerable mothers. The community skills base of knowledgeable breastfeeding mothers has been lost, and this is most true in the poorest areas. Within the hospital setting, breastfeeding must continue to be prioritised, with healthcare workers educated in the skills necessary to successfully help mothers to initiate and maintain breastfeeding. Attendance at the 20-hour course should be mandatory for the healthcare workers who have patient contact. The mother's personal choice in how she feeds her infant should be respected at all times; nevertheless, breastfeeding should be assumed to be the default method of infant feeding, as opposed to an intention to bottlefeed being assumed. The antenatal visits must be considered as a prime opportunity to access mothers for education regarding breastfeeding benefits and skills. Traveller mothers who might wish to breastfeed should be strongly encouraged to do so. The Buetler test should be prioritised for these mothers in the first day post partum, and the mother be either allowed to breastfeed, or supported to express breastmilk, whilst awaiting the results.

Strong links need to be maintained between the hospital and community services, to ensure that breastfeeding mothers always have an access point for assistance. Instead of the current disincentives to breastfeeding (such as the Free Formula Milk scheme), breastfeeding should be positively incentivised, with consideration to provision of such supports as open access to healthcare services such as GP visits for issues relating to breastfeeding, or access to free or low cost breastfeeding-specific equipment (breast pumps, vitamin D drops etc.).

Breastfeeding need to be brought back into our communities, and to lose its status as the minority method of infant feeding. The mother's partner and own mother can provide valuable support, if they have been engaged with and educated. The support of community opinion leaders and respected community health workers can help individual mothers to persist with breastfeeding. Even in a period of challenging national economic conditions, we must continue to support those

community groups which promote breastfeeding. By empowering mothers to breastfeed today, and by establishing the concept amongst women, currently at highest risk of not breastfeeding, that breastfeeding is truly a natural, normal way to feed one's infant, we take a positive step to promote the health of children and adults for generations to come.

## **2 BACKGROUND AND CONTEXT**

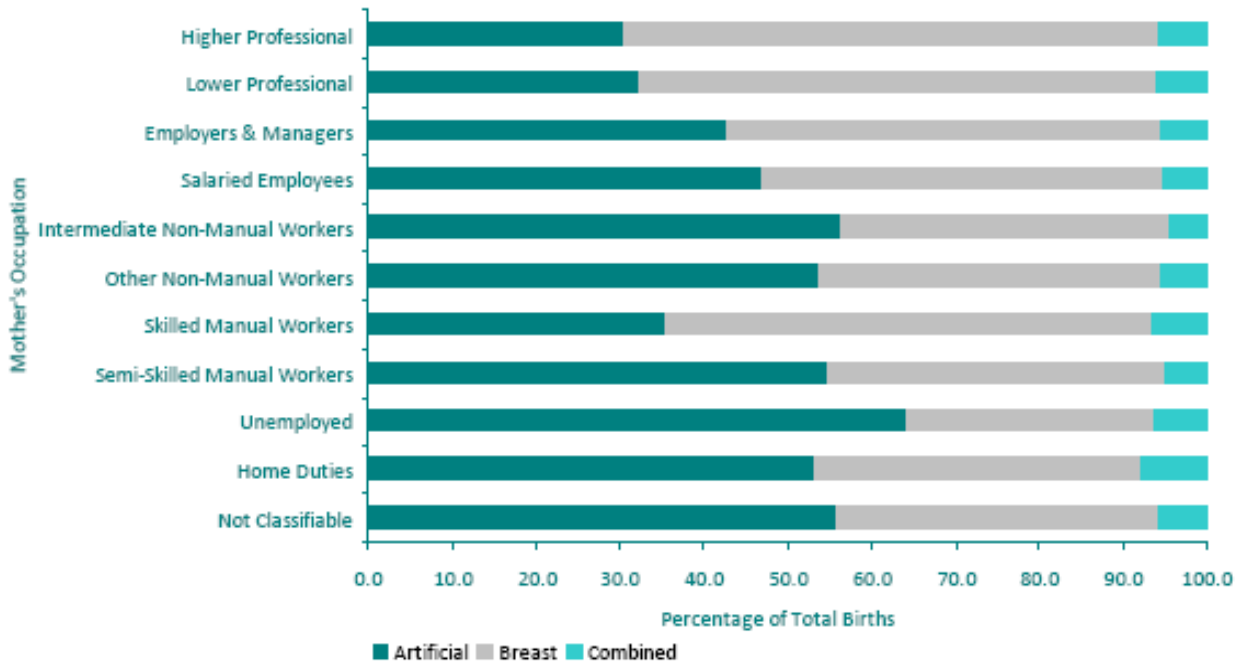
### **2.1 Introduction**

Breastfeeding is widely recognised as the optimal way to feed infants. It has multiple advantages over other artificial feeding methods. First, there are considerable benefits for the infant. Compared with infants who do not receive breast milk, the infant who is breastfed for at least 13 weeks is five times less likely to have a diarrhoeal illness requiring hospital admission (Howie et al., 1990), five times less likely to develop a urinary tract infection (Wright et al, 1989), and two times less likely to have a respiratory illness requiring hospital admission (Saarinen & Kajosaari, 1995). Ever breastfeeding compared with exclusive bottlefeeding is associated with a 23% odds reduction (95% confidence interval (CI) 9 to 36%) in acute otitis media, and this odds reduction increases to 50% when exclusive breastfeeding for 3 to 6 months is compared with bottle feeding (Ip et al, 2007). Compared with artificial breastmilk substitute or “infant formula” milks, breastmilk feeding in premature infants is associated with much lower rates of necrotizing enterocolitis, a life threatening condition in this vulnerable group, and one which is associated with a significant morbidity and mortality burden (Meinzen-Derr, 2009).

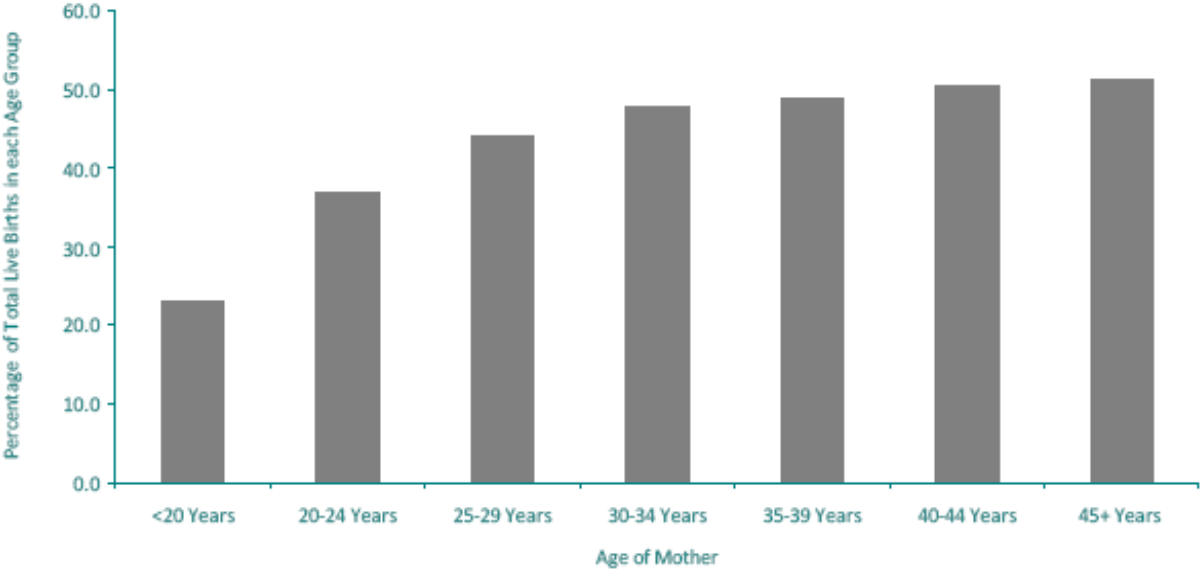
There are benefits to the mother also from breastfeeding. In observational data, ever having breastfed, compared with never having breastfed, is associated with a 25% risk reduction for pre menopausal breast cancer in women with a family history of breast cancer (Stuebe et al, 2009). There is also limited evidence that breastfeeding may be associated with a reduction in ovarian cancer (Ip et al, 2007) Breastfeeding may aid maternal weight loss post partum, although this data comes from small studies only (Kramer et al, 1993; Dewey, Heinig & Nommsen, 1993). From two large cohort studies, mothers without gestational diabetes mellitus who breastfeed have a lower risk of developing diabetes, with the benefit increasing with increasing duration of breastfeeding (Stuebe et al, 2005).

Despite these known benefits, breastfeeding remains the minority method of infant feeding in Ireland. Within the general population of mothers both in Ireland and internationally, there are subpopulations that are less likely than the average to initiate and maintain breastfeeding. A common finding in Western nations is that both recent and established immigrants have higher breastfeeding initiation rates than do Western-born white women (Celi et al, 2005). Other general factors which are associated with longer durations of breastfeeding include a positive attitude to breastfeeding and a positive intention to breastfeed, a non smoking mother, maternal education and ease of breastfeeding in the first week to month (Scott et al., 2006; DiGirolamo et al, 2005). Maternal employment shows an equivocal association with breastfeeding, with some studies showing this as a negative association with breastfeeding (Scott et al, 2006), and others, a positive (Ward et al, 2004). However, consistent negative associations with breastfeeding intention, initiation and duration are maternal socio economic deprivation (ESRI, 2006), younger maternal age (Fitzpatrick, Fitzpatrick & Darling, 1994), and lower maternal education status (Ward et al, 2004). At a national level, the ESRI's perinatal statistics group collect hospital discharge data on all mothers, and report on a breastfeeding rate calculated on the number of mothers of live births who are breastfeeding at hospital discharge. Their report from 2007 shows the distribution of breastfeeding mothers by mother's occupation, mother's age and by county of residence, for all live births (Figures 2.1 to 2.3). Clearly, the younger women and the semi skilled and unemployed families have markedly lower rates of breastfeeding than other groups. It should be noted that mothers who describe themselves as being engaged in home duties also have relatively low rates of breastfeeding. From the SLAN report of 2007, when asked the question "Did you breastfeed any of your children?", 56% of mothers in social class 1-2 replied, "Yes", compared with only 33% in social class 5-6 (Morgan et al, 2008).

**Figure 2.1 Percentage of mothers breastfeeding at hospital discharge in Ireland, by mother's occupation. Reproduced with permission from the 2007 National Perinatal Statistics report (ESRI, 2007)**



**Figure 2.2 Percentage of mothers breastfeeding at hospital discharge in Ireland, by age of mother. Reproduced with permission from the 2007 National Perinatal Statistics report (ESRI, 2007)**







## **2.2 Aims**

This document aims to describe the barriers to breastfeeding in Ireland in groups with the lowest rates of breastfeeding: specifically, women who are at socio-economic disadvantage, including low income women, and women within the Travelling community.

## **2.3 Objectives**

To perform a literature search and review of the association of social disadvantage and lower breastfeeding initiation and duration rates, and of the barriers to breastfeeding identified in studies of these women.

To identify and examine sources of data on breastfeeding in socio economically disadvantaged women, and to identify predictors of breastfeeding in same.

To perform an audit of existing hospital and community breastfeeding services and maternity hospital breastfeeding practices, which aim to provide support to women in initiating and continuing breastfeeding.

To identify attitudes to breastfeeding and barriers to same in women with markers of socio economic deprivation (medical card holders, members of the Travelling community) as identified by the mothers themselves, through qualitative data collection methods.

To identify attitudes and perceived barriers to breastfeeding in socio economically disadvantaged women and other groups less likely to breastfeed, as identified by key opinion leaders and healthcare groups, through qualitative semi-structured interviews.

To synthesize the qualitative and quantitative data, and draw conclusions on where the barriers lie for initiation and continuation of breastfeeding in families and communities with low breastfeeding rates.

To make appropriate recommendations based on the above findings.

## **3 LITERATURE REVIEW**

### **3.1 Introduction to the literature review**

This review of the literature is intended to provide an overview of both the association of social disadvantage and lower breastfeeding initiation and duration rates, and of the barriers to breastfeeding identified in studies of these women. The initiation and duration rates in Ireland and other westernised countries are first of all examined. The relationship between socio-economic status and breastfeeding both in Ireland and internationally is then discussed. The qualitative research both in Ireland and internationally is then presented to examine the cultural and psychosocial barriers, which underlie the low rates of breastfeeding in socio-economically deprived communities.

### **3.2 Methods**

Relevant literature was identified from a number of sources. A number of search terms including 'breastfeeding', 'qualitative', 'barriers' and 'socio-economic status' were used to identify studies from Ireland and other westernised countries from key electronic databases (e.g., PubMed). In addition, the reference lists of relevant papers were searched. Furthermore, the Health Promotion Research Centre in NUI Galway provided the research team with a bibliography of Irish infant-feeding related research, which they recently collated for the formation of a searchable database of Irish infant-feeding research for the HSE. This bibliography provided a comprehensive list of published and unpublished studies and post-graduate theses related to infant-feeding in Ireland. On the basis of this bibliography, a searchable database is being constructed by the HSE. It is intended that this database will be made publicly available on the [www.breastfeeding.ie](http://www.breastfeeding.ie) website. As the database is not yet publicly available, the bibliography of Irish infant-feeding related research was used to identify relevant Irish research for this literature review.

### **3.3 Results**

#### **3.3.1 Breastfeeding rates in Ireland**

Despite strong evidence of the benefits of breastfeeding and the widely endorsed WHO recommendation of exclusive breastfeeding until 6 months and the continuation of breastfeeding thereafter in combination with suitably nutritious complementary foods (solids) until 2 years of age or older, the breastfeeding initiation and duration rates in Ireland remain very low. The National Perinatal statistics (ESRI, 2002-2007) are the only data on breastfeeding rates, which are routinely collected on a national basis by the HSE. The National Perinatal Statistics provide the breastfeeding rates for all live births upon discharge from the maternity hospitals. However, there is no further reliable, accurate recording of breastfeeding rates on a national basis after discharge from hospital. The National Perinatal Statistics 2007 show a gradual increase in exclusive breastfeeding upon discharge from 31.9% in 1991 to 38.4% in 2000 and 45.2% in 2007 (ESRI, 2007). Although, the figures are increasing over time they still remain strikingly low in comparison to international rates. Recent regional or hospital based studies in Ireland all show an initiation rate of 51%<sup>2</sup> (Twomey et al., 2000; Ward et al., 2004; Tarrant, 2008). Large longitudinal studies in other developed countries show higher initiation rates including 76% in the UK (Bolling et al., 2007), 69.5% in the USA (Ryan et al., 2002) and 88% in Australia (Scott, 2001). Initiation in many northern European countries is even higher again, with an initiation rate in Norway of 99% (Lande et al., 2003).

To supplement this information, the National Infant Feeding Survey 2008 was recently carried out by Begley et al. (2009) on behalf of the HSE. This is the first national longitudinal survey of infant feeding practices in Ireland since the 1980s. The women were surveyed about their infant feeding practices at birth to 48 hours, with a follow-up at 3-4 months post birth and 6-7 month post birth. Women who gave birth to live babies at 24 weeks gestation, or greater in all 20 of the Irish

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<sup>2</sup> It should be noted that the Perinatal Statistics reported here are based on exclusive breastfeeding at discharge from the maternity hospital, whilst the initiation rates generally refer to any attempts at breastfeeding post birth.

maternity hospitals/units (or under the care of 19 independent midwives) in the Republic of Ireland during the month of April 2008 were asked to take part. For the first phase of the study, the women were asked to fill out a survey, at discharge from hospital, or at 48 hours if the woman had not been discharged by that time. A total of 2,527 women took part in the first phase of the study (birth to 48 hours), giving a response rate of 33% for all women eligible to take part in the month of April 2008. Fifty-five percent of women who took part in the first survey reported initiating breastfeeding ('put the baby to the breast') in the first 48 hours after birth. There was large regional variation in initiation rates, with the highest breastfeeding initiation rate in Dublin South East (78%) and the lowest in Waterford and Louth (38%). Nationality also influenced feeding decisions with 50% of Irish national women compared with 76% of non-Irish national women initiating breastfeeding.

The National Infant Feeding Survey 2008 (Begley et al, 2009) provides valuable baseline data on national breastfeeding rates from which the targets set in the Department of Health and Children's 5 year Strategic Action Plan for breastfeeding can be evaluated (DOHC, 2005). The National Infant Feeding Survey 2008 also addresses a number of limitations of much previous Irish and international research on breastfeeding prevalence rates. These limitations include the lack of standardised definitions of breastfeeding in the survey instruments used, and a lack of information about the reliability and validity of the survey instruments used. The National Infant Feeding Survey 2008 used the WHO (2003) breastfeeding definitions (exclusive breastfeeding, predominant breastfeeding, partial breastfeeding, complementary feeding bottle feeding and artificial feeding), which allows the results to be accurately compared with international research. In addition the survey instrument used was derived from a well-tested survey instrument used in the UK over several decades.

One possible limitation of the national survey noted by the authors is that the 67% of women who did not respond to the first phase of the survey may have differed in their infant feeding practices from those who did respond. The initiation rate of

55% observed in the survey may be a slight over-estimation of the rate of breastfeeding initiation in Irish women in April 2008, for reasons such as that the women who initiated bottle feeding may have been less motivated to respond to the survey. The authors of the national survey note however that the research team went to great lengths to ensure that over-sampling of women who were more likely to breastfeed did not occur. The validity of the findings is also increased by the congruence of the findings with other recent Irish research and the similarity of the demographic data of the study participants with demographic data for Ireland (Begley et al., 2009).

The breastfeeding duration rates in Ireland are also much lower than most other European countries. The Euro-Growth study measured infant feeding practices of 2245 infants from 22 centres across Europe between 1990 and 1996 (Freeman et al., 2000). By four weeks post birth, 80.4% of women in the Dublin centre had stopped exclusive breastfeeding, versus 17.9% in Umea, Sweden and 33.1% in Vienna, Austria. Some of the centres in France and Spain also had high cessation rates for exclusive breastfeeding at four weeks (e.g., 72.2% had stopped in Nancy, France), but the Dublin rate was higher than all other centres. It should be noted that the feeding practices measured in this study were not based on nationally representative samples, however they provide a useful indication of how Ireland's rate of breastfeeding compares to other European countries.

The low duration rates for breastfeeding in Ireland found in the Euro-Growth study are corroborated by other recent Irish studies (Begley et al., 2009; Twomey et al. 2000; Ward et al. 2004 & Tarrant, 2008). As mentioned, Begley et al, (2009) followed up the feeding practices of Irish women who gave birth in April 2008 in 20 maternity hospitals (or under the care of 19 independent midwives) in Ireland. Although 55% of the respondents reported initiating breastfeeding, by 3-4 months only 19% of the women who responded to the survey were exclusively breastfeeding their babies, with a further 15% partially breastfeeding. At phase 3, 13% of those still breastfeeding at phase 2 (3-4 months) were exclusively breastfeeding at 6 months. In a recent study by Ward et al. (2004), the infant

feeding methods of mothers who gave birth between January and February 2003 in the North Eastern Health Board area were measured. At 14 weeks post birth, only 13% of mothers reported that they were breastfeeding exclusively. It should be noted however that there was an over-representation of high socio-economic status women in the study, which may have inflated the breastfeeding rate.

A recent study by Tarrant (2008) investigated the diets of infants born in the Coombe Maternity hospital for the first 6 months of life. She found that the non-national mothers (n = 49) were significantly more likely to breastfeed their infants than national mothers (n=401), with 79.6% of non-nationals initiating breastfeeding and 47.1% of national mothers initiating breastfeeding. The rate of exclusive breastfeeding declined rapidly in both groups of women. At 6 weeks post birth, 40.8% of non-national mothers were exclusively breastfeeding versus 14.5% of national mothers. By 6 months post birth only one national mother out of the two groups was still exclusively breastfeeding. The rate of 'any' breastfeeding at 6 months postpartum was relatively high for non-national women at 46.9%, but was markedly low for national mothers at 9.6%. Taken together these findings by Tarrant (2008) suggest that non-national mothers are much more likely to start breastfeeding than national women and to continue some breastfeeding for at least 6 months. They also suggest that in the west Dublin region, in which the Coombe hospital is located, almost no women are following the WHO recommendation of exclusive breastfeeding for 6 months.

### **3.3.2 Breastfeeding and socio-economic status**

Although overall breastfeeding rates are low in Ireland, evidence from several studies show that women of lower socio-economic status are even less likely to breastfeed than their socio-economically advantaged counterparts (Twomey et al 2000; Ward et al. 2004; Begley et al., 2009). The association between socio-economic status and breastfeeding initiation and continuation has been observed in both Irish and international studies. As Braveman et al., (2001) note, socio-economic status (SES) is a complex multi-dimensional construct and that measures should be population specific and based on explicit conceptual grounds. Heck et al.

(2006) used multiple measures of SES in a sample of over 10,000 US women, to examine the association between SES and breastfeeding. They found that those women with higher family incomes, and who had or whose partner had higher educational attainment, were more likely than their counterparts to breastfeed. They also observed that women who had, or whose partner had professional or executive occupations were more likely to breastfeed. In a large UK sample, Kelly and Watt (2004) conducted parental interviews on the initiation of breastfeeding and its exclusivity at 1, 4 and 6 months post birth. They found that mothers with routine jobs, with the least favourable working conditions were more than four times less likely to breastfeed compared with women in higher managerial and professional jobs. Mothers in routine jobs were also less likely to exclusively breastfeed their infants at 1 and 4 months than those employed in higher managerial or professional jobs. Women in high status jobs may be more likely to have a work place that is more supportive and facilitative of breastfeeding. Women in low status jobs may have more obstacles to breastfeeding or expressing milk during work time. Several studies have also shown that full-time maternal employment was associated with earlier cessation of breastfeeding, whilst part-time employment was not associated with decreased breastfeeding duration (Kurini, et al., 1989; Gielen, et al., 1991; Fein & Roe, 1998). Part-time employment may be protective for breastfeeding duration, as time constraints for breastfeeding and possible milk expression would be eased.

The relationship between SES and breastfeeding may be mediated by cognitive emotional factors. Flacking et al. (2007) found strong associations between SES and breastfeeding rates in Swedish mothers of both term and preterm infants. Therefore, despite the high breastfeeding rates in Sweden, the free childcare system, the high level of social expenditure (including 450 days parental benefit) and low income inequality, there is still a strong association between SES and breastfeeding. They note that interventions to improve breastfeeding in countries with moderate breastfeeding rates and high income inequality are similar to the supports already implemented in the Swedish health care services. They argue that the difficulties in constructing successful interventions aimed at improved

breastfeeding rates in vulnerable groups may be due to the narrow approach taken, in which educational interventions prevail. Drawing on Starrin and Jonsson's (2006) finance-shame model, Flacking et al. (2007) also suggested that having low socio-economic status may reduce the reserve capacity of an individual dealing with stressful situations, mediate feelings of inferiority, insecurity or shame and lower self esteem. Therefore they argue that interventions ought to regard both individual and societal aspects. They noted that interventions using empowerment and resource based approaches have proved effective in promoting the well-being within families, as well as preventing child maltreatment (e.g., McLeod & Nelson, 2000 cited in Flacking et al., 2007). Flacking et al. (2007) proceeded then to suggest that a similar approach may be effective in interventions used to promote health behaviours such as breastfeeding.

The findings of the international literature on SES and breastfeeding are closely paralleled in Irish studies. In a longitudinal study of mothers who gave birth in the North Eastern health board region, they found that completing third level education was significantly associated with breastfeeding initiation and continuance to 6 and 14 weeks post birth (Ward et al., 2004). This effect remained significant when other demographic and psychosocial variables were controlled for statistically. Twomey et al. (2000) found an association between initiation of breastfeeding and the following SES indicators: father's SES, father's employment status and medical card eligibility. It should be noted however that these variables were not investigated simultaneously and therefore some of these effects might be attenuated if other variables measured in the study had been controlled for statistically. Finally, in Tarrant's (2008) longitudinal study of the infant feeding practices of women who gave birth in the Coombe maternity hospital in west Dublin, she found an association between breastfeeding rates and SES variables for Irish national mothers. For the national mothers, completing third level education was not a significant independent predictor of breastfeeding initiation, but it was a significant independent predictor of 'any' breastfeeding at 6 weeks after birth. Paternal membership of social class 1 (professional/managerial and technical) was also a significant independent predictor of 'any' breastfeeding at 6 weeks post birth. This



overview of recent Irish studies, which looked at the association between breastfeeding and SES, would suggest that maternal education is the most consistent predictor of initiation and duration of breastfeeding for Irish mothers. Further study using nationally representative samples and statistical control of possible confounding factors is needed however, to provide a clearer insight into the relationship between SES and breastfeeding in Ireland.

### **3.3.3 Breastfeeding among the Irish Traveller population**

One socio-economically disadvantaged group with extremely low rates of breastfeeding is the Irish Traveller community. Poor housing, with little privacy and facilities, low levels of literacy and a lack of public transport are socio-economic factors which have a cumulative effect on Traveller women's experiences of maternity care (Reid & Taylor, 2007). These socio-economic conditions limit Traveller women's access to breastfeeding support, if required, as they have limited mobility for accessing care and they may have difficulty reading information leaflets given to them, or accessing information sources themselves (e.g. the internet, baby books, breastfeeding support groups). In addition, for those living on halting sites it is likely they would also not have the privacy that they may consider necessary for breastfeeding. Traveller women are historically modest, and a threat of exposure of one's breasts would be unacceptable.

Another major barrier to breastfeeding in the Irish Traveller population is that Traveller mothers can be discouraged from breastfeeding in the maternity hospitals, until they have been tested for an inborn error of metabolism known as galactosaemia. This condition causes a build up of galactose in the body's organs, and can present in infancy as a life-threatening illness. Infants with galactosaemia should not consume breast milk (or standard baby milk formulae) as it contains galactose, but instead must be placed on a life-long galactose-free diet. Although the incidence of galactosaemia is approximately 1 in 30,000 in the general non-Traveller Irish public, it is much more common in the Irish Traveller population, with a quoted incidence of 1 in 480 (Murphy et al, 1999). The Beutler test is one of a set of five tests which are usually performed on infants aged 3 to 5 days old,

through heel prick blood sampling. However, it is recommended that the test be performed on all Traveller infants at 1 day old (National Newborn Screening Laboratory, 2001), with galactose-free soya-based formula being given in the period between sampling and the availability of the test result. The time lag between sampling and result can vary (from 4-6 hours to several days) depending on the time it takes to get the sample to the metabolic screening laboratory in Dublin and whether the birth takes place over the weekend. In the interim, hospital staff are advised to counsel Traveller mothers not to breastfeed.

*'Mothers of Traveller infants and of siblings of known cases are advised to withhold Galactose containing feeds until the results of the test are declared normal'*

(Programme for Action for Children: Review of the National Newborn Screening Programme for Inherited Metabolic Disorders, 2004)

In the case of a positive Beutler test result, the result is phoned through within 4 to 6 hours. However, negative results are sent by post, and by the time they have been received, the mother is likely to have been discharged. It can prove difficult to then contact the mother, who may have a nomadic way of life, to inform her of this result. Furthermore, this test is not available on a 24-hour basis. At the weekend, the Beutler assay is carried out on Saturday mornings and on Bank Holiday Mondays on samples received in the National Newborn Screening Laboratory in Temple Street, Dublin, by 10am. Therefore, there are a number of steps along the process where delays may mean that the identification of Traveller infants who may receive breastmilk is not possible in a timely manner. If delays occur, then by the time this reassurance is achieved, it will likely be too late to initiate the regular suckling required to stimulate breastmilk and breastfeeding will not be achievable. This is a clear example of a lack of a consistent and timely service to support breastfeeding in this vulnerable group.

### **3.3.4 International qualitative studies: breastfeeding among low income groups**

Qualitative studies are useful for exploring the reasons behind the low levels of breastfeeding in less socio-economically advantaged groups. Quantitative surveys tend to identify the mother's age, level of education and social class as determinants of infant feeding methods (e.g., Hamlyn et al. 2002). However, as Bailey & Aarvold (2004) note 'qualitative research is increasingly drawing attention to the deep rooted processes which these quantitative indicators mask' (p. 241). Numerous qualitative studies have focused on the experiences of infant feeding among low income samples. The international qualitative research on breastfeeding among low income groups is discussed in this section, whilst the relevant qualitative research conducted in Ireland is discussed in the next section.

Many of the international qualitative studies focus on low income women's lived experience of feeding infants and the complex inter-related cultural and psychosocial influences on feeding practices. Although many of the international studies focus on low income women's own perspectives, some of the research also focuses on the attitudes of health professionals and the women's families. The international qualitative research on breastfeeding among low income groups will be discussed under five headings (1) Antenatal intentions, beliefs and experiences; (2) Breastfeeding difficulties in the early post-natal period; (3) Health professional support; (4) Social support –partner, family and friends; and finally (5) Embarrassment in public and the bottle-feeding culture. These headings are not necessarily mutually exclusive. For example, aspects of health professional support are discussed under the first two headings. The concepts were discussed under the heading which was considered most appropriate, but the reader is referred to other sections as required.

#### *3.3.4.1 Antenatal intentions, beliefs and experiences*

Studies of low SES women's feeding intentions, beliefs and experiences have shown that they generally have low confidence in their ability to breastfeed, even before the baby is born. Bailey et al. (2004) interviewed 16 women in late pregnancy and

again when their babies were three to nine weeks old. All of the women were living in low income areas of North Tyneside in north east England, which has low breastfeeding initiation rates. Most of the women expressed a desire to breastfeed in the first interview (during pregnancy), and many of the women described it as 'natural' or 'good for the baby'. They tended to speak about breastfeeding as something they would 'try' to do. They would 'give it a go' (p. 242). The authors suggested that these women had an expectation of failure and that this contradicted their image of breastfeeding as natural and healthy. Most of the women expected difficulties such as pain, cracked nipples, partner feeling left out, feeling tired and not having enough milk. A number of the women also described difficulties with breastfeeding that their friends or relatives had experienced. Difficulties were seen as potentially impossible to overcome. The authors interpreted these findings as evidence of a 'give it a go' breastfeeding culture. They also suggested that if the women acknowledged failure as a possibility and that breastfeeding difficulties were often beyond their control, they could then deal with possible moral judgements from others in the event of failure. In the second interview (after birth) several of the women suggested that antenatal education should be more realistic and focused more clearly on how to overcome possible difficulties. The women also expressed the notion that this more realistic approach to antenatal education should be couched within an 'it does get better' framework (Bailey et al, 2004, p. 242).

This finding by Bailey et al. (2004) that low income women, who intended to breastfeed had strong expectations of difficulties and even failure, is corroborated in other samples of low income women. In one such study, Hoddinott & Pill (1999a) conducted qualitative semi-structured interviews with 21 low income women from an inner London health authority, early in pregnancy and at 6-10 weeks after birth. This study examined how women who belong to a socio-economic group with low rates of breastfeeding decide whether or not to initiate breastfeeding. They found that most of the women felt inadequately prepared for motherhood, especially in terms of practical skills such as feeding, comforting and bathing. Mothers with high exposure to newborn babies before birth and/or mothers who had strong support

from a trusted person with recent experience of looking after a newborn were more likely to feel adequately prepared for motherhood. Most of the women however did not have much exposure to new born babies and therefore coming home was a time of high anxiety. Antenatal classes or reading provided theoretical knowledge, but often left them unprepared practically and emotionally for looking after a newborn. The women felt that they did not gain the practical skills such as putting the baby to sleep when in hospital, and therefore when they got home they felt unprepared for their new role. Some women with low exposure to breastfeeding before birth thought that the baby would just take to it naturally or instinctively like in the animal world and therefore breastfeeding would be easy. Themes identified from analysis of the data included a need for practical skills training, with a focus on how to overcome common problems and the need for breastfeeding role models along with a more apprenticeship style of learning of feeding skills. These themes are similar to the recommendations for realistic problem-oriented antenatal education made by Bailey et al. in their 2004 study discussed above. Further themes which arose in the study by Hoddinott & Pill (1999a) included a neglect of the emotional aspects of breastfeeding and the belief that the target for health professionals was prolonged breastfeeding, whereas the target for the women was a contented happy baby.

Antenatal experiences of breastfeeding were also explored in Scott & Mostyn's (2009) study of low income Scottish women. The purpose of the study was to investigate the acceptability and effectiveness of a peer support intervention for breastfeeding, which was ongoing in deprived areas of Glasgow. The women took part in a series of focus groups to discuss their experience of breastfeeding in a predominantly bottle-feeding culture. Similar to the studies of women in North Tyneside and London discussed above, these women had little prior exposure to breastfeeding. They found that the few mothers in their sample with high prior exposure to breastfeeding had higher confidence in their ability to breastfeed. The authors argued that the low levels of prior exposure to breastfeeding are a major contributing factor to the low initiation and early cessation of breastfeeding in Glasgow.

The authors also observed that the promotion of breastfeeding as natural was interpreted by the women as meaning it would come naturally and easily. These unrealistic expectations meant that the women were then unprepared for problems they encountered with breastfeeding. The women felt that the message that breastfeeding is not easy in the beginning was not put across by health professionals. In accordance with this finding, Hoddinott and Pill (1999b) observed that a sample of low income women in the east end of London reported hearing few negative stories prenatally and felt that both health professionals and other women painted idealized pictures to promote breastfeeding. In a similar vein, Pain et al. (2001) found that many of the women thought that breastfeeding was an innate skill and were unaware that initial problems and discomfort are the norm. Furthermore, women that planned to breastfeed, but changed to formula feeding owing to initial difficulties, had to negotiate a sense of failure and the feeling that others place moral judgements that 'good' mothers breastfeed and 'successful' mothers continue with it. Finally, in the study by Scott & Mostyn (2009), the Glaswegian women felt that expectant mothers should be told of the possible difficulties, but also that breastfeeding would get better if they persevered with it.

#### 3.3.4.2 Breastfeeding difficulties in the early post natal period

Studies of low income women's breastfeeding experiences demonstrate that the first 4-6 weeks and especially the first week after leaving hospital can be fraught with difficulties for new mothers. Many low SES women give up breastfeeding during this crucial period, as they do not have the confidence and support from experienced others to overcome these difficulties (Hoddinott & Pill, 1999b). An in-depth qualitative approach was used by Whelan & Lupton (1998) to identify factors which promote or discourage successful breast feeding in a sample of low SES women from the South West of England. In terms of social and environmental factors, they found that women who continued to breastfeed were more likely to have a positive attitude towards breastfeeding and they often expressed comments about finding it convenient, satisfying and natural, and also that it enabled a special bond between themselves and the baby. The authors observed that women who

continued to breastfeed were more likely to have higher self esteem, a supportive mother, or friend and a partner who was not against breastfeeding. Women who persevered with breastfeeding were also more likely to have realistic expectations about what breastfeeding entailed particularly during the first week postpartum. Therefore they were better equipped to handle difficulties such as cracked/sore nipples and frequent feeding. In contrast women with unrealistic or no expectations, who experienced difficulties were more likely to stop breastfeeding as they do not know how to overcome the issue. For example, if a baby was feeding more frequently than every three or four hours these women often felt that they had an inadequate milk supply and they were more likely to stop or supplement breastfeeding as their first course of action (Whelan & Lupton, 1998).

This finding of perceived milk inadequacy ties in with the observation by Bailey et al. (2004) that in predominantly bottle feeding cultures the rules of bottle feeding sometimes inform expectations about how to feed babies from the breast. Rules such as feeds needing to be spaced out at regular intervals across the day and needing visual evidence of how much milk the baby is getting, can hinder success when applied to breastfeeding. According to Bailey et al. (2004) failure to breastfeed because of these misconceptions can then inform cultural myths about breastfeeding such 'as not having enough milk' (p. 245). In their study of low income women in North Tyneside, they found that the women had expected the possibility of not having enough milk even before giving birth. Not having enough milk was cited as a major reason for giving up breast milk in a UK national survey (Hamlyn et al. 2002). Dykes and Williams (1999) note that 'inadequate milk syndrome' is rarely a physiological reality in industrialised countries (1-5% maximum), and in societies where breastfeeding is highly valued, almost unknown (Akre, 1991 cited in Dykes and Williams, 1999). As Dykes (2002) notes:

"...this phenomenon is underpinned by a complex interaction between socio-cultural, physiological and psychological factors that are particularly evident in countries where there is a strong influence of Western medicine and heavy marketing of infant formula." (p. 495)

Dykes (2002) conducted a longitudinal qualitative study in England of 10 lactating women's perceptions of their breast milk and their ability to exclusively breastfeed their baby. The author used a machine production metaphor to interpret the narratives of the women. According to Dykes (2002), the women viewed breastfeeding as a mechanical, manufacturing process, and they carefully monitored their own food and liquid input, their output of breast milk and implemented quality control by assessing the baby's weight gain. The author also observed that health professionals contributed to these women's' perceptions, as they showed mechanistic assumptions in relation to breastfeeding, which reflected their cultural entrenchment in the biomedical paradigm. This study was conducted with women from a range of socio-economic backgrounds. These findings suggest that misconceptions about the adequacy of breast milk are held by high income women, as well as low income women. According to Dykes (2002) the influence of Western capitalist ideologies have led women to view breast milk as a product which can be prone to failure, and that women should instead be encouraged to make a holistic assessment of their baby's well-being, rather than relying solely on measurement indices such as weight.

#### 3.3.4.3 Health professional support

Previous research has shown that low income women often felt pressured by health professionals to initiate and continue breastfeeding and to follow advice that was unsuitable, or inconsistent with other advice received. Hoddinott and Pill (2000) used qualitative semi-structured interviews to explore low income women's perceptions of how health professionals communicate about infant feeding. They interviewed first time Mothers in their home early in pregnancy and 6-10 weeks after birth. Many women perceived pressure to follow other people's advice about infant feeding from both family and health professionals. They found that many women complained of conflicting advice about infant feeding from family, friends, books as well as health professionals. They also observed that women whose family lived at a distance and those with little experience of newborn babies were more likely to complain about unsuitable or conflicting advice. They were also more likely



to experience a mismatch between their antenatal expectations and the reality of their postnatal experiences and thus lose confidence in their mothering ability. These new mothers felt that everyone seemed to be an expert except them and expected their advice to be followed. A few women lied to family and health professionals to avoid conflict and to keep in control of decision making. Women also reported feeling pressure to both start and to continue breastfeeding against their wishes. Women who chose to bottle feed often felt neglected in comparison to breastfeeding women on post-natal wards. The women recommended a more even-handed approach to the provision of information and advice on infant feeding (Hoddinott & Pill, 2000).

The women also felt dissatisfaction with the way health professionals often talked about infant feeding (Hoddinott and Pill, 2000). For example the widely used statement 'breast is best' was perceived as judgemental, especially by women who had difficulty breast feeding. They also commented on the way health professionals and women who previously breastfed tended to emphasise successful stories about breastfeeding and say little about the possible difficulties. Women clearly preferred advice that was 'woman centred' rather than 'breastfeeding centred' (p. 229). The manner in which health professionals conveyed information about infant feeding was vitally important to women when they were feeling tired and emotionally fragile after birth. They felt that 'words alone' were not enough and they had a clear preference for health professionals who seemed to really care rather than those who seemed more impersonal (p. 229). They preferred midwives to spend time patiently watching them feed, bath and comfort their baby rather than taking over the care. This need for midwives to watch over their efforts and tell them where they were going wrong is also echoed in a study by Whelan and Lupton (1998) described in the '*Experiences of the early postpartum period*' section. The women commented that that the midwives often 'do rather than teach' as this quote illustrates:

"I don't think they really give you any advice as such. I think the only time you know is if you've got a problem and they (staff) come and grab hold of it

(the breast) and pull it, get it in the baby's mouth and I think it's quite embarrassing you know. They don't sit there and tell you how it's done, they show you rather than tell you and explain things." (p. 98)

Turning again to Hoddinott and Pill's (2000) study, they found that women with low exposure to new born babies and little family support expressed a need for an expert, who would be available 24 hours a day in the early days follow birth.

Hoddinott and Pill (2000) reported that women were often told by health professionals to persevere with breastfeeding and it would succeed. If this advice to persevere was given without also providing practical and emotional support, it was often resented. When problems arose with breastfeeding, the women were often told that the baby was positioned incorrectly on the breast. This was often perceived by women to mean it was their fault, leading to guilt and loss of confidence. As noted earlier in other studies (e.g., Scott and Mostyn, 2009), the women believed that breast feeding should come easy and natural. In Hoddinott and Pill's (2000) study, the emotional effect of failing at breastfeeding was strongly expressed by the women, but rarely discussed with health professionals.

In Hoddinott and Pill's (2000) study, the majority of women did not take initiative in seeking support from health professionals for breast or bottle feeding. The authors suggested that the passivity reflected an underlying lack of confidence in coping with the new bodily experiences in the unfamiliar environment of the post-natal ward. As noted earlier by Flacking et al. (2007), women from low SES backgrounds may have more shaming experiences than their counterparts, which may increase their feelings of inferiority and thus reduce their reserve capacity to deal with stressful situations. On this basis, the new mothers from low SES backgrounds in Hoddinott and Pill's (2000) study may have lacked the confidence to seek help from health professionals during this stressful period. They may not have wanted to risk looking uninformed, or incompetent in front of health professionals, who they may have perceived as having higher status than them.

Continuity of support also seems to be an important factor in successful breastfeeding. In a study by Hoddinott and Pill (2000), they found that the women valued support from the midwives with whom they had built a trusting relationship. The authors noted that it was often the return of the midwife who attended the birth that made the difference to the women, who were finding breastfeeding very difficult. Similar findings were reported in Whelan and Lupton's (1998) study of the obstacles and facilitators of successful breastfeeding among a sample of low income mothers. They found that the women who continued to breastfeed were more likely to have felt that they had received much greater continuity of midwifery input. They were also more likely to have felt they were able to spend sufficient quality time with a midwife in order to work with them to overcome difficulties, as and when they occurred.

Qualitative studies of low income women have shown that they are aware of the health benefits of breastfeeding, but these are often only one factor in their decisions regarding initiation and continuation of breastfeeding (Hoddinott & Pill, 2000). Body confidence, social relationships, baby behaviour and emotions are all tied in with women's ultimate goal of maternal and baby well being. Embodied knowledge gained through seeing breastfeeding in public places and in their social network can have a greater influence on women's decisions than theoretical knowledge gained from health professionals and written materials. The desire for a fat baby as seen on advertisements for formula feed can override health professional messages that 'breast is best'. A study by Shaw et al. (2003) of young, low income, white, Bangladeshi and Pakistani mothers suggested that perceptions of infant feeding behaviours are becoming more homogenous across ethnic groups. Steady weight gain through painless formula feeding met the embodied desire for many women to feel like a 'good' mother with a fat, nurtured baby, despite knowing that breastfeeding has greater health benefits. Hoddinott and Pill (1999) hypothesised that women from lower socio-economic groups who learn skills through apprenticeship may be more influenced by embodied knowledge. In contrast, women with higher educational qualification may be more influenced by theoretical knowledge. Health professionals may need to find ways to increase

women's positive embodied knowledge of breastfeeding, possibly through the use of an apprenticeship style of teaching new skills, as advocated by Hoddinott and Pill (1999a).

Time pressures in hospital wards can hinder the development of a supportive relationship between mothers and health professionals. In Dyke's (2005) ethnographic study of encounters between midwives and breastfeeding mothers in post natal wards, she found that the midwives were usually far too busy to spend much time supporting breastfeeding mothers. The midwives were also frequently moved to other parts of the hospital at a moment's notice, which hindered them from taking their time with patients, as they knew staffing levels could change quickly. The midwives noted that being regularly moved around the hospital prevented them from getting to know their patients well enough to understand their support needs. The women observed the scarcity of the midwives' time and tended to struggle on with problems, rather than request some of their scarce time. The researcher also observed that the women from low socio-economic occupational groups were the least likely to assert their need for help. In McInnes and Chamber's (2008) qualitative synthesis of breastfeeding support research, they suggest that the root of poor mother- health professional relationships observed in numerous studies may be lack of time and staffing on post natal wards. Lack of time may cause health professionals to teach breastfeeding skills by doing it themselves (e.g., latching the baby onto the woman's breast), instead of telling women what to do and then patiently watching over them till they get it right. Dykes noted that in some situations the midwives were able to 'take time and touch base' with breastfeeding mothers, but this was not the norm due to the midwives busy schedules.

#### 3.3.4.4 Social support- partner, family and friends

In pervasive bottle-feeding cultures, the lack of experience and knowledge of family and friends makes breastfeeding much more challenging. In a recent study by Scott and Mostyn (2009) of women's experiences of breastfeeding in deprived areas of Glasgow, it was found that many women received little support from family or

friends, (with the exception of partners) in their attempts to breastfeed. Many of the women experienced continual pressure, often well meaning, to just give the baby a bottle. For some women the negative pressure increased their determination to continue. The authors noted that the women who breastfed in these areas demonstrate a high level of commitment to breastfeeding that distinguishes them from their social peers. The authors noted that many women will not continue to breastfeed in the face of difficulties, which they get no help from their family and friends to overcome. From Hoddinott and Pill's (1999a) analysis of their interview data, they identified a cyclical picture of how new mothers cope with breastfeeding. They found a pattern by which low levels of exposure to newborns prenatally can lead to unrealistic or unmet expectations, leading to a sense of failure and difficulty coping with problems that arise. Confidence as a mother declines, often reaching a time of crisis, where the mother feels something has to change. They then change to bottle feeding to regain a sense of control and facilitate coping. The authors also note that women are reluctant to socialise and go outside the home until they are feeling confident and in control again. This reduces exposure of other women in their social network to newborn babies and breastfeeding and thus completes the cycle. They also note that women's support system, both lay and professional, is crucial to influencing all stages of the cycle and in determining feeding outcome and the mothers' and babies' well-being.

In a study by Pain et al. (2001) of how women's parenting is influenced by their cultural contexts, it was again found that the woman's family and friends can influence infant feeding practices. In situations where bottle feeding had been the norm, the family and intimate circle were perceived as supportive of the women's efforts to breastfeed, but they had little practical advice to offer. With little practical support and low confidence in their ability to breastfeed, these women often changed to artificial feeding. The authors also noted that new mothers often seek out other new mothers from similar socio-economic backgrounds during the first few months after birth. These support networks can also be more formalized. For example, a friendship group of middle class women in their study all attended a breastfeeding support group. The authors noted that these friendship networks

reinforce or redefine concepts and values of motherhood. They also note that these networks are important modes of transmission of feeding practices and beliefs and it is likely that they make a significant contribution to successful breastfeeding.

Pain et al. (2001) also found that the middle class men displayed more relaxed attitudes to their partner's breastfeeding in front of others than the working class men. They suggested that a strong sense of local working class masculinity persists in north east England, which partly underlies the discomfort about breastfeeding in front of others. In contrast some of the middle class men described reading the breastfeeding literature during the antenatal period and actively helping their partner initiate and maintain breastfeeding (e.g., by helping to latch the baby on the breast). The middle class men discussed being influenced by 'the emotional correctness that we live with now' (p.267). They felt they had to give different performances of masculinity depending on the environment. In addition, they felt that they were expected to be relaxed in the presence of women breastfeeding in the home, whilst they felt that in the male environment of their workplace, they couldn't be seen to show sensitivity in regards to things like breastfeeding.

#### 3.3.4.5 Embarrassment in public and the bottle-feeding culture

Qualitative research with low SES groups in Britain has highlighted the pervasiveness of the bottle-feeding culture in many communities and the strong sense of embarrassment about breastfeeding in public. In the study by Scott and Mostyn (2009) described earlier, virtually all of the Glaswegian women were embarrassed at the idea of breastfeeding in public and often went to much trouble to avoid doing so (for example by expressing at home before going out, or expressing milk, or feeding in a toilet stall). Many of the women stayed indoors to avoid the need to nurse in public, but this confinement wasn't feasible for extended periods, and therefore many of the women had to overcome their embarrassment and begin to breastfeed in public. Some of the women described feeling less concerned about breastfeeding in public once they had gotten over the initial embarrassment. They considered it other people's problem if they were offended by it. When away from home, most of Glaswegian women preferred to find a private

room to breastfeed in. However, mother and baby changing rooms in supermarkets and shopping centres were often primarily used as baby changing facilities and were considered by most women as unpleasant places to breastfeed. Most of the women were embarrassed to breastfeed in public, as they were afraid of how other people would react to it. The majority of the women agreed that there was nothing shameful or disgusting about breastfeeding, but they felt that other people saw it as something dirty. The sense of embarrassment about breastfeeding in public because of the fear of negative reaction from others observed in Glasgow is mirrored by very similar findings of studies conducted in other locations. Examples of these locations include Newcastle upon Tyne, (Pain et al., 2001) and the South West of England (Whelan and Lupton, 1998).

### **3.3.5 Qualitative research in the Irish context**

A study by Kelleher et al. (1998) also used qualitative and quantitative techniques to explore socio-economic influences on infant feeding practices. It was commissioned by the Eastern Health Board and co-authored by one of the authors of the present report. A survey and focus groups were used to explore attitudes to breastfeeding in the Eastern Health Board region. A survey was administered to a representative quota sample of adults in the Eastern Health Board region, and focus groups were conducted with recent mothers to compare the infant feeding practices of medical card holders and non-medical card holders from the same region. As part of the survey, respondents were asked in an open ended format to identify a barrier to breastfeeding. The most common barriers identified by respondents were the 'attitudes of others', followed by 'inconvenience and lack of mobility'. More men than women identified the 'attitudes of others' as a barrier, whilst 'inconvenience and lack of mobility' was the main obstacle identified by women. A closed-ended question regarding attitudes to breastfeeding showed social class differences. Participants from social class 4-6 were more likely to agree with negative descriptions of breastfeeding, such as 'embarrassing/disgusting' than participant from social class 1-3.

Socio-economic differences in attitudes to breastfeeding were also explored in the focus groups. Focus groups were held with four groups of mothers with a baby under the age of one: (1) breastfeeding non-medical card holders (2) breastfeeding medical card holders (3) bottle feeding non-medical card holders and (4) bottle feeding medical card holders. Influences on infant feeding decisions, as well as experiences and support around infant feeding were explored in these groups. The findings were presented in both qualitative and quantitative terms. The woman's lay network and health professional input were perceived as important influences on the decision to bottle feed or to breastfeed. Breastfeeding mothers reported more positive interactions with health professionals than bottle feeding mothers. Many of the women who bottle fed reported feeling pressurised by health professionals to breastfeed. Some of the women who breastfed and some of the women who bottlefed described their infant feeding decision as natural, but the meaning of natural differed between the two groups. The women who breastfed described their decision as natural, as they were fulfilling the natural purpose of the breasts, whilst the women who bottlefed described their decision as natural, as it was the normal, automatic thing to do in their social context. Convenience was cited as an influence on the decision to bottle feed, but not the decision to breastfeed (Kelleher et al., 1998).

Some of the breast feeders expressed a strong sense of self determination to breastfeed, whilst many of the bottle feeders felt that breastfeeding 'wasn't for' them. Infant feeding decisions were therefore interpreted as closely bound with the women's sense of self. As breastfeeding rates are very low in Ireland, breastfeeding may be perceived as requiring a very strong commitment to overcome potential difficulties and therefore many women may view it as beyond their capability. There were more *positive* features of breastfeeding cited (bond, health, convenience), than bottle feeding (convenience) by the groups. However, there were also much more *negative* features of breastfeeding cited (tiredness, physical problems) than bottle feeding by the groups. The authors suggested that the positive aspects of breastfeeding as well as the women's strong commitment to it may have encouraged them to continue breastfeeding despite the numerous difficulties encountered (Kelleher et al., 1998).



The theme of support was also evident in the focus group discussions. In terms of health professional support, breast-feeders were perceived as receiving more support than bottle feeders. There was an absence of explicit accounts by bottle feeding mothers of positive experiences of professional and community support, which runs counter to the policy of equity within Irish health care. Socio-economic differences in the use of support groups by breastfeeding mothers were also observed. The La Leche League support group was often praised by the non-medical card holders who breastfed, but was never mentioned by the medical card holders who breastfed. The authors also mentioned their difficulties in accessing a sample of low income breast feeders for the study, as there were virtually no support groups used by these women. This finding may represent the use by middle class women of their social capital to set-up and access community support, as noted in a UK study by Pain et al. (2001) described earlier. The low income breastfeeding mothers particularly emphasised the care and availability of the public health nurses, which suggested that this support was particularly helpful for this group. As breastfeeding mothers were likely to be atypical within their social networks, a supportive public health nurse may be crucial in terms of providing knowledge and ongoing advice. The breastfeeding participants generally described positive support from family and friends, but they also described numerous incidents of negative reactions to breastfeeding in public. The participants suggested that while people generally thought breastfeeding was good for baby's health, they did not want to see it being done. This was explained in terms of embarrassment about seeing breasts in public and sexual taboos in society (Kelleher et al., 1998).

The National Infant Feeding Survey, which was commissioned by the HSE used focus groups and individual telephone interviews to explore the experiences and views of women who are least likely to breastfeed in Ireland (Begley, et al., 2009). The results of the preceding longitudinal survey showed that lower socio-economic groups were least likely to breastfeed. Therefore, women who had low levels of education, or had an occupation classified as semi-skilled or unskilled, and who

formula fed all of their infants, were recruited for the focus groups and telephone interviews.

Three main themes emerged from the analysis of the narratives of the women: personal attitudes towards feeding methods, external influences on infant feeding and future attitudes towards infant feeding. Firstly, the women had a generally positive attitude towards formula feeding. Many of the women expressed the attitude that 'breastfeeding is just not for me' and felt very committed to their choice of formula feeding (p. 151). They also felt that bottle feeding was just as good as breastfeeding, despite knowledge of the benefits of breastfeeding. The women also cited convenience as positive attribute of bottle feeding. For example, it enabled the women to share feeds with their partner, to have some time for themselves, and to devote more time to the needs of their other children. The women were not against breastfeeding for other women and felt it was a natural thing to do. They felt uncomfortable however about the physical notion of breastfeeding themselves. Many of the women also had little or no previous experiences of seeing someone breastfeed, whilst some of the women recounted incidents of seeing a woman breastfeed, which made them feel uncomfortable, and which may have influenced their choice to bottlefeed.

External influences were evident from the family, health professionals and the Irish culture. The influence of the family on feeding method was mostly from female relatives and friends, with the partner seen as having no influence on their decision. Many of the women did perceive however bottle feeding as a means of enabling bonding with the baby's father. Some of the women had positive experiences of breastfeeding within their family, whilst other recounted negative experiences. The influence of family members on feeding method was generally seen as subtle, rather than having a strong influence. In contrast, health professionals were generally described as pushy in their promotion of breastfeeding. However those who had bottlefed their other children, were not encouraged to breastfeed their infants, as it was taken for granted that they wouldn't. The Irish culture was also perceived as an influence on their feeding choice. A pervasive bottle feeding culture

was identified by the women, with previous and current generations reinforcing bottlefeeding as the preferred method of feeding.

The women's attitudes toward infant feeding in the future showed little expectation for success in terms of breastfeeding promotion. When asked about ways of promoting breastfeeding some of the women did suggest giving pregnant women an opportunity to see a woman breastfeed (e.g., by asking a breastfeeding mother to attend an antenatal class and to breastfeed in front of the women). The women offered strategies for breastfeeding promotion, but gave a clear message that they were not interested in breastfeeding in the future, with only one of the women suggesting that she might consider breastfeeding in the future.

On the basis of their findings the authors had a number of recommendations. They argued that the promotion of breastfeeding must normalise breastfeeding within Irish society and that breastfeeding role models are needed for bottle feeding women in order to counter negative discourses about breastfeeding in Ireland. They also noted that health professionals should promote breastfeeding to all mothers and not make assumptions based on their previous feeding methods. Interestingly, embarrassment did not emerge as a barrier to breastfeeding in this study, even though it has been identified a barrier to breastfeeding initiation by many other Irish studies (e.g., Tarrant, 2008)

There have been a number of other studies of attitudes to breastfeeding using qualitative techniques among non-disadvantaged groups. For example, Connolly et al., (1998) used a questionnaire with closed-ended questions and focus groups to examine attitudes of adolescents (age range 16-19 years) to breastfeeding (this study was co-authored by one of the authors of the present report). The focus groups were analysed using a form of content analysis, with results reported in both qualitative and quantitative terms. Reasons for breastfeeding in the focus groups included its naturalness, facilitation of bonding and adequate nourishment. Reasons against breastfeeding included embarrassment in public, but mainly related to practicalities of feeding. The majority of the focus group participants

intended that their children would be breastfed, although the boys felt powerless in terms of having any influence on feeding decisions. They found that embarrassment and discomfort were the predominant emotions expressed in relation to breastfeeding, and that the majority of participants did not agree with breastfeeding in public.

Other studies on breastfeeding among samples of Irish women have used some open-ended questions in their surveys. In a recent study of infant feeding practices during the first 6 months of life, mothers who chose to bottle feed were asked in an open-ended format what their main reasons were for choosing this method (Tarrant, 2008). Content analysis was used to identify the women's principal reason for not breastfeeding. Embarrassment was identified as the principal reason for not initiating breastfeeding (31%), followed by lifestyle and time issues (24%) and negative perception of breastfeeding (11%). The principal reason given for discontinuing breastfeeding during the first 6 weeks postpartum was maternal tiredness (26%), constant feeding/demanding/ restrictions (23%) and perceived inadequate milk supply (17%). Loh et al. (1997) interviewed women recruited from an outpatient antenatal department about their feeding practices (this study was co-authored by one of authors of the present report). They were all interviewed within 48 hours of delivery. More than half of the mothers indicated that no health professional had discussed infant feeding methods with them other than to record their choice at the first antenatal visit. The main reason given by the women for not breastfeeding was 'convenience', followed by 'no difference between methods' and then 'social embarrassment'.

A few Irish studies, which have used a qualitative approach to explore women's experiences of maternity care, have made some reference to breastfeeding in their findings. Cronin (2003) explored the needs, perceptions and experiences of young first time mothers. The young women felt a great deal of pressure to breastfeed, but all of the mothers chose to bottle feed. Breastfeeding was promoted by the midwives, but was not acceptable to the women. Murphy-Lawless (2005) explored women's experiences of maternity care in the North Eastern Health Board region.

They found that women derived tremendous support from the midwives particularly during labour and birth. This support was not so apparent during the postnatal period, particularly in relation to breastfeeding and advice on baby issues. Reid and Taylor (2007) explored Traveller women's experiences of maternity care in Ireland. They used a snowball sample of 13 Traveller women aged 19-42 years. For most of the women, choice of feeding method does not arise, as it was assumed that bottle feeding was the only option. The authors noted that 'bottle feeding seemed well rooted in the Traveller culture, with breast feeding being actively militated against' (p. 254). They also noted that women were too 'shamed' to breastfeed mainly due to embarrassment and lack of privacy in their homes (p.254). Unfortunately, none of the women had any memory of midwives providing information on, or encouraging them to breastfeed.

Taken together these qualitative and mixed method studies in the Irish context suggest that social embarrassment and practicalities of feeding are key influences on decisions about infant feeding methods. In a study by Scott and Mostyn (2009) mentioned earlier, they noted that embarrassment about feeding in public evident in their sample of Glaswegian women is also evident in an Irish study of breastfeeding (Fitzpatrick et al. 1994). They hypothesised that social embarrassment about breastfeeding may explain some of the differences in rates of breastfeeding between Western countries. They note that in Australia, which has a very high rate of breastfeeding initiation, research has shown that breastfeeding in public is seen by parents of young infants as routine, necessary and unavoidable. Of the women who chose to formula feed from birth, only 5% of them indicated that they chose to do so because they were too embarrassed to breastfeed (Binns and Scott, 2002).

### **3.3.6 Free infant formula milk schemes**

Despite repeated health service policies (DOH, 1994, DOHC, 2005) to improve breastfeeding rates among lower socio-economic groups, there still exist some anomalies in the actions of parts of the health and social welfare system. In some HSE areas, supplies of infant formula milk are still provided free of charge to

mothers in severe socio economic disadvantage: initially up until the infant is 6 weeks old, and subsequently to 6 months, once application to the Community Welfare officer has been made and approved. A review of this process in 1999 revealed that the cost of this practice in one health board area in 1996 was IRE£90,000 (FSAI, 1999). Since then, at least two HSE community care areas have withdrawn the scheme, but it continues in certain urban areas, where the free formula milk is dispensed through the HSE health centres. Free infant formula is also provided to Traveller mothers; and to recent immigrants and asylum seekers through direct provision centres.

Such practices are likely to be perceived as a mixed message by mothers, who would understandably question why the HSE would provide infant formula if they do not believe that it is optimal nutrition for newborn infants and babies. There is no comparable entitlement for impoverished breastfeeding mothers. The FSAI report of 1999 questions this practice, in terms of the equity of such an arrangement, and the danger that prescribing set amounts of formula may not meet an individual baby's needs:

While it is imperative that all mothers have access to appropriate food for their infants, the practice of giving out formula milk for which mothers do not pay discriminates against the breastfeeding mother and could discourage low-income mothers from choosing to breastfeed. Furthermore, the quantity of formula milk allocated may not meet the infant's requirements, leading to the possibility that feeds will be over-diluted or that other milk, for example unmodified cows' milk, will be given inappropriately to infants." (FSAI, 1999)

The direct provision centres have developed a code of practice to encourage breastfeeding in the immigrant and refugee community, as these groups are at risk of adapting to the prevailing bottle-feeding cultural norm here in Ireland when they find themselves in a situation where they do not have their usual family support, usual maternal nutrition for breastfeeding mothers, and where the free formula may be interpreted as having a subtext that suggests formula is preferable to

breast milk. From the "Infant feeding guidelines for direct provision centres in Ireland" report (HSE, 2005), direct provision centres should take steps to accommodate and promote breastfeeding, with greater flexibility in the meals supplied to breastfeeding mothers, and infant formula being kept out of general view. Direct provision centres provide all of a family's meals and day to day needs, so some availability of infant formula for mothers unable to breastfeed must be maintained. However, the question of provision of free infant formula for other groups is a debatable one. The "Final Report on the Pilot Project to Promote Breastfeeding in Community Care Area 1" (ERHA, 2002) states that the means-tested, free infant formula which is currently available in the Eastern Regional Health Authority should be curtailed. However, the more recent publication "Breastfeeding in Ireland: A five-year strategic action plan" (DOHC, 2005) is less directive, suggesting in action number 32 the principle that

"Policies and practices that are barriers to breastfeeding, like the 'free infant formula milk schemes', have been reviewed and the review findings have been acted upon." (DOHC, 2005, p.42)

Individual groups, such as La Leche League, Galway, have suggested that instead of free formula, food vouchers should be provided to all mothers in these groups, thus removing the disincentive to breastfeed inherent in this scheme (Regional Breastfeeding Policy Working Group, HSE Western Area, 2004). However, no consensus has yet been achieved.

### **3.3.7 Conclusions**

Previous research has demonstrated that Ireland has the lowest rate of breastfeeding in Europe. The breastfeeding rate at discharge from hospital in Ireland (as given by the Perinatal Statistics) has increased slowly, but steadily since the early 1990s. There is no further mandatory recording of infant feeding method after discharge from hospital, which makes it difficult to accurately establish breastfeeding duration rates in Ireland. National and regional based surveys suggest that the duration rates breastfeeding fall far short of WHO

recommendations, with very few women in Ireland exclusively breastfeeding for 6 months and the continuation of breastfeeding beyond 6 months is also very rare. Quantitative surveys have also demonstrated that lower socio-economic groups are less likely to breastfeed than higher socio-economic groups; with lower levels of maternal education most consistently associated with a lower incidence of breastfeeding. Mixed messages are a problem for some lower socio-economic groups. Breastfeeding is actively promoted by the HSE. However Traveller mothers are instructed not to give their babies breastmilk until their test for galactosaemia has been shown to be negative, thus providing a major obstacle to breastfeeding in this community. In addition some HSE agencies provide benefits in the form of free infant formula to socially disadvantaged bottle-feeding mothers, with no reciprocal benefit to mothers who undertake to breastfeed.

International research on breastfeeding, which used qualitative techniques with low income samples, comes mainly from the UK. The experiences of women in the UK may have certain similarities with experiences in the Irish context. Recurrent themes in the UK qualitative studies include social embarrassment, inadequate milk supply, use of embodied knowledge to make breastfeeding decisions, lack of knowledge among friends and family, and lack of exposure to newborns in bottle feeding cultures. These qualitative studies are not designed however to be generalisable to other populations. The Irish qualitative research on breastfeeding among low income groups has uncovered many similar findings to the research in the UK. Key obstacles to breastfeeding initiation among lower socio-economic groups in Ireland include social embarrassment, perceived inconvenience of breastfeeding, lack of exposure to breastfeeding women and the pervasiveness of the bottle feeding culture. Lack of time on postnatal wards for health professionals to adequately support infant feeding is also a common theme. It is also apparent that most of the Irish qualitative research on barriers to breastfeeding among lower socio-economic groups has elicited the views of low income mothers on infant feeding, but there has been little research exploring the views of health professionals and other breastfeeding support services.



This review of the literature suggests that breastfeeding promotion should specifically target lower socio-economic groups, as recommended by the Strategic Action Plan (DOHC, 2005). More longitudinal and nationally representative research is needed however to gain a clearer insight into the relationship between socio-economic status and breastfeeding and to identify other factors which influence feeding choice. Qualitative research with a range of lower socio-economic groups and their breastfeeding service providers (e.g., midwives, public health nurses and breastfeeding support groups) is also necessary to gain a multi-faceted understanding of the cultural and psycho-social influences on women's choice of feeding method. Finally, there has been very little research conducted on the policies of Irish maternity hospitals in relation to breastfeeding. An audit of the infant feeding policies of maternity hospitals in Ireland is therefore necessary to understand the ethos of Irish health service providers in relation to breastfeeding service provision and to identify any gaps in these policies in relation to international best practice for supporting breastfeeding.

## **4 QUANTITATIVE ANALYSIS OF SECONDARY DATA SOURCES OF BREASTFEEDING PRACTICES IN IRELAND**

### **4.1 Introduction to the quantitative analysis**

Ireland currently has no national data collection system to audit infant feeding after discharge from our maternity units. The recent publication of the 2008 National Infant Feeding Survey contributes substantially to our knowledge, nevertheless there is an ongoing need to update our knowledge on the extent of breastfeeding initiation and continuation among the general Irish population, in addition to attitudes towards breastfeeding and potential barriers to breastfeeding. The aim of this chapter is to provide a review on current breastfeeding practices in Ireland using secondary data analysis of existing Irish and UK datasets. These datasets include the Lifeways Cross Generation cohort study (O'Mahony et al, 2007), the All-Ireland Traveller Health Study (2008), and all three waves of the Survey of Lifestyle, Attitudes and Nutrition (SLÁN) study (Kelleher et al, 1998; Kelleher et al, 2002; Morgan et al, 2007). For comparability purposes, an analysis of the Northern Irish sample from the UK Millennium Cohort Study (Dex & Joshi, 2005) is also conducted, in addition to an analysis of the whole UK sample from the Millennium Cohort Study. A more detailed description of each dataset can be found below. These data represent the most up to date information on breastfeeding practices in Ireland. The analysis involves a complete review of the content of each survey at each point in time to draw out all relevant breastfeeding information.<sup>3</sup> Specifically, the chapter aims first to describe breastfeeding initiation rates and duration of breastfeeding in these secondary data sources relating to Ireland and Northern Ireland and the rest of the UK. Second, regression models are used to examine the predictors of breastfeeding initiation and duration in multivariable models, with a view to identifying the socio demographic characteristics which are associated with these outcomes in Irish and UK populations. Finally, this chapter will draw conclusions on the relative importance of these various factors on breastfeeding rates in Ireland.

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<sup>3</sup> A full analysis of the All-Ireland Traveller Health Study findings was not possible as only preliminary unpublished data were available at this time, kindly provided by the AITHS Investigators and Steering group.

The chapter is organised as follows: Section 4.2 describes the datasets used in the analysis. Section 4.3 describes the statistical methods used and the socio-demographic factors included in the models. Section 4.4 presents the descriptive statistics for the analysis examining the incidence and duration rates of breastfeeding in the last ten years in Ireland. Section 4.5 presents the results from the regression analyses and Section 4.6 concludes.

## **4.2 Data employed**

The current analysis draws upon three national studies and one UK study covering the period 1998-2007. These studies are described below.

### **4.2.1 Lifeways Intergenerational Longitudinal Study**

*The Lifeways Intergenerational Longitudinal Study* is a cross-generation cohort study comprising three generations of the same family. Lifeways is unique in Ireland as it can link health information from the ante-natal stage through childhood but is also highly novel in international terms, being one of few studies with information across three generations. Its goal is to identify opportunities for development, change and improvement in the healthcare and well-being of the Irish population. Between October 2001 and Jan 2003, 1124 pregnant women were recruited in the ante-natal clinics of the Coombe Hospital Dublin and University College Hospital, Galway. Sampling insured both urban and rural communities were included. 1088 babies were born to 1076 mothers. Fathers (n=331), maternal grandparents and paternal grandparents (n=1231) were subsequently recruited. This cohort has been followed for five years to date and is now comprised of 520 three-generation families for whom detailed breastfeeding data and rich socio-demographic data is available. Therefore the breastfeeding information used in this analysis was recorded retrospectively when the children were five years old. Please see Appendix A for the exact question wording. Further information on the Lifeways cohort can be found in a special edition of the Irish Medical Journal (2007, Volume 100, Issue 7).

#### **4.2.2 SLÁN: Survey of Lifestyle, Attitudes and Nutrition**

*SLÁN* is a national survey of the lifestyle, attitudes and nutrition of people living in Ireland which has been conducted in 1998, 2002 and 2007. The overall aim of the surveys is to provide nationally representative data on the general health, health behaviours and health service use of adults living in Ireland. The 1998 survey was commissioned by the Health Promotion Unit of the Department of Health & Children and carried out at the Centre for Health Promotion Studies at NUI Galway and in 2002 at the UCD School of Public Health and Population Science. There were eight sections in the self-complete questionnaire which covered general health (including self-reported height and weight), exercise, tobacco, illegal substances, accidents, household details and dietary habits. A similar *SLÁN* survey was repeated in 2002 and 2007 (Morgan et al, 2008). Each questionnaire covered general health (including self-reported height and weight), exercise, tobacco, illegal substances, accidents, household details and dietary habits). All three surveys also contain detailed information on the breastfeeding practices of the respondents (if female and have children). As in the Lifeways survey, this information is asked retrospectively when the children are different ages therefore there is a potential recall bias in regards the breastfeeding information depending on the age of the respondents' child at the time of the survey. The questions vary from survey to survey and are reported in Appendix A.

#### **4.2.3 All-Ireland Traveller Health Study**

The Department of Health and Children in conjunction with the Department of Health, Social Services and Public Safety in Northern Ireland commissioned the UCD School of Public Health and Population Science to conduct the All-Ireland Traveller Health Study. It is the first study of Travellers' health status and health needs that involves all Travellers living in the island of Ireland. The study identifies health needs as identified by Travellers and Health Services Providers and measure the health status of Travellers. The findings from the study will provide a framework for policy development and practice in relation to Travellers. Peer researchers drawn from the Traveller community play a key role in data collection for the study. The study is divided into the following 4 Sub-Studies: 1) Census of Traveller

Population; 2) Examination of Health status of Travellers; 3) Quantitative Study on the factors influencing the health status of Travellers and their access to health services, 4) Review of services with a view to ascertaining best practice. This analysis used the Census component of the study which includes information on the breastfeeding practices of the respondents.

#### **4.2.4 UK Millennium Cohort Study**

The *Millennium Cohort Study* (MCS) is a longitudinal study of 18,819 babies who were born in the four countries of the UK. The sample includes babies born from late 2000 to early 2002. The cohort of children was identified through Child Benefit records, which were provided to the MCS team by the Department of Social Security. There have been three waves of the study to date. Wave 1 was carried out in 2001-2002 when the babies were nine months old. Mothers and their partners were interviewed on questions relating to the pregnancy and the delivery, the child's health and development, childcare and parenting practices, and their participation in employment and education. Over two years later, the families were interviewed once again and information was obtained on the parental situation, child's health, breastfeeding, childcare, employment and income, the nature of parenting activities. At this time, when the children were approximately 3 years of age, the children's cognitive and social/emotional development were assessed and their physical measurements were taken. The third wave was conducted in 2006/07 when the children were of school-going age. The longitudinal dimension of the dataset provides users with the ability to link circumstances in the first survey with these later child outcomes. The analysis is conducted for the entire MCS sample and a separate analysis is conducted for the Northern Ireland sample. Please see Appendix A for the exact question wording.

#### **4.3 Methods and covariates**

The analysis involves two steps. First descriptive statistics on the breastfeeding initiation and duration rates for each survey and time point are presented. Where possible the analysis is divided into the duration of exclusive and non-exclusive breastfeeding. It should be noted that exclusive breastfeeding only became a best

practice recommendation in 2004, therefore this should be borne in mind when interpreting the results from the SLAN surveys which were conducted before and after 2004. The second step involves a more in-depth quantitative analysis of the factors associated with the breastfeeding initiation and duration rates. This involves estimating a series of binary regressions modeling the incidence of breastfeeding, and linear regressions modeling the duration of exclusive and non-exclusive breastfeeding.

The breastfeeding literature has identified a number of different risk factors which are associated with breastfeeding practices. These factors are included in the models. They include characteristics of the child including gender and birth weight; parental characteristics including marital status and number of children in the household; and maternal characteristics including the mother's educational attainment, and whether the mother smokes and works during the child's first year. These factors were chosen as they were common across all datasets (apart from the SLÁN data where child characteristics were not available due to the nature of data collection).

#### **4.4 Results: Descriptive Statistics**

Tables 4.1 to 4.4 present the breastfeeding initiation and duration rates for all four datasets. Table 4.1 shows the initiation rates for the Lifeways data (wave 1 and 2), the Northern Irish and whole UK sample of the Millennium Cohort Study and the All-Ireland Traveller Health Study. Table 4.2 shows the initiation rates for the three waves of SLÁN. The SLÁN data is presented separately as it includes the initiation rates for women who have 'ever breastfed' and for those who breastfed their last child.

Overall the breastfeeding initiation rates in Ireland are below that of the UK. The initiation rate of 54% in wave 2 of Lifeways is slightly higher than the Northern Irish rate of 48% and the SLÁN rates of 41% in 2002 and 44% in 2007. The initiation rate for SLÁN respondents in relation to their last child is consistently lower at 30% in 1998 and 2002. The question wording in the SLÁN 2007 survey

was changed from previous waves. Only women who had children under the age of five were asked the breastfeeding questions. Therefore, of the 2007 sample who had children under the age of 5, 22% of them initiated breastfeeding.

Table 4.3 shows the breastfeeding initiation rate, by age groups, for married women within the All-Ireland Traveller Health Study. It shows that the breastfeeding rate among Travellers is lower, at about 10% overall, compared to non-Travellers. In particular, the rate has been falling over time, with the younger cohort initiating breastfeeding less than the older cohorts. Specifically, 48% of Traveller women over the age of 65 report having breastfed any of their children, while the figure falls significantly to just 12% among the 45-64 age group, 7% among the 30-44 age group and just 4% among those currently under the age of 30. Note that these samples are quite small.<sup>4</sup>

In summary, the Irish breastfeeding initiation rates of between 30%-54% have not improved over time and are significantly below the UK's initiation rate of 66%. The breastfeeding rate is particularly low for younger Traveller women.

**Table 4.1: Breastfeeding initiation rates in the Lifeways and Millenium cohort studies**

	<b>Lifeways Wave 2 2007</b>	<b>MCS N. Ireland 2000-02</b>	<b>MCS All 2000-02</b>
<b>Yes</b>	54.06%	47.82%	65.58%
<b>No</b>	45.94%	52.18%	34.42%
<b>N</b>	542	1951	18764

<sup>4</sup> No further information on breastfeeding is available from the Traveller Health Study at this time, as the final report has not yet reached the public domain.

**Table 4.2: Breastfeeding initiation rates in the SLÁN surveys**

	<b>SLÁN 1998</b>	<b>SLÁN 2002</b>		<b>SLÁN 2007</b>	
	Breastfed last child	Breastfed any child	Breastfed last child	Breastfed any child	Breastfed last child (if have child under 5)
<b>Yes</b>	30.37%	41.36%	30.15%	44.24%	21.59%
<b>No</b>	69.63%	58.64%	69.85%	55.76%	78.41%
<b>N</b>	2101	2478	2464	3978	1084

**Table 4.3: Breastfeeding initiation rates in All-Ireland Traveller Health Study 2008-09**

<b>Age group</b>	<b>Yes</b>	<b>No</b>	<b>N</b>
Under 30	4.3%	95.7%	210
30-44	6.6%	93.4%	122
45-64	11.8%	88.2%	102
65+	47.5%	52.5%	40
Total	10.3%	89.7%	495

Table 4.4 presents the duration rates of non-exclusive breastfeeding across five categories (never breastfed, breastfed for less than 1 week, breastfed for between 1 and 3 months, breastfed for between 4 and 6 months, and breastfed for more than 6 months). Between 70 to 80% of women in the Irish samples do not breastfeed at all, compared to 52% in the Northern Irish sample and 34% in the whole UK sample. For those who do breastfeed, the largest category across all data sources is between one and three months (10-12% in SLÁN, and 16% in MCS Northern Ireland). 8% or less of women breastfeed for between four and six months, and 2 to 9% of women breastfeed beyond six months. In all cases, the proportion of women breastfeeding in the UK sample is higher than the Irish sample, with the Northern Irish duration breastfeeding rate being shorter than the whole UK rate, yet longer than the Irish rate.



**Table 4.4: Duration of non-exclusive breastfeeding in the Lifeways, SLÁN, and Millennium cohort studies**

	<b>SLÁN*</b> <b>1998</b>	<b>SLÁN*</b> <b>2002</b>	<b>SLÁN</b> <b>2007</b>	<b>MCS</b> <b>N.</b> <b>Ireland</b> <b>2000-02</b>	<b>MCS</b> <b>2000-02</b>
Never BF	70.92%	70.5%	80.19%	52.18%	34.42%
BF<1 week/month	4.56%	5.45%	1.13%	17.22%	13.63%
BF 1-3 months	12.17%	11.1%	10.09%	15.89%	22.92%
BF 4-6 months	7.03%	7.13%	5.85%	5.43%	8.12%
BF>6 months	5.33%	5.82%	2.74%	9.28%	20.91%
<b>N</b>	2063	2441	1060	1,951	18,763

**Note:** \* Exclusive breastfeeding only. Please see Appendix A for the exact question wording.

Tables 4.5 and 4.6 show the average number of weeks of exclusive and non-exclusive breastfeeding across all datasets.<sup>5</sup> These figures exclude women who have never breastfed. Of the women who do breastfeed, the average duration of exclusive breastfeeding is between 11 and 17 weeks in the Irish samples, 6 weeks in the Northern Irish sample and 8 weeks in the whole UK sample. The longer durations of breastfeeding in the Irish sample compared to the Millennium samples may be partly explained by the differing nature of the data collection. The Irish samples are based on retrospective questions asked when the children are mostly beyond breastfeeding age, while the Millennium survey was conducted when the children were all about nine months old, and hence, many of them may have gone on to be breastfed for longer durations. A similar pattern is observed in regards to non-exclusive breastfeeding. The average number of weeks of non-exclusive breastfeeding is between 19 and 23 weeks in the Irish samples, 12 weeks in the

<sup>5</sup> Note that only the duration of exclusive breastfeeding is not available in SLÁN 1998 or 2002.

Northern Irish samples and 17 weeks in the whole UK sample. These breastfeeding duration rates are still well below the WHO guidelines recommendation of 6 months of exclusive breastfeeding and up to 2 years of non-exclusive breastfeeding.

**Table 4.5: Duration of exclusive breastfeeding in weeks (if ever breastfed) (%)**

	<b>Lifeways Wave 2 2001-03</b>	<b>MCS N. Ireland 2000-02</b>	<b>SLÁN 1998</b>	<b>SLÁN 2002</b>	<b>SLÁN 2007</b>	<b>MCS 2000- 02</b>
<b>Mean</b>	11.45	6.48	na	na	16.79	7.72
<b>St. dev</b>	17.27	6.99	na	na	19.23	7.52
<b>N</b>	292	933	na	na	188	12305

**Table 4.6: Duration of non-exclusive breastfeeding in weeks (if ever breastfed) (%)**

	<b>Lifeways Wave 2 2001-03</b>	<b>MCS N. Ireland 2000-02</b>	<b>SLÁN 1998</b>	<b>SLÁN 2002</b>	<b>SLÁN 2007</b>	<b>MCS 2000- 02</b>
<b>Mean</b>	18.52	11.83	21.60	22.60	na	16.76
<b>St. dev</b>	27.7	14.07	24.05	24.05	na	15.54
<b>N</b>	294	933	576	710	na	12305

## 4.5 Results: Regression models

### 4.5.1 Incidence of Breastfeeding

Table 4.7, 4.8, and 4.9 report the results from the binary models examining the incidence of breastfeeding in the Lifeways<sup>6</sup>, SLÁN, and MCS datasets respectively. The factors associated with breastfeeding are similar across all waves of SLÁN and in the Northern Irish and whole MSC samples, with almost all included factors reaching statistical significance<sup>7</sup>. In the Lifeways sample, only three factors are statistically significant (at the 5% or less) across both waves, with only one common factor being significant in both models (mother having a third level degree). In terms of the child characteristics, gender is not associated with the incidence of breastfeeding in either the Lifeways or MCS samples, while birth weight is only associated with breastfeeding in Lifeways wave 1. These child factors are not available for SLÁN.

The common maternal factors that are associated with an increased incidence of breastfeeding in all three SLÁN waves and the MCS (N. Ireland and the UK sample) include parental marital status, mother's age, and mother's educational levels. Married or cohabitating mothers, older mothers, and those with higher levels of educational attainment are significantly more likely to breastfeed their children. Note that mother's age is positively associated with breastfeeding in wave 1 and 2 of SLÁN, yet has a negative association in wave 3. This result could be driven by the change in question wording in wave 3 of SLÁN which asks about the incidence of breastfeeding if the respondent currently has a child under the age of 5 (therefore the respondents in wave 3 are a much younger age cohort, with the mean age being 33 compared to a mean age of 44 and 46 in wave 1 and 2

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<sup>6</sup> The regression analysis for the Lifeways wave 1 data is based on 196 observations. The sample size is constrained by the availability of data for the breastfeeding questions which comes from the Parent Held Child Health Records.

<sup>7</sup> Consistent with the literature, p-values below 0.05 (5%) are considered to be statistically significant. A p-value of less than 0.5 (5%) and 0.01 (1%), 0.001 (0.01%) conveys that the probability that the difference between the two groups is due to chance is less than 5%, and 1% respectively. Trend level results were reported if the p value was equal to or less than .10.

respectively). While the positive impact of maternal education is also significantly associated with breastfeeding in Lifeways (wave 1 and 2), none of the other identified relationships in the other datasets are replicated here.

Maternal employment has differing effects in the UK and Irish samples. Maternal employment is positively associated with breastfeeding in SLÁN (wave 1 and 2). However, maternal employment has no statistical impact on breastfeeding in the Northern Irish sample of MCS, and is negatively associated with breastfeeding in the whole UK sample. This may be explained by the differing sample frames. MCS is a cohort study and maternal employment is measured when their children are 9 months old. Therefore maternal employment at 9 months may act as a barrier to breastfeeding. The SLÁN study, on the other hand, is not a cohort study and maternal employment is measured contemporaneously. Therefore employment it is not necessarily a barrier to breastfeeding as their children are, in general, beyond breastfeeding age. Instead, maternal employment may be considered a proxy for higher social class which is typically associated with higher breastfeeding rates.

The number of children in the household also has diverging effects in the Irish and UK samples. While a greater number of siblings is positively associated with breastfeeding in Lifeways (wave 2) and SLÁN (wave 1 and 2), it is negatively associated with breastfeeding in the Northern Irish and whole UK samples.

The one risk factor that is consistently associated with breastfeeding is maternal smoking, which is associated with a lower incidence of breastfeeding in SLÁN (waves 1 and 3), and MCS Northern Irish and whole UK samples.

In summary, the factors associated with the incidence of breastfeeding in the UK and Ireland are mixed and are dependent on the dataset under analysis. Maternal education is the only factor which plays a consistent role, with higher education being associated with an increased probability of breastfeeding. There also appears to be differing effects in the SLÁN and MCS samples compared to the Lifeways sample, with a greater number of factors influencing the decision to breastfeed in

the latter datasets. This may be related to the relatively small sample size of the Lifeways models.

**Table 4.7: Characteristics associated with the incidence of breastfeeding as reported in Lifeways Wave 1 and Wave 2**

	Breastfed (Wave 1)	Breastfed (Wave 2)
Child's gender: female	-1.00(0.34)	-0.95(0.19)
Child's Birth weight	-1.00*(0.00)	-1.00(0.00)
Parents: Married/Cohabiting	2.42(1.32)	1.16(0.39)
No. of children	1.15(0.24)	1.24*(0.13)
Mother's age	1.05(0.04)	1.03(0.02)
Mother works	-0.78(0.32)	1.51 <sup>†</sup> (0.37)
Mother smokes	-0.77(0.40)	-0.71(0.19)
Mother's education: Complete secondary education	-0.94(0.56)	1.46(0.47)
Mother's education: Some third level education	3.31 <sup>†</sup> (2.26)	1.57(0.57)
Mother's education: Complete third level education	3.89*(2.36)	5.50**(1.86)
Sample size	186	503

**Notes:** Odds ratios and standard errors in parentheses reported. Significance levels: \*\* $p < .01$ ; \* $p < .05$ ; <sup>†</sup>  $p < .10$

**Table 4.8: Characteristics associated with the incidence of breastfeeding as reported in SLAN 1998, 2002, 2007**

	<b>SLÁN 1998</b>	<b>SLÁN 2002</b>	<b>SLÁN 2007</b>
Parents:	1.50**(0.22)	1.75**(0.23)	1.46 <sup>†</sup> (0.31)
Married/Cohabiting			
No. of children	1.38**(0.07)	1.42**(0.07)	1.02(0.07)
Mother's age	1.02**(0.01)	1.03**(0.01)	-0.97*(0.01)
Mother works	1.34*(0.17)	1.58**(0.18)	-0.84(0.14)
Mother smokes	-0.74*(0.10)	-0.84(0.11)	-0.49**(0.11)
Mother's education:	2.87**(0.41)	1.91**(0.27)	2.24**(0.66)
Complete secondary education			
Mother's education: Some third level education	3.64**(0.71)	3.00**(0.52)	3.45**(1.00)
Mother's education: Complete third level education	7.02**(1.27)	5.14**(0.82)	5.89**(1.77)
Sample size	1734	2000	1060

**Notes:** Odds ratios and standard errors in parentheses reported. Significance levels: \*\* $p < .01$ ; \* $p < .05$ ; <sup>†</sup>  $p < .10$

**Table 4.9: Characteristics associated with the incidence of breastfeeding as reported in Millennium Cohort Study**

	Breastfed (N. Ireland)	Breastfed (All)
Child's gender: female	1.07 (0.11)	-0.96 (0.03)
Child's Birth weight	1.17 <sup>†</sup> (0.11)	1.00 (0.03)
Parents: Married/Cohabiting	1.37* (0.21)	1.56** (0.07)
No. of children	-0.82** (0.04)	-0.79** (0.01)
Mother's age	1.05** (0.01)	1.05** (0.01)
Mother works	-0.96 (0.11)	-0.84** (0.03)
Mother smokes	-0.80 <sup>†</sup> (0.09)	-0.64** (0.02)
Mothers Education: O level/GCSE grades A-C	1.98** (0.27)	1.45** (0.06)
Mothers Education: A/ AS/ S Levels	3.55** (0.70)	2.85** (0.19)
Mothers Education: Diplomas in Higher Education	4.07** (0.84)	2.95** (0.21)
Mothers Education: First Degree	8.81** (1.83)	6.67** (0.55)
Mothers Education: Higher Degree	8.26** (2.54)	6.69** (1.00)
Sample size	1844	17191

**Notes:** Odds ratios and standard errors in parentheses reported. Significance levels: \*\* $p < .01$ ; \* $p < .05$ ; <sup>†</sup>  $p < .10$

#### **4.5.2 Duration of Breastfeeding**

Tables 4.10, 4.11, and 4.12 report the results from the models examining the duration of exclusive and non-exclusive breastfeeding in the Lifeways (wave 2), SLÁN, and MCS datasets respectively. Maternal education is consistently associated with the duration of exclusive and non-exclusive breastfeeding. High maternal education is associated with longer periods of breastfeeding in all of the Irish, Northern Irish, and UK samples. The number of children in the household also consistently associated with longer periods of exclusive and non-exclusive breastfeeding in all samples apart from SLÁN wave 3. Neither gender nor birth weight is associated with the duration of breastfeeding in any of the Irish or Northern Irish samples, while both are positively associated with non-exclusive and exclusive breastfeeding in the whole UK sample. Therefore, for the UK, girls are likely to be breastfed for longer than boys, and higher birth weight is associated with longer periods of breastfeeding.

Mother's age plays a relatively consistent role in regards breastfeeding duration, with older mothers being associated with longer breastfeeding durations compared to younger mothers in Lifeways (wave 2), SLÁN (wave 1 and 2), and in the Northern Irish and whole UK samples. Again, the differing findings in SLÁN 2007 compared to the other datasets in regards maternal age and number of children may result as the SLÁN 2007 is a younger cohort. By contrast, marital status has a weak and inconsistent effect across datasets. Maternal employment is not statistically associated with the duration of breastfeeding in Lifeways, SLÁN or the Northern Irish samples. However, it is negatively associated with the duration of exclusive and non-exclusive breastfeeding in the whole UK sample. Therefore mothers who are in employment are more likely to stop breastfeeding before mothers who do not work. Similarly, there is no statistical association between maternal smoking and duration of breastfeeding in Lifeways, SLÁN (wave 1 and 2), or in the Northern Irish samples. In contrast, maternal smoking is negatively associated with the duration of breastfeeding in SLÁN (wave 3) and the whole UK sample. In all cases, the correlates of exclusive and non-exclusive breastfeeding are largely similar. Overall, the number of factors identified as being associated



with the duration of breastfeeding is greater in the UK sample, compared to the Irish and Northern Irish samples. This may be driven by the much larger sample size of the MCS.

**Table 4.10 Characteristics associated with the duration breastfeeding as reported in Lifeways Wave 2**

	Duration	
	breastfed Non-exclusively	Duration breastfed exclusively
Child's gender: female	1.20 (1.66)	0.96 (0.98)
Child's Birth weight	0.00 (0.00)	0.00 (0.00)
Parents: Married/Cohabiting	-5.38 <sup>†</sup> (2.90)	-1.15 (1.71)
No. of children	2.24* (0.87)	1.49** (0.51)
Mother's age	0.56** (0.19)	0.15 (0.11)
Mother works	1.10 (2.07)	1.22 (1.22)
Mother smokes	-1.24 (2.26)	-1.14 (1.33)
Mother's education: Complete secondary education	0.74 (2.72)	0.51 (1.61)
Mother's education: Some third level education	4.13 (3.10)	2.66 (1.84)
Mother's education: Complete third level education	11.16** (2.81)	5.92** (1.66)
Sample size	502	500

**Notes:** OLS coefficient and standard errors in parentheses reported. Significance levels: \*\* $p < .01$ ; \* $p < .05$ ; <sup>†</sup>  $p < .10$

**Table 4.11: Characteristics associated with the duration of non-exclusive breastfeeding as reported in SLÁN 1998, 2002, 2007**

	<b>SLÁN 1998</b>	<b>SLÁN 2002</b>	<b>SLÁN * 2007</b>
Parents: Married/Cohabiting	0.13 (0.88)	1.76* (0.86)	-0.01 (0.71)
No. of children	2.24** (0.34)	2.38** (0.34)	0.19 (0.25)
Mother's age	0.15** (0.03)	0.15** (0.03)	0.01 (0.03)
Mother works	-0.39(0.85)	1.48 <sup>†</sup> (0.81)	-0.38 (0.61)
Mother smokes	-0.91 (0.83)	-1.25 (0.86)	-1.86** (0.67)
Mother's education: Complete secondary education	3.49** (0.92)	2.23* (0.94)	0.85 (0.85)
Mother's education: Some third level education	6.12** (1.35)	6.03** (1.23)	2.43** (0.88)
Mother's education: Complete third level education	12.59** (1.24)	10.60** (1.12)	4.43** (0.96)
Sample size	1696	1976	1037

**Notes:** OLS coefficient and standard errors in parentheses reported. Significance levels: \*\* $p < .01$ ; \* $p < .05$ ; <sup>†</sup>  $p < .10$ . \*Slan 2007 only includes duration of exclusive breastfeeding.

**Table 4.12: Characteristics associated with the duration of breastfeeding as reported in MCS**

	Duration breastfed Non-exclusively		Duration breastfed exclusively	
	N. Ireland	UK	N. Ireland	UK
Child's gender: female	0.64 (0.92)	0.90** (0.28)	0.81 <sup>†</sup> (0.46)	0.61** (0.14)
Child's Birth weight	1.18 (0.79)	1.33** (0.23)	0.38 (0.40)	0.63** (0.11)
Parents:				
Married/Cohabiting	2.41 (1.59)	1.02* (0.46)	0.63 (0.80)	0.32 (0.23)
No. of children	0.98* (0.48)	0.71** (0.15)	0.60*(0.24)	0.32** (0.07)
Mother's age	0.33** (0.10)	0.42** (0.03)	0.10 <sup>†</sup> (0.05)	0.14** (0.01)
Mother works	-1.10 (1.03)	-3.18** (0.30)	0.05 (0.52)	-0.83** (0.15)
Mother smokes	-0.72 (1.15)	-3.22** (0.34)	-0.88 (0.57)	-0.95** (0.17)
Mothers Education: O level/GCSE grades A-C	2.44 (1.48)	1.84** (0.40)	0.75 (0.74)	1.08** (0.20)
Mothers Education: A/ AS/ S Levels	2.34 (1.87)	4.86** (0.52)	0.52 (0.94)	1.96** (0.26)
Mothers Education: Diplomas in Higher Education	3.98* (1.88)	4.61** (0.54)	1.44 (0.94)	2.02** (0.27)
Mothers Education: First Degree	5.65** (1.66)	8.98** (0.49)	1.57 <sup>†</sup> (0.83)	3.45** (0.24)
Mothers Education: Higher Degree	7.10** (2.11)	11.11** (0.72)	2.41* (1.06)	4.38** (0.36)
Sample size	886	11230	886	11230

**Notes:** OLS coefficient and standard errors in parentheses reported. Significance levels: \*\* $p < .01$ ; \* $p < .05$ ; <sup>†</sup>  $p < .10$

## 4.6 Summary

Breastfeeding rates in Ireland are well below the WHO recommendations in terms of both exclusive and non-exclusive breastfeeding. Based on these national datasets for the last ten years, the Irish breastfeeding initiation rate of 41%-54% has not improved over time and is significantly below the UK's initiation rate of 66%. However, the average number of weeks of exclusive breastfeeding among the Irish samples is between 11 and 17 and the average number of weeks of non-exclusive breastfeeding is between 17 and 23 weeks, both of which are longer than the UK sample. This may be driven by the timing of the Irish and UK surveys. The Irish surveys are based on retrospective questions asked when the children are generally beyond breastfeeding age, while the UK samples are asked when the children are around nine months old. Furthermore, the 2005 UK Infant Feeding Survey (Bolling et al., 2007) would suggest that 21% of all UK mothers are breastfeeding exclusively at 6 weeks, compared with 19% of respondents in the 2007 Irish National Infant Feeding Survey (Begely et al., 2009), who were exclusively breastfeeding at 3-4 months. Overall, these breastfeeding duration rates are still well below the WHO guidelines recommendation of 6 months of exclusive breastfeeding and up to 2 years of non-exclusive breastfeeding. The breastfeeding rates are particularly low among the Traveller population, with the initiation rate of just 4% for women under the age of 30. As shown in the analysis, the initiation rate has been falling dramatically across age cohorts.

In regards the quantitative analysis, the primary factor associated with the incidence of breastfeeding in the UK and Ireland is maternal education. As shown in previous research, more educated mothers are more likely to breastfeed their children. Marital status, maternal age and smoking also play a role in breastfeeding decision across all samples; however in general there appears to be differing effects in the SLÁN and MCS samples compared to the Lifeways sample, with a greater number of factors being associated with the decision to breastfeed in the former datasets. The factors influencing the length of breastfeeding also differ across samples. While maternal education and the number of children play a consistent role in breastfeeding duration, few other factors are statistically significant across

all samples. Overall, the number of factors identified as being associated with the duration of breastfeeding is greater in the UK sample, compared to the Irish and Northern Irish samples. Finally, the correlates of exclusive and non-exclusive breastfeeding are largely similar.

Note however that this analysis is constrained by a number of limitations. First, the changing of the question wording between the earlier and later SLÁN waves means that these data are not directly comparable. As the SLÁN survey only asked the breastfeeding questions of women with young children, it is likely that the resulting data is from a sample of young mothers who may have different breastfeeding patterns than older mothers. In addition, the sampling frames across the various datasets differ, rendering a direct comparison of the datasets challenging, which may reflect the differing results. Nevertheless, the analysis presented in this chapter adds substantially to the existing evidence of overall picture of the Irish mother who is less likely to breastfeed: the younger, less educated mother; who may smoke and who may not be in employment. These disadvantaged mothers are at greatest risk of not optimising their infants' health by considering and undertaking breastfeeding.

## **5 AN AUDIT OF SERVICES AVAILABLE TO MOTHERS INTENDING TO BREASTFEED OR CURRENTLY BREASTFEEDING**

### **5.1 Introduction**

Breastfeeding is the most natural way to feed an infant, but it is also a skill which must be learnt by the new mother. In modern Ireland where much of the family knowledge of the skills relating to breastfeeding have been lost, community and hospital services have to act to re-establish this lost knowledge. This substudy will perform an audit of existing hospital and community breastfeeding services and maternity hospital breastfeeding practices, which aim to provide support to women in initiating and continuing breastfeeding.

### **5.2. Background to the international principles which inform breastfeeding service provider policies**

Breastfeeding has been an international health priority for almost 30 years. In response to the marketing practices of the breastmilk substitute manufacturers, the International Code of Marketing Breastmilk substitutes ("the Code") was published in 1981 (WHO, 1981). The Code prohibits the promotion of bottle-feeding, and sets out requirements for the labelling of artificial breast milk substitutes and standards for information on infant feeding (Box 5.1.). Ireland voted in support of the WHO International Code of Marketing Breastmilk substitutes in 1987.

In 1989, the WHO published the "Ten steps to successful breastfeeding" (WHO, 1989), as part of a document outlining the role of the maternity services in promoting breastfeeding. The Ten Steps are outlined in Box 5.2.

The WHO has since published a discussion document reviewing the evidence-base underlying these "Ten steps" (WHO, 1998). The most robust steps, and the ones which are the most cost effective, are the steps relating to education of the mother and the establishment of breastfeeding support groups (Steps 3, 5 and 10). These "Ten steps", along with adherence to the Code, have since formed the basis of the

prerequisites of the Baby-Friendly Hospital initiative (BFHI), a UNICEF-guided global campaign which was instigated in 1991. Over 300 European hospitals have achieved Baby-Friendly status, and the Irish BFHI was initiated in 1998. As of September 2009, 19 of the 20 Irish maternity hospitals were participating in the BFHI, with six hospitals described having achieved “Baby Friendly” status at the time of writing: Portiuncula Hospital, Ballinasloe; St Munchins’ Hospital, Limerick; the Rotunda Hospital, Dublin; University College Hospital Galway; Our Lady of Lourdes Hospital, Drogheda; and Cavan General Hospital, Cavan. To achieve Baby-Friendly status, a maternity service must demonstrate that the WHO Ten steps are implemented in their unit, through visits and assessments from the BFHI coordinator.

**Box 5.1 The principles of the WHO International code of marketing breast-milk substitutes (1981), summarised by Levitt et al (1996)**

<p>No advertising of breastmilk substitutes to the public</p> <p>No free samples to be given to mothers</p> <p>No promotion of products in health care facilities</p> <p>No mothercraft nurses from the companies to advise mothers</p> <p>No gifts or samples to be given to health care workers</p> <p>No words or pictures (including pictures of infants) idealising artificial feeding to be on the labels of products</p> <p>Information to health care workers must be simple and factual</p> <p>All information on artificial infant feeding, including on product labels, should explain the benefits of breastfeeding and the hazards of artificial feeding</p> <p>Unsuitable products should not be promoted for babies</p> <p>All products should be of high quality and take account of the climatic and storage conditions where they will be used.</p>
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**Box 5.2 The Ten steps to successful breastfeeding. Source: Protecting, promoting and supporting breastfeeding. The special role of maternity services. (1989) WHO: Department of Child and Health Development, Geneva.**

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in - that is, allow mothers and infants to remain together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Audits of breastfeeding practice in maternity hospitals have been performed by other researchers in Canada, the USA and Scotland, amongst other places. Campbell et al (1995) examined ten maternity hospitals in Scotland, using the criteria from the BFHI. Multiple sources of data were used, with the problems identified including the practice of removing the baby from the mother overnight, with the idea to "give the mother a rest"; conflicting advice given to mothers; low



levels of awareness of breastfeeding practices and of the breastfeeding policy within the hospitals' staff; insufficient postnatal support; the presence of advertisements for baby formula; and a hypoglycaemia protocol which included repeated heel pricks and discouraged some mothers from breastfeeding. Levitt et al (1996) examined breastfeeding policies in maternity care hospitals across Canada using a postal questionnaire. 572 hospitals were surveyed, with 58.4% (296/507) reporting the existence of a written protocol, and only 4.6% (21/454) having a policy which complied with the WHO Ten Steps, and only 6/453 complying with both the Ten steps and the Code. Andrea Crivelli Kovach (2002) surveyed 35 hospitals with maternity units in Philadelphia, USA, through interviews with key hospital personnel. 48.6% of the hospitals were found to be implementing the Ten steps only either partially or minimally.

In summary, wide variations in practices exist between different countries, and even between individual units in individual countries. Auditing of hospital services can take the form of a questionnaire, interviews, or a review of policies. We undertook the latter approach in this part of the study, with qualitative information sourced from health service providers in Section 7.

### **5.3 Aims of this audit study**

To identify the services available to new mothers for breastfeeding support within the Irish maternity system

To gather information from the community services with respect to their remit, activities and accessibility.

To identify the criteria used in determining Baby-friendly hospital status

To gather information from all Irish public maternity units on their breastfeeding policies, and to obtain a written copy of that policy

To describe the Irish public maternity units' adherence to the WHO Ten Steps, based on the principles incorporated into their policy documents.

To make recommendations for breastfeeding services, based on any gaps found in this audit sub study.

## **5.4 Methods**

We undertook an audit of current hospital- and community based services for mothers intending to or currently breastfeeding. Community services were identified by searching the HSE's website [www.breastfeeding.ie](http://www.breastfeeding.ie) and through other links and information derived from the interviews. Community services were audited through their published information (hard copy and web-based). Further information was gleaned from the qualitative studies of health service providers (Section 7).

The maternity hospitals were approached by post and with follow up letter and phone call to provide a written copy of their breastfeeding policy. All policies were read and data were abstracted on a number of items. These data items included identification of the "Ten Steps", and identification of the core statements of the Code: specifically, prohibiting the promotion of infant formulas and bottle feeding paraphernalia, prohibiting free formula at hospital discharge, prohibiting the sale of infant formula on the hospital premises, and not accepting low cost or free milks or free or low cost bottle feeding paraphernalia for the hospital nursery.. Data was inputted into an Excel spread sheet, and simple descriptive statistics were generated.

## **5.5 Results of the audit of community services**

### **5.5.1 Overview of the services for mothers considering or currently breastfeeding.**

The community services identified for mothers who are considering breastfeeding or who are currently breastfeeding are as follows:

- I. HSE & Department of Health and Children services
  - Services arising from the individual maternity hospitals
  - HSE Public Health Nursing services and breastfeeding support groups
  - General practitioner and practice nurse services

Health Promotion Policy Unit at the Department of Health and Children  
HSE website: [www.breastfeeding.ie](http://www.breastfeeding.ie)  
HSE Community mothers programme  
Independent home birth midwives

II. Voluntary organisations

La Leche League of Ireland  
Cuidiu – the Irish childbirth trust  
[www.thebreastway.com](http://www.thebreastway.com) (This site has a commercial component)

III. Private support structures

Lactation Consultants  
Private maternity and baby nurses

### **5.5.2 HSE community services for mothers considering or currently breastfeeding**

HSE services vary across different regions of Ireland. Some of the maternity units provide discharge information on breastfeeding meetings and one-on-one sessions, which mothers may attend after discharge home, should a problem arise relating to breastfeeding. One example of this is the service which the National Maternity Hospital, Holles St publicise on the HSE's [www.breastfeeding.ie](http://www.breastfeeding.ie) website. Under the Maternity and Infant Care Scheme care extends to 6 weeks after the birth. Under this scheme mothers and babies can either attend the maternity hospital (or their GP if they availed of combined care) if problems arise during this period.

Individual HSE health centres and public health nurses may also provide breastfeeding support meetings which mothers can attend to seek support and information from professionals and fellow breastfeeding mothers. Again, these are an ad-hoc provision. However, the Public Health nurse also has an important role in providing one-on-one advice and counselling with regard to breastfeeding. General practitioners should also be ideally placed to provide individual counselling to

mothers encountering challenges in relation to breastfeeding, and previous research would suggest that GPs are positively disposed towards promoting breastfeeding, although only 10% of GPs in the surveyed group (n=164) had received formal training in breastfeeding issues (Finneran and Murphy, 2004).

The Community Mother's Programme (CMP) is an intervention which is available in parts of North and West Dublin. It consists of home visits on a monthly basis to the homes of pregnant women and first time and second time mothers of infants aged 0 to 2 years, who live in regions of social disadvantage, with a view to improving their parenting skills and self esteem. The Mothers who conduct the visits are experienced local mothers, who have been trained and are working under the guidance of a Family Support Nurse. At any one time, there are 150 Community mothers, under the guidance of 15 family Support nurses, attending 1,000 families. Although not exclusively a breastfeeding resource, the CMP can assist with breastfeeding queries and provide prenatal breastfeeding information and support. However, the programme is at present limited to certain geographic areas.

### **5.5.3 Voluntary community services for mothers considering or currently breastfeeding.**

La Leche League of Ireland is part of the international La Leche League (LLL) organisation. It is a voluntary group, with the mainstay of the groups' functions being a monthly meeting in a member's home. LLL Leaders are mothers who have breastfed themselves, and who have completed an accredited training course. During the meeting, the Leader facilitates a discussion related to breastfeeding topics, and encourages mothers to share their experiences. The emphasis is on a sharing of expertise between mothers to solve problems, in tandem with external sources of assistance such as doctors and other health care professionals.

In Ireland, LLL mothers facilitate 38 groups across the country, and provide 24-hour telephone assistance, on a voluntary basis. Besides offering client support and taking client referrals from HSE staff, LLL Leaders support the work of the HSE by participating on Breastfeeding Committees and participate in the training of health

care workers. LLL also participate in outreach programmes aimed at the general population, and in this way they aim to reach women who may not have been aware of the organization otherwise.

LLL Leaders have a regular information stand in the National Maternity Hospital; other Groups around the country have information points at anti-natal and postnatal classes. Groups are involved in information evenings on women's health and some groups are invited to visit second level schools to speak to students on the advantages of breastfeeding. A number of groups have "Breastfeeding Café" style meetings in local coffee shops which are open to all and raise the profile of breastfeeding in the wider community. Some Leaders are invited to speak to employees of large companies in their area. LLL actively recruits new members on a continual basis and newly recruited LLL Leaders are provided with a detailed programme of training before being accredited as Leaders. Existing Leaders are also given regular training up-dates to maintain their skills. LLL of Ireland also maintains a user-friendly website with information and contact points for mothers.

In terms of accessibility, LLL meetings are open to all interested parties, and the phone numbers can be accessed by anyone. LLL leaders will always ensure that they speak to the mother herself. Since some of the meetings take place in private homes, they may not be accessible to all mothers, and particularly not to those who do not drive, or have access to transport. To counteract this, and because some of the meetings have increased their attendance rates over time, LLL will also use public venues for meetings such as church halls, HSE facilities etc. Leaders have noted that the non-Irish national community tends to be well represented at meetings at present.

Cuidiu, or the Irish Childbirth Trust, is a voluntary organisation, initially established in 1979 in the model of the UK's National Childbirth Trust. There are now 14 branches of Cuidiu across the country, with most of the activity focussed in Dublin and Cork. Cuidiu offers ante natal counselling and support, breastfeeding support and post natal and parentcraft support. The various Cuidiu branches organise their

own activities, but the functions include Mother and baby support meetings and playgroups, breastfeeding support meetings, "Bumps and Babes" meetings, and branch library facilities. Fathers are also engaged, with some branches organizing social sessions for men, with an emphasis on fatherhood and parenting. Breastfeeding support meetings are facilitated by trained counsellors. Cuidiu also maintain an up-to-date website at [www.cuidiu-ict.ie](http://www.cuidiu-ict.ie) , with information on breastfeeding now available in seven languages, and with links to [www.breastfeeding.ie](http://www.breastfeeding.ie). Cuidiu staff also act as advocates for national breastfeeding practice, with involvement in policy writing such as Cuidiu's Infant feeding survey, 2000.

A recently established web-based breastfeeding resource is [www.thebreastway.com](http://www.thebreastway.com). Set up by a mother and medical doctor, it provides a forum for mothers with internet access to ask questions and read other mothers' stories. It also contains information on other support networks, and links to a number of private breastfeeding and lactation counselors.

#### **5.5.4 Privately-run community services for mothers considering or currently breastfeeding.**

The Association of Lactation Consultants in Ireland ([www.alcireland.ie](http://www.alcireland.ie) ) provides a list of international Board certified Lactation consultants, some of whom work in the public hospital setting, and some of whom provide private consultancy, including one-on-one home visits, breastfeeding classes and telephone support. Some of the health insurers fund these consultations.

## **5.6 Results of the audit of hospital services**

### **5.6.1 Response rates**

19 public or mixed public and private maternity units were identified in the Republic of Ireland, and contacted by standard letter requesting a copy of the hospital breastfeeding policy. After follow up letters and phone calls were made, a total of

15 policies were received (one policy relating to two hospitals, and one policy relating to four hospitals). Thus, policies relating to all the maternity units identified were received (100% response rate).

Of all the units identified, five were fully certified as “Baby-friendly”, with all units participating in the scheme to some degree.

### **5.6.2 Results of the audit: WHO Ten Steps**

All 15 policies were assessed for statements of compliance with the WHO “Ten Steps”. The results are shown in table 5.1.

All hospitals had a policy in place, although 5 did not state whether the policy was routinely communicated to staff. A commitment to staff training was evident from most of the policies (14/15), with 8 policies (53.3%) stating that training would take place within 6 months of staff appointment. Training commitments varied from different grades of staff, with most policies recommending a 20 hour training programme from “front line” maternity staff.

With regard to hospital practices relating to promoting initiation breastfeeding, all policies suggested that a “baby-led” feeding regime and rooming-in be followed. The issue of timing of the first feed is less clear. The WHO states that this should be within the first half-hour post delivery. However, only 6/15 policies explicitly stated that the feed should take place within 30 minutes, with a further 6 stating that it should take place within the first hour or “before leaving the labour ward”. A further 3 policies only made the comment that the first feed should take place “when the baby is ready”. All policies stated that skin-to-skin contact between mother and baby in the immediate post delivery phase was standard.

**Table 5.1 Compliance with the WHO “Ten Steps to successful breastfeeding” in the Irish maternity units audited**

<b>Step</b>		<b>Number of hospital policies endorsing the step: n (%)</b>
1.	Written Breastfeeding policy in place	15 (100%)
	Policy is routinely communicated to all staff	10 (66.7%)
2.	All health care staff are trained in breastfeeding skills	14 (93.3%)
3.	All pregnant women are informed as to the benefits of breastfeeding	14 (93.3%)
4.	Mothers are helped to initiate breastfeeding within half an hour of birth	6 (40%)
5.	Mothers are shown how to breast feed	15 (100%)
	Mothers are shown how to express their milk	14 (93.3%)
6.	Newborns do not receive any supplements, unless medically indicated	11 (73.3%)
7.	Mothers and babies “room-in”	15 (100%)
8.	Breastfeeding is “on-demand” or “baby-led”	15 (100%)
9.	No artificial teats or soothers are given to babies	14 (93.3%)
10.	Foster breastfeeding support groups	6 (40%)
	Encourage mothers to attend same	15 (100%)

For the baby in the neonatal special care unit, we looked for assurances that skin-to-skin contact or “kangaroo care” was facilitated as much as possible, that mothers were being encouraged to express, and that breast pumps were being made available within 6 hours of separation for mothers who were obliged to be separated from their infants. 11/15 (73.3%) policies stated that kangaroo care was endorsed, and 9/15 (60.0%) of policies indicated that a breast pump would be



made available to mothers whose babies were in the special care unit. Five policies stated that the pump and help in expressing would be available within 6 hours, and four more stated that it would be available "as soon as possible".

The issue of giving supplements to newborns is also a contentious one. Mothers who chose not to breast feed at all are of course giving supplements from the start, in the form of infant formula. In terms of a commitment not to give unnecessary supplements to infants whose mothers intend to breastfeed, we were looking in the policies for a commitment to ensure that any supplements given where medically necessary, were given where possible with the mother's approval, and were appropriately documented in the hospital notes. 11/15 (73.3%) of policies fulfilled these criteria. With regards to using artificial pacifiers or "soothers", one policy made no mention of this Step, whereas of the other 14 policies, 3 said that soothers were prohibited, and 11 said that soothers were discouraged. In practice, soother usage in the Irish maternity units is likely at the discretion of the mother.

In terms of the provision of practical information to mothers, 14 out of 15 policies stated that the benefits of breastfeeding were made clear to pregnant women. There was also specific information on teaching the mother how to express their milk in 14/15 policies, although there was very little emphasis on teaching the use of breast pumps for mothers. Surprisingly few policies explicitly stated the WHO guidance on optimal duration of breastfeeding. Only 8/15 (53.3%) stated that babies should ideally be given breastmilk exclusively until 6 months, and only 7/15 (46.7%) stated that breastfeeding up to 12 or 24 months was also desirable. Regarding breastfeeding and the working mother, a number of policies discussed provision of expressing facilities for breastfeeding mothers working within the maternity unit, but only 2/15 (13.3%) policies made any mention of the possibility and practicalities of working and breastfeeding with regards to other work places. All units recommended the use of post natal support groups to new mothers, with 6/15 (40.0%) mentioning ways in which the maternity service was supporting this (either by providing a support service which mothers could attend even after discharge, or by working with the community group).

Overall, when rated by their adherence to the Ten Steps, the mean score out of ten for endorsement of the Ten Steps in the 15 policies reviewed was 8.47 (standard deviation (SD) 1.19). When they were compared by whether they had achieved “Baby Friendly hospital” status or not, the Baby Friendly Hospitals’ policies had a higher rate of endorsement of the Ten Steps than did the policies of the hospitals which had not yet achieved this status (mean number of the Ten Steps endorsed 9.17 (SD 0.75) vs 8.00 (SD 1.22), two sided t test  $t=-2.07$ ,  $p=0.059$ ).

### **5.6.3 Results: Adherence to the principles of the International code of marketing breast-milk substitutes**

The audit of hospital policies also took note of the presence of endorsement of some of the principles of the International Code of marketing of breastmilk substitutes in the hospital policies. The results are presented in table 5.2. If a policy did not mention the specific principle, it was described as “not endorsing” it.

**Table 5.2 Number of maternity unit or hospital policies expressing compliance with practices coherent with the principles of the WHO International code of marketing breast-milk substitutes (1981) in the audit of maternity units' breastfeeding policies**

<b>Hospital practice in keeping with the Code</b>	<b>Number of Hospital policies endorsing the practice. n (%)</b>
Prohibit the promotion of artificial breastmilk substitutes	14 (93.3%)
Prohibit the promotion of bottle feeding paraphernalia	13 (86.7%)
Prohibit antenatal classes on the practice of bottlefeeding	10 (66.7%)
Prohibit the provision of free formula to mothers on discharge	1 (6.7%)
Prohibit the sale of formula on the premises	3 (20%)
The maternity unit or hospital does not accept free or low cost baby formula	2 (13.3%)
The maternity unit or hospital does not accept free or low cost bottles or teats	2 (13.3%)

The majority of hospital policies stated that artificial breastmilk substitutes (i.e. formula) would not be promoted in any form in the hospital. One policy also stated that no gifts could be made to hospital staff by formula companies. However, the policy on the acceptance of low cost bottle feeding formula and equipment was not made explicitly clear in most policies, leaving us with considerable uncertainty as to the hospital or units practices in this regard.

## **5.7 Discussion**

From the audit of breastfeeding services and hospital policies, it is apparent that multiple community services exist to assist the mother who wishes to breastfeed. Many of these services are voluntary, and are staffed by enthusiastic and

committed women who are advocates of breastfeeding and have personal experience of same. These services can help to normalise breastfeeding, and bring it back into the community consciousness. However by their nature they are not distributed evenly geographically, and access may not always be possible for the more marginalised community groups. Furthermore, from previous research we know that whilst non medical card holders who breastfeed were well aware of the support available to them through organisations like LLL, medical card holders who breastfeed did not mention such groups (Kelleher et al., 1998). Other services are associated with a fee for service, and this will mitigate against usage by the more socially disadvantaged mothers, even though in the longer term, breastfeeding may be economically more prudent for them, given the cost associated with infant formulas.

The maternity units themselves also provide differing levels of community support. Whilst all policies mentioned the community services available to mothers, some going into substantial detail with phone numbers etc, only 6 out of the 15 policies surveyed mentioned a community element to their breastfeeding practice, with provision of hospital drop in clinic for women post discharge being only sporadically provided. A service like this may well be of great interest to new mothers, who will have built up a level of trust and reliance on their local maternity unit, and who would likely value this level of post-discharge breastfeeding care. However, for many units, the remit of the breastfeeding resources would appear to be focussed on the women whilst they are inpatients. Indeed, remarkably few of the policies mention the WHO guidelines for exclusive and non exclusive breastfeeding.

Nevertheless, the audit has revealed an encouraging picture of the policies undertaken by the Irish maternity units and hospitals, which are broadly consistent with the WHO "Ten Steps to successful breastfeeding". Some of the policies go beyond this remit again, providing extensive instruction and guidance on breastfeeding skills and trouble-shooting for both the patients and the health care provider.

This audit has some limitations. We have accepted the data from the hospital policies, and did not perform on-site visits in order to triangulate and corroborate findings from the audit. It is hoped that the stated aims in the policies are being upheld to the best of that unit's ability; and indeed this corroboration has been the role of the BFHI, who perform on-site visits and interviews to confirm that the "Ten Steps" are being implemented in the day-to-day hospital practice. The ongoing roll-out of the BFHI within the Irish maternity services is to be applauded, and from this audit alone it can be seen that the hospitals which have achieved Baby-Friendly status have a higher rate of endorsement of the "Ten Steps" than those which have not.

### **5.8 Summary and conclusions**

An audit of hospital and community breastfeeding services and practices has shown the multiplicity of services available to mothers intending to breastfeed and those who are currently breastfeeding. Consistent provision of these services, and consistent reinforcement of the WHO "Ten Steps for successful breastfeeding" within the maternity services through such initiatives and the BFHI, are key to supporting women in initiating and maintaining breastfeeding.

## **6 QUALITATIVE STUDIES**

### **6.1 Barriers and facilitators to breastfeeding among mothers from lower socio-economic groups**

#### **6.1.1 Introduction for interviews with mothers**

There is a need for qualitative research with women from a range of lower socio-economic groups to explore the array of influences on infant feeding decisions. The present study used focus groups and individual interviews to explore infant feeding decisions among low income Irish mothers in both urban and rural communities, as well as in the Traveller community. This study aimed to identify barriers to breastfeeding, as well as factors which encourage breastfeeding, in order to gain an in-depth understanding of the reasons behind the low rates of breastfeeding in lower socio-economic groups.

#### **6.1.2 Study design for interviews with mothers**

The research used a qualitative approach to gain an understanding of low income Irish mothers' infant feeding decisions. Perceived obstacles and facilitators to breastfeeding initiation and continuation were also explored. Both focus groups and individual semi-structured interviews were used to elicit the views of lower socio-economic groups about infant feeding. Focus groups were chosen as a methodology, as they are known for their effectiveness in promoting group interaction and debate, which can produce insights, which would not be derived from individual interviews. This group dynamic can be useful in illuminating group norms and dominant cultural values (Kitzinger, 1995). An individual interview was conducted in cases for which focus group attendance could not be arranged. The use of semi-structured interviews allowed the research team to access the views of women who would not normally attend a focus group. In addition the use of individual semi-structured interviews allowed the participants an opportunity to provide in-depth information about their infant feeding decisions, which they may not have felt comfortable sharing in a focus group situation.

Low income urban and rural women, as well as Traveller women were recruited to explore infant feeding decisions across a diverse range of lower socio-economic status groups. In the focus group with Traveller women, it was also intended to explore intergenerational changes in feeding practices in the Traveller community. Both women who bottlefed and women who breastfed, were recruited for this study. Breastfeeding initiation was defined as having ever breastfed their infant initially post birth. This includes putting the baby to the breast with the intention of breastfeeding, even if this was only once (Bollig et al., 2007).

Separate interview guides were developed for (i) the individual interviews (ii) the focus groups with urban and rural women and (iii) the focus group with Traveller women. Open-ended questions were used in each of the interview guides. Each of the interview guides was developed to explore five aspects of infant feeding: (1) feeding decision -influences and motivations; (2) support - family, health professional, community; (3) knowledge about breastfeeding and information received; (4) perceived barriers to breastfeeding; and (5) perceptions about changes needed to support breastfeeding. For both the focus groups and the semi-structured interviews, one researcher used the interview guide to facilitate the discussion, while a second researcher made observational field notes.

Ethical approval for this study was obtained from the Human Research Ethics Committee of University College Dublin. An information sheet about the study was given out at the start of the focus groups and semi-structured interviews and written consent was obtained from each of the women.

### **6.1.3 Data collection for interviews with mothers**

A total of 43 mothers were interviewed for this research. Five focus groups and 13 semi-structured interviews were conducted. The five focus groups ranged in size from four to 10 participants, with a total of 31 women participating in the focus groups. Two focus groups were held with urban women, two focus groups were held with rural women and one focus group was held with Traveller women. Each of the

focus groups lasted for approximately one hour and each of the individual interviews lasted for approximately twenty minutes.

#### 6.1.3.1 Traveller women

One focus group was conducted with a sample of 10 mothers from the Traveller community. The focus group was held in Pavee Point Traveller's Centre in Dublin. A peer researcher co-facilitated the discussion in the focus group with Traveller women. The peer researcher was a member of the Traveller community, who was trained by the 'All Ireland Traveller Health Study' in co-facilitating focus groups. The focus group with Traveller women consisted of three young recent mothers (20s age group approx.), four middle-aged women (late 30s/40s age group approx.) and three older women (50s and 60s age group approx.). One of the young mothers initiated breastfeeding after birth, but then changed to formula feeding on the same day, whilst the other two young mothers initiated formula feeding. None of the middle-aged women initiated breastfeeding and all of the older women breastfed some or all of their children. No demographic information was collected from the Traveller women.

#### 6.1.3.2 Rural women

Two focus groups and one individual semi-structured interview were conducted with a total of 10 low income rural women. Mothers with children below the age of 5, but generally below the age of 2 were recruited for the research. Medical card holders only were recruited to ensure a low income sample. Mothers living in rural areas were recruited from two settings: (1) a G.P. practice in the south east of Ireland and (2) the patients of a public health nurse working in the west of Ireland. One rural woman was interviewed individually, as she could not attend the focus group organised in the south east of Ireland. The two rural focus groups and the individual interview were each held in a room in a hotel in the local area.



### 6.1.3.3 Urban women

Two focus groups and 12 individual interviews were conducted with a total of 23 mothers residing in low income urban areas. Mothers with children below the age of 5, but generally below the age of 2 were recruited for the research.

Mothers living in low income areas of north Dublin were selected for the two urban focus groups. Mothers with young children were recruited from an early childhood intervention called *Preparing for Life* (PFL) operating in North Dublin. The PFL programme involves the antenatal recruitment of a cohort of 200 pregnant mothers residing in three designated disadvantaged areas of north Dublin (Darndale, Belcamp and Moatview) for a 5 year school readiness intervention. Enough women could not be recruited from the PFL project for the two focus groups. Therefore, low income mothers who worked part-time in a crèche in a deprived part of north Dublin, as part of the FÁS community employment scheme were also recruited for the two urban focus groups. These women lived and worked in the same catchment area as the *Preparing for Life* project. The FÁS scheme helps long-term unemployed people and other disadvantaged people to re-enter the active work force. The two urban focus groups were held on the same morning in a room in a community centre in North Dublin.

**Table 6.1: Characteristics of the urban and rural participants**

	Urban (n=23)	Rural (n=10)	Total (N=33)
	n (%)	n (%)	N (%)
No. of focus groups	2	2	4
No. of individual interviews	12	1	13
Medical card holder	20 (87)	10 (100)	30 (91)
Initiated breastfeeding with youngest child	14 (61)	7 (70)	21 (64)
Duration of breastfeeding youngest child:			
Bottle-fed only < 1 week/ put baby to breast only	9 (39)	3 (30)	12 (36)
1-6 weeks	3 (13)	1 (10)	4 (12)
> 6 weeks	5 (22)	5 (50)	10 (30)

Twelve individual semi-structured interviews were conducted with low income mothers, who were patients from an urban G.P. practice, which serves a socio-economically deprived inner city area in Dublin. It was intended to organise focus groups with the women from the urban G.P. practice, but the G.P. informed us that it was highly unlikely that the women would return to attend a focus group. We decided therefore to conduct an individual semi-structured interview with recent mothers who attended the practice over a two day period in February 2009. The women were interviewed in a separate room before they went in for their doctor's appointment. Medical card holders only were recruited from the G.P. practice to ensure a low income sample.

#### **6.1.4 Urban and rural sample characteristics**

Table 6.1 shows the characteristics of the 33 urban and rural participants. The median age of the participants was 33. Seven of the women had given birth to their first child, and the remainder had between 2 and 6 children. The median age of their youngest child was 13 months. Twenty one of the urban and rural participants initiated breastfeeding (including attempted breastfeeding) and the remaining 12 initiated formula feeding. Ninety one percent of the urban and rural women were medical card holders.

Although a low income sample was obtained, a relatively high proportion of the women initiated breastfeeding. This may be partly due to breastfeeding women having more interest in participating in research about infant feeding than formula-feeding women. In addition, 3 low income non-Irish born women (all of whom had initiated breastfeeding) were included in the sample to provide an insight into cultural differences regarding infant feeding choice. Moreover, the sample is not intended to be statistically representative of the Irish population of low income recent mothers, but instead is intended to reflect the diversity of views within the given population, as is the goal of much qualitative research (Barbour, 2001). Therefore, the inclusion of low income women from a range of urban and rural settings, with a variety of infant feeding practices, and from both Irish and non-Irish backgrounds should provide an insight into the diversity of views about infant feeding.

### **6.2 Healthcare and breastfeeding care providers' beliefs regarding barriers and facilitators to breastfeeding among mothers from communities with low breastfeeding rates**

#### **6.2.1 Introduction to the service providers' interviews**

Given the gaps in breastfeeding rates between the socio economic groups, it was deemed important to gather information from breastfeeding service providers, both within the HSE and in the voluntary services, at maternity unit and community levels.

### **6.2.2 Methodology used in the service providers' interviews**

Interviewees were selected on the basis of their position or role in breastfeeding support. Particular efforts were made to obtain the views of providers working with lower socioeconomic groups. Interviewees were selected from urban and rural community and hospital settings. Individual interviewees were identified through contact with professional bodies, through contact with individual maternity units and community services, and through word-of-mouth recommendation of persons with particular expertise in this regard. Ethical approval was sought and obtained from the UCD Human Research Ethics Committee, and an individual ethics application was made and approved from the Rotunda Hospital also. All potential participants were approached by phone or email contact, and a study information sheet and consent form were forwarded to them for their approval.

A topic guide (see appendix) was developed in conjunction with the service-user research which was used to frame the research question. All interviews were performed by a single trained researcher. In order to increase our understanding of the variety of breastfeeding supports available, providers included Midwives; Lactation Consultants; General Practitioners; Public Health Nurses (PHNs); Voluntary Groups; Obstetricians; Neonatologists; Dieticians and Baby Friendly Hospital Initiative representation.

A total of 40 individual telephone interviews were conducted, transcribed and analysed. Interviewees' involvement in breastfeeding support was wide-ranging, from strategic steering committee membership to one-to-one breastfeeding support. Therefore the results of this substudy provide information from a diverse country-wide, multidisciplinary provider group working in hospital, community and voluntary groups (Table 6.2.). Due to the large consultative nature of this study a variety of roles are included. Some but not all interviewees had a specific remit to work with women from lower-socioeconomic groups including teenage mothers and Travellers. Many providers draw on their more generalised and occasional experiences working with this target group.

**Table 6.2 Description of the roles and settings of the breastfeeding service providers interviewed**

<b>Setting in which the service providers work:</b>				
<b>National</b>	<b>Hospital</b>	<b>Community</b>	<b>Specialist</b>	<b>Voluntary</b>
Baby Friendly Hospital Initiative staff	Obstetrician (x 2)	Independent Midwife Community Midwife (x 3)	Consultant paediatrician neonatologist	LLL
Breastfeeding Steering Committee (Dietetic Manager)	Midwife (x 3)	GP (x 3) Practice Nurse	Neonatal Midwife (x 5)	Cuidiu (x 2)
	Lactation Consultant/ Specialist (x 5)	Traveller liaison PHN (x 2) Midwife Teen Parents Programme PHN (x 3)	Dietician – Paediatric neonatal (x 2) Dietician (x 2)	Community Mother (x 2)

### **6.3 Data analysis**

Individual and focus group interviews were completed and transcribed. The transcripts were analysed qualitatively as per National Institute for Health Research Guidelines (2007). The results have been analysed and collated into key factors which provide a greater understanding to the barriers and supports to lower-socioeconomic groups' participation in breastfeeding. A Thematic analysis approach was used which included the review, anonymising, coding, categorizing and themeing of transcripts. Further analysis supported the refinement of these themes as demonstrated in the written report with excerpts. Subsequent comparative analysis facilitated the collation of both service user and service provider transcripts using adequate systematic use of the original data. A broad perspective of these interviews is supported by the use of triangulation – the incorporation of both service user and service provider accounts. Validation is supported through peer

review of collated theory and methodology which support of the overall analysis and findings.

The views are those of individuals gathered in a qualitative study which gives valuable insight into parents and providers everyday working knowledge, experience and attitude to breastfeeding. These individual qualitative accounts represent individual perspectives.

## **6.4 Results of qualitative studies**

'It's not just one issue, it's lots of issues and it's the way society has changed, the way our health system has changed and I don't know, it's a complex issue.' (B36)

The results of the qualitative studies are presented by the themes identified, with information from both the mothers and the service providers synthesized under each theme.

### **6.4.1 Information sources**

#### ***6.4.1.1 Information sources: parents***

Interviewees are influenced by breastfeeding observations and communications with family, friends and professionals. Many learnt how to 'successfully' breastfeed from previous experiences.

'I was very ignorant the first time round. Even though I was persistent and I kept it up I realise how stupid I was with things. Very stupid, but I didn't get any help.' (0502.7)

Most of our interviewees come from families who bottle-feed- breastfeeding is never discussed. These women, for the most part, have only seen and known bottle-feeding. The lack of breastfeeding experience within families has resulted in a loss of the techniques and support to breastfeed.

'I'd never seen anyone actually, personally, family wise breastfeed so it was automatically baby, bottle, formula' (3.2)

Interviewees identified familial influence, in particular the influence of their own mother and her contribution and support to breastfeeding (1.2; 3.4; 0502.3). Aunts, sisters and sister-in-laws were sometimes mentioned for having views and experiences on the subject of breastfeeding. There are cases where the women who breastfed did so because of the supportive influence of their family (3.4). In contrast a mum who bottle-fed her children stated that her children would be appalled at the idea of breastfeeding 'I think the fact that it's your boob and they'd be latched onto it, they'd just be disgusted. If you even mention it like. It must be just coming from me and their aunties.' (1.3) Husbands and partners were seldom addressed except in the context of bottle-feeding at night and developing a bond with baby.

The majority of interviewees' friends bottle-feed and the exceptions to bottle-feeding were noted amongst the women (PFL1.4; PFLFG2.3; 1102.5; 0502.7; 0502.5). Whether or not their friends breastfed, the women interviewed did say they would support rather than discourage other women who choose to breastfeed.

Beyond family and friends, the hospital is perceived to be the core provider of information, particularly at the 'visits.' The interviewees had little experience of hospital staff discussing breastfeeding information during the pregnancy. Most of the women, in their opinion, didn't receive any breastfeeding information except when at the hospital visits when asked if they chose to breast or bottle-feed. (1.1; 1102.5). Many women reported that they did not attend antenatal classes but do attend antenatal check-ups.

'Nobody's there telling you. I don't think there's any, anybody telling you, probably in antenatal class but I never went to them so. Maybe they do tell you in them.' (0502.1)

Women who do attend antenatal visits / classes request more information and demonstrations including opportunities to discuss breastfeeding with professionals during their visits (1102.3; 0502.7). Professionals are asked to be more supportive to encourage breastfeeding without pressurising women to breastfeed (3.2; 3.0).

'For an easy life at the antenatal classes, I just said em yeah I'll think about it, I'll think about it. To be honest with you, yeah.' (3.0)

Women's experiences have indicated that professionals are more likely to communicate to mothers about breastfeeding immediately after the birth. The women did not find this practice satisfactory: they would prefer to receive more support during the pregnancy (4.8; PFL1.1). Interviewees made numerous suggestions regarding the required support and content of breastfeeding information e.g. shown a video; talk to an experienced breast-feeder and more time with a dedicated breastfeeding nurse; provision of a good resource pack during the pregnancy.

'You just did first aid course and you're doing CPR and they bring in dummies and show you exactly what they're doing and how to hold the mouth as they're breathing and everything. Why couldn't they do something like that with breastfeeding? That would be so much easier.' (1.2)

During the interviews there is evidence to suggest that the use of the term 'antenatal' may lead to misunderstandings, as the interviewees expressed different understandings of the term.

With regard to sources of information which the women were aware of, little or no information was retained through leaflets (although leaflets were noted as provided) or books, however there are some exceptions.

'Yeah but anyone could read a leaflet and not understand it. You want to be shown, you want to be taught, you want to be prepared for it. You don't want, here you go, go in there for five minutes and read it over.' (1.1)



Baby books of a general (non-specific to breastfeeding) nature were read. Media campaigns, breastfeeding awareness week, hospital videos and posters were also mentioned. Most of the women did not spend time finding out information about breastfeeding. Those women who did source information had decided during their pregnancy to breastfeed and actively sought to be informed (1102.5).

'La Leche League, I found their book. And I, that's how I basically got em, a lot more knowledge. You know.' (0502.7)

Advertising artificial food campaigns are mentioned. Although such campaigns mention breastfeeding, the women are aware that they are created to encourage consumption of formula / bottle-feeding. The women recommend more advertising, endorsement and promotion of breastfeeding (1102.5; 1.1)

Word of mouth and demonstrations appear to be the most effective means of communication amongst this group, reading materials were seldom consulted. The leaflets provided were not effective in supporting women to breastfeed. Some of the interviewees were involved in a 'Community Mothers' programme; community early intervention programme and Traveller Primary Health Care Project which provided access to sources of information and discussion groups. In the main, Traveller women addressed the same issues in terms of breastfeeding promotional support as the other women interviewed. However some suggestions specific to Traveller Groups were made including literacy levels; communication through word-of-mouth; and the Traveller Primary Health Care Projects (4.6):

'Literacy is a huge problem. If you look at all the materials that you get in hospital today, it's all reading materials. And the lack of literacy between the Traveller community is poor.' (4.8)

Despite the information that is available to women, the breastfeeding levels amongst this group are low (3.0).

'It's very different, from the, you know, from the reality of things. Even though we were told in the class, it was a mystery.' (0502.7)

#### 6.4.1.2 Information sources: service providers

Providers addressed one or two of the many information sources listed (see appendix). The internet, conference and course attendance are used as means to update provider knowledge on new and best practice. The 20 hour breastfeeding course is mentioned regularly but sometimes noted under different title variations. Much information is sought from midwives or lactation consultant and parents are referred on accordingly (B25):

'Inaccurate information is unacceptable – with the likes of the HSE website.'  
(B04)

The need for consistent reliable information is the greatest challenge to service providers. Providers are aware of the requirement to keep informed, attend training and communicate consistent information within and across professional groups. There is incorrect information being delivered and professionals need to be supported in emphasizing the importance of breastfeeding (B8, 19, 24, 28, 32, 34).

'I think own experience is wonderful, I think it can be better than any training.'  
(B41)

Personal or familial experience is often drawn on in the provision of professional breastfeeding support (B21, 32, 41). The issue of drawing on personal or familial breastfeeding experiences despite the available evidence is criticised (B17, 21, 32, 33, 35). Some providers are not informed of standardised information delivery and have little external input into their professional practice or training but still provide a 'breastfeeding' service to mothers which is not supportive of breastfeeding (B19, 38).

'Have to throw all the recommendations out the window...give the baby a bottle'  
(B36).

Providers, working closely within a team, have greater access to breastfeeding information and are more actively pursuing a consistent message e.g. neo-natal staff, special interest groups, Dieticians, Lactation Consultants. These providers draw on their networks and their associated Professional Bodies for information and

some of these providers are also involved in training. Within the community, structured information provision, training and support networks are less apparent. Community providers would argue that it is up to them to keep informed informally. Interested community providers mainly access special interest groups for information e.g. La Leche League and some HSE and DoHC health promotional literature.

'PHNs and post-natal whatever, GPs, Practice nurses and it (advice to mothers) is not standardized information.' (B08)

Midwives obtain most of their information from experience working with mothers, the 20 hour Breastfeeding Course, and Hospital Lactation Consultants. Lactation Consultants are perceived to be a central point of contact for health professionals in the provision of research, training, problem case management and referrals (B2, 28). Lactation Consultants are also most likely to refer to guidelines for information. There is also some contention over the content and consistent adherence of guidelines and whether or not these guidelines are supported in practice (B19, 24, 30, 36, 38). Practices of contention include e.g. when to initiate feeding; when to introduce express pump; screening Travellers with the Beutler Test; and which guidelines to follow.

The 'Baby Friendly Initiative' is referenced as a medium for breastfeeding information dissemination and is perceived to have a positive impact on breastfeeding practice and as a leverage to gain political support for breastfeeding. The Baby Friendly Initiative is getting greater recognition through standardisation and dedicated resources including Lactation Consultants (B1, 3, 12). Maintaining the standards is difficult but the benefits include the opportunities to get management actively involved and committed in maintaining best hospital practice (B4, 10, 12, 17).

'We're overloading them with all this information. And half the time it's left on the bedside locker (B36).

Providers who are informed are challenged for 'not taking the bull by the horns...that information is not being given because the professionals are too scared to give it.' (B19). In addition providers are aware that some information they receive is not correct but will not refute information (e.g. increased IQ or lose weight) that is going to encourage a mother to breastfeed, but would encourage mothers to inform themselves (B07/11). 'I don't advocate it, but I don't knock it either (top-up for the last feed at night) (B41). 'You don't want to be contradicting what they've been told inside.'

The variety of information sources (see Appendix G) accessed by providers are not enabling providers to communicate standardised best practice. The lack of coordinated dissemination of different guidelines, policies and training on the one hand and provider attitude and experience on the other is a challenge to best practice. Inconsistent information and lack of adherence to best practice is an issue of frustration amongst providers and parents (B19, 21, 24, 28, 35), but the issue is seen to be improving (B36).

### **Information sources**

- **Providers need to be supported to access information of high quality and to disseminate this information to targeted lower socio-economic groups.**

**Source:** 1 & 2. Ten Steps to Successful Breastfeeding. *Protecting, promoting and supporting breastfeeding. The special role of maternity services.* WHO (1989)

## **6.4.2 Knowledge of breastfeeding**

### 6.4.2.1 Knowledge of breastfeeding: parents

Regardless of feeding decision there is plenty of evidence that the women interviewed are aware of and confident in their knowledge of the benefits to breastfeeding, including giving the baby the best start in life, and its natural immunity properties in comparison to artificial milk. The main perceived benefits

included immunity, bonding, weight-loss, reduced-cost and general well-being of the mother and baby.

'It's brilliant to breastfeed, I feel it is, because, the baby won't get sick, as much as with the bottle. You don't have to sterilise. The milk is always the proper temperature. Every, it's just perfect for the baby, you know. Em, it's getting all the vitamins, all of everything that it needs, from the boob, you know.' (1102.1)

The women are aware that many Irish women bottle-feed and are therefore careful in their remarks, and were sensitive to the feeding choices made by mothers. Debate did arise over the proposed superior benefits of breast milk to artificial foods. Bonding between breast-feeding mothers and their baby was discussed and challenged over the 'fairness' to say bonding is strengthened with breastfeeding. The conveniences of breastfeeding was mentioned in terms of milk availability; the freedom from preparing and cleaning bottles and ease of night-feeds due to instant access to food. Debate did arise over whether or not breastfeeding was convenient for the mother. The breastfeeding mother is the only one who can feed the baby and this impacts on her personal time. Some women also mentioned the flexibility of both breastfeeding and the addition of expressed milk or formula bottles. Although demanding, many interviewees stated that it is worth it. Interviewees would agree that breastfeeding is less expensive but cost was not a factor in their decision. The topic of free formula was raised by a few interviewees.

Many women stated that they didn't know how to breastfeed. Women are surprised to find they can have difficulty breastfeeding, but even more surprised at how little knowledge and practical support is available to help them to rectify the situation. Women questioned the level of breastfeeding knowledge held by professionals, and a number described that they had received incorrect information.

Younger mothers did not feel supported to breastfeed in their communities and would welcome targeted support where they could talk with other women their age (0502.6). Some of the younger interviewees felt the choice to breastfeed was taken

away from them and were not asked whether or not they choose to breastfeed, but instead were handed a bottle (3.3).

'Even the doctors said to me oh I'm surprised a girl your age breastfeeding, you don't really see it. So you don't have anyone.' (PFL1.4)

Some of the other younger women thought that bottle-feeding was more convenient for them as they are living at home; they are not given any information on breastfeeding; they are too embarrassed to breastfeed and they do not ask any questions about breast-feeding (0502.1). Older women also stated how their views on breastfeeding have changed since their younger days (4.6).

'I think I was older, you know, thinkin it'd be better... You think more of the baby like when you're older, yeah' (1102.4)

Some women felt that is more difficult to breastfeed when there are more children demanding your time and attention. Women also felt that health professionals assumed that because they bottle-fed their first child, they would do the same on their subsequent children (1102.1).

Women gave many examples of supports they would like to see available such as early education for young people; support groups and workshops; breastfeeding workshops; engaging with Traveller Primary Health Care Projects; websites at multiple locations including the school and GP (4.6, 0502.5).

'Maybe educate the younger girls before they, take the taboo off it, cos like I said, my two, (are) appalled...start getting them used to it (PFL1.3)

Many of the mothers weren't aware of breastfeeding facilities and others noted an improvement, some women were shocked at the lack of breastfeeding facilities in hospitals and health clinics (3.3; 3.4). Some shopping centres and children's retail centres were noted as having good breastfeeding facilities but others argued that these are nothing more than big toilets. Breastfeeding facilities are important to interviewees to support them to breastfeed privately and avoiding spending money in order to sit down in e.g. a restaurant to feed their baby. Some women however

wanted to see more women breastfeed in public and questioned why breastfeeding facilities are needed. Positive experiences and recommendations are made of experiences in other countries including England and Germany. Women appreciate when facilities are equipped with comfortable chairs and access to drinks in a quiet, private location.

'Germany they have a little room that you go into and you breastfeed your baby. ...it's like a lamp and you sit there and they have all, like the chair, and you put your feet up and they have the tea and all beside you so it's real comfortable.' (PFLFG2.1)

#### 6.4.2.2 Knowledge of breastfeeding: service providers

The main barrier to breastfeeding is perceived to be the lack of training and time available to staff to support breastfeeding at one level and the need for a culture that supports breastfeeding in Ireland (B24).

'All health care professionals should have basic training so that they can give the right advice.' (B04)

Providers recognise the need for sufficient training in the provision of breastfeeding support (B34, 38, 40). Education and training is needed to reduce the variation and to support people to work to a standard protocol of breastfeeding care and prevent orientation from policy (B4, 20, 34). The introduction of a specific breastfeeding course is recognised as beneficial in terms of supporting consistency and appropriate referrals through education. This training is then passed onto parents which reduces confusion around breastfeeding.

'It's an 18-hour breastfeeding work that we all do and at least the knowledge now is on par for everyone.' (B17)

The HSE 18 hour breastfeeding course is often cited. This course is now being run in Dublin jointly between the hospital and the community inclusive of PHNs, practice nurses, midwives and doctors. A one-day update of the 18 hour course (run by Lactation Consultants) is to be attended by PHNs every 2 years (B3, 6, 7).

This course can also be completed by midwives as part of their midwifery training (B26). Neo-natal midwives are up to date in their training and are qualified lactation consultants (B21). International Certified Board Consultant exams are also run which require recertification every 5 years. Breastfeeding training/information days are also run by Cuidiu and La Leche League. Nationally standardized training must be mandatory for all midwives, in the first instance and then to be extended to all (B04). Trained staff must keep up to date and complete refresher courses and be recertified (B06, 17). Trainers need to acknowledge the various professional skill-sets and knowledge base as some providers have no specialist support or medical/nursing training to draw on e.g. the new PHN training which excludes midwifery training (B11, 36, 40, 32). Training needs to be accessible and inclusive of community providers (B18).

'They've (mothers) got to get it (information) really from true professionals...if you cannot support breastfeeding you should never try to promote it.' (B38)

Staff need to be facilitated to attend mandatory study days as current challenges include releasing staff due to shortages of numbers, skill mix, turnover and the numbers being allocated on the course (B36,20,22).

'We may have a shortage, but they've got to prioritise what's important for the health long-term of the babies and the mothers...ensure they have these 18 hour courses, that they're refreshed sufficiently.' (B02)

### **Knowledge of breastfeeding**

- **Trained, skilled breastfeeding providers support parents to make an informed choice about the benefits and management of breastfeeding.**

**Source:** 2 & 3 Ten Steps to Successful Breastfeeding *Protecting, promoting and supporting breastfeeding. The special role of maternity services.* WHO (1989)



### **6.4.3 Feeding decision and experience**

#### 6.4.3.1 Feeding decision and experience: parents

'Breastfeeding never entered me head now to be honest. I just went out and I bought bottles and formula.' (0502.3)

The majority of women interviewed come from a family or social group where bottle-feeding is the norm and did not consider their feeding choice. (0502.1; 0502.2). Some women who chose to bottle-feed, could not give reasons for their decision and would not be persuaded to breastfeed (3.0). Many women however, could give numerous reasons that influenced their choice to bottle-feed. The fact that it is the norm within their family and social groups is also a factor as is the perceived convenience of bottle-feeding and the demands placed on the mother in terms of breastfeeding. For many women too, the embarrassment of breastfeeding in public prevents them breastfeeding (3.2).

Women who chose to breastfeed did so for numerous reasons 'I just knew. I just wanted em, what was best and what came natural.' (0502.7). The reasons often mentioned included: giving their child the best start in life (3.3); building their childs' immunity (3.4); supporting maternal-child bonding (PFLFG2.8) (4.7); convenience of breastfeeding (3.4) and maternal weight-loss (0502.7). The fact that most women knew of the benefits to breastfeeding did not result in them breastfeeding. In many cases this did not influence them to attempt to breastfeed. Women still chose to bottle-feed (3.1; 4.11).

'I think that there is good information there but it's up to yourself whether you want to breastfeed or not.' (4.11)

Women who intend to breastfeed often change their decision due to their ill health such as a difficult birth, or an ill child, such as one born prematurely. Some members of the Travelling community were not given a choice to breastfeed due to the galactosaemia test protocol. The main reason for not breastfeeding is a lack of available support (1.2).

'Because it wasn't an option for me... I wanted to breastfeed but I didn't know how to do it.' (0502.4)

The interviewees perceived their breastfeeding experiences as attempts by trial and error without professional support. The initiations ended after the first attempt in some cases and after 2 or 3 days for many. Many attempts failed due to lack of knowledge and support of how to breastfeed resulting in soreness. Many women didn't receive or ask for help or information. Some women described their initial attempt at breastfeeding, and how they were too tired immediately after the birth to continue.

'So the nurse just said listen we'll try him with a bottle and then when you're better later we can try him on the breast again. Maybe if they could have held him for me and put him on the boob, just until I was able to do it myself, I would have been very appreciative of that, you know.' (1102.1)

Many of the mothers who continued to breastfeed, did so as a result of actively seeking information and support, and a number came from non-Irish backgrounds (3.1). On completion of interview/focus group, some women expressed a future interest in breastfeeding as they now feel they know more about it. Some women did mention that they are disappointed they did not breastfeed or try to breastfeed. Some women expressed the fact that they feel guilty for not having breastfed their child.

'Like you hear more stuff now about it being healthier and stuff like for the kids and stuff so, I probably would now, yeah.' (1102.5)

Some women tried to breastfeed their child who was born prematurely as they were told it was the best for the child. The women shared their knowledge of the importance of breastfeeding premature babies (4.1; 0502.2). One woman explained her experience of needing but not receiving support when she tried to provide expressed milk for her incubated child:

'I went up and I said look nothing's happening there's no milk coming out they said well we'll just bottle feed and that was it, there was no more said about it. When I went down (special baby unit) they were actually feeding her through a tube with a bottle. I basically had no choice. Once I tried there was no milk. I got no support from anyone to help me' (3.3)

#### 6.4.3.2 Feeding decision and experience: service providers

One provider is shocked at the number of women that she meets at antenatal classes who have never seen a baby being breastfed (B19). Many providers see a bottle-feeding culture as their greatest challenge (B19). Despite policy or Baby Friendly status the availability of bottles on the hospital ward, is perceived to undermine breastfeeding and support a bottle-feeding culture (B29, 30). Bottle feeding 'supplementation' or 'top-ups' are perceived as the norm rather than the exception (B18, B20, B19).

'You can't be being baby friendly on one hand and giving "just in case" bottles on the other hand.' (B19).

In other parts of the world, such as Australia, formula is not offered on the ward and they have to support a mixture of cultures 'so if it can be done there, you'd wonder where are we going wrong?' (B15). Some providers argue that supplementation is only recommended on maternal request or of medical necessity (B19,36). Staff on the neonatal ward encourage mothers to express in preference to not breastfeeding (B29). The formula top-up is held by some to be a result of mis-management and lack of professional and parent information on the benefits of breastfeeding (B14, 19, 21, 22, 29). The issue of supplementation is thought to be a more wide-spread issue in the community (B19, 32).

The policy and practice of receiving free formula through Social Welfare and Direct Provisions is addressed. This practice is perceived to have a negative impact on breastfeeding amongst the lower-socioeconomic group, particularly among asylum seekers (B6, 19, 28, 36). Mothers are perceived to choose to formula feed in

hospital in order to avail of free formula at hospital discharge (B28). Few providers raised the issue of free formula, and providers stated that their lower socioeconomic group with medical cards do not have access to it (B16, 41). One provider argued that if free formula is offered it will be taken (B28). In the UK if you are on low income vouchers can be obtained towards formula or an equivalent amount of vouchers for healthy eating if you are breastfeeding (B28).

'Why would it encourage young mothers or teenage mothers all these people who are the catchment group to want to breastfeed? Because they get everything free, anyway.' (B36)

Some focus was given to the challenges set to promote breastfeeding in competition with formula milk companies and their promotional work. Promotions in e.g. nursing magazines of formula milk products conflicts with breastfeeding support (B22). 'Often things are batted about that formula milk is as good you know...that is actually not true' (B03). Advertising legislation in Ireland needs to be enforced (B28).

Providers are supportive of delivering more breastfeeding promotion to develop a breastfeeding culture (B25, 31). Providers primary focus is on education across the life-cycle and a positive assumed breastfeeding approach is recommended – 'best for baby, positive for mother and amazing experience' (B2, 10, 11, 36). To develop a positive attitude to breastfeeding requires creating awareness and issuing a slow feed of information on what to expect when breastfeeding -the benefits, physicality and normality of breastfeeding (B19, 26, 27, 31, 35). Preparation for the unexpected is also key -to know what to do if problems arise (B24). Family members and partners are encouraged to be involved so that they too will understand and support breastfeeding (B35). Providers are to give breastfeeding solutions rather than the bottle (B19).

'Initially asking them (women) what advice they will need rather than giving them loads of advice – it can be overwhelming.' (B08)

During this ante-natal period providers and mothers need to create a personal link addressing the mothers needs and respecting them (B18, 19). Providers need to sit down and explain the written information while avoiding overloading them (B2, 8, 26). This is best achieved antenatally, at clinics or breastfeeding skills workshops. Opportunities to talk and have questions answered by this mother is encouraged (B19, 22). Targeted young people and Traveller antenatal workshops are recommended to promote attendance and to tailor education according to their specific needs (B4, 38). Antenatal attendance is encouraged in order that mothers are able to draw on this information during the postnatal period (B38). The importance of early skin to skin contact is encouraged in supporting early initiation of breastfeeding (B12, 20). The issue of privacy in the hospital setting is particularly acute in the lower socioeconomic group and due consideration should be given to this.

### **Feeding decision and experience**

- **Providers knowledgeable and supportive of mothers while acting as agents in the development of a national breastfeeding culture.**

**Source:** 3, 6, 9, 10. Ten Steps to Successful Breastfeeding *Protecting, promoting and supporting breastfeeding. The special role of maternity services.* WHO (1989)

### **6.4.4 Hospital experience**

#### 6.4.4.1 Hospital experience: parents

There is a strong influence of the hospital staff on breastfeeding, in particular the midwifery and nursing staff. They are seen to be the primary information providers and support network for breastfeeding. Women expressed the opinion that the hospital staff in general are supportive, particularly the midwives. These women however did perceive that they were under pressure to breastfeed from some hospital staff (1.1). Women feel pressured to breastfeed to get the breastfeeding rates up, as many women understood that Irish rates were very low. There is a

perception amongst mothers that breastfeeding is a high priority within the maternity hospitals. This perception conflicts with the perceived lack of support to breastfeed within the practice setting or 'ward' observed to be due to staff shortages and crowded hospitals. Many examples were given of differences in breastfeeding attitudes and support practices across hospitals. 'Prioritisation' of breastfeeding is perceived to be stronger in some hospitals over others.

'I was in X and they push it more in X... like if I said I want a bottle they'd say would you not just try it first, you know. So then you end up trying it.'  
(PFLFG2.2)

Some women chose not to breastfeed in defiance of efforts by individual staff members to make them breastfeed (1.3).

'Yeah they were very pushy. They were pushing it on you and then they weren't round to help you do it, well, in my personal experience.'  
(PFL1.1)

Most interviewees perceived their breastfeeding support experiences to be ad-hoc in delivery and dependent on individuals. Some of the interviewees perceived the nurses and midwives to be 'pushy' or 'forcing' breastfeeding upon them against their will. Others felt that more could be done to support mothers to choose to breastfeed. Interviewees noted the requests from hospital staff to 'try' to breastfeed, but support in terms of practical information was lacking. Some women felt let down by the fact that they were pressured into attempting to breastfeed, but didn't receive the support to establish breastfeeding. Many interviewees wanted a few minutes of staff time to consult with them about how to breastfeed. Women noted the fact that if they had bottle-fed other children, staff assumed they would do so again, but this is not always the case. Other women expressed the view that because they chose to bottle-feed, staff were less supportive than had they chosen to breastfeed.

'It wasn't an option, the minute I had the baby they'd say like the baby's hungry what milk will we give it and they'd recommend the milk and that was that.'  
(0502.4)

Those who asked for support had mixed experiences of the quality of the support received. Some women found the support they received was unhelpful or contradictory while others were positive (6.5).

'First of all in the hospital today there is a lot of contradictive information, you ask one person and you get the complete opposite answer to a question than from the person before.' (0502.5)

'Nurses were great in the hospital, they'd actually sit with you and just help you along, you know, they'd take their time with you and it wasn't just rushing to get onto the next patient.' (6.5)

Interviewees shared their experience on the hospital ward, watching other women feeding their babies and being influenced by what they saw. Interviewees mentioned their discomfort and embarrassment at breastfeeding on the ward, the apparent ease of access to bottles and witnessing women's crying at the pain of breastfeeding (6.1). Traveller women also noted their feelings of isolation being on a settled ward.

'Where in the hospital, where there is discrimination in the hospitals for Travellers and Traveller women do feel isolated being in a cubicle with nothing but settled women.' (4.6)

The embarrassment of breastfeeding in public wards was expressed. Interviewees mentioned the lack of privacy and the presence of male visitors. Interviewees recommended supports such as a designated support person or particular ward for breastfeeding, which would support mothers to ask questions and receive information. Other suggestions included having their own room, curtains to pull around them and or support in the home.

'I think they should have somebody just for the people that are breastfeeding... That goes round and helps the women.' (PFLFG2.1)

Some interviewees noted that bottles were readily handed out in the interest of saving time and convenience. Women stated that providing bottles is easier on the

staff as women know what to do with them, unlike breastfeeding where more time and support is necessary.

'They don't, they just say, bottle or breast and they just give you a bottle.'  
(PFLFG2.3)

#### 6.4.4.2 Hospital experience: service providers

'We do see the odd few who are willing to breastfeed and don't because of lack of support basically.' (B11)

Providers acknowledge that the antenatal period is the key time to inform mothers about breastfeeding as mothers are overwhelmed after the birth. Providers acknowledge that every mother's case is different (B17, 20). Providers support hospital policy in relation to birthing practices such as 'rooming in'; 'skin-to-skin' contact with mum or dad and early breastfeeding initiation (B18, B20, B33, 35).

Although the wards are busy, providers are recommended one to one support at each feed to establish good technique ((B6, 11, 20, 22, 25, 27, 35, 38).

Information from providers is to be consistent and in line with breastfeeding best practice (B17). Convenient access to video links on breastfeeding support demonstrations is recommended (B33). Constant encouragement is recommended (B1, 38). Information on supplementation, such as with Vitamin D, should be given (B31). Mothers need to be knowledgeable about feeding adequately and knowing what to expect in terms of wet and dirty nappies and not to focus exclusively on weight gain (B24).

Encourage mothers to address physiological problems early and to get support quickly. Formula supplementing is to be avoided until breastfeeding is established, and only then should expressing breastmilk be considered by mothers (B12). Neo-natal unit providers are to encourage breastfeeding, and if the mother is expressing breastmilk, providers should provide support, explanations, and ensure the mother is comfortable with and aware of to the facilities (B21).



## Hospital experience

- **Parents supported to manage breastfeeding in an environment conducive to breastfeeding.**

**Source:** Steps 1, 3, 5, 6, 7, 9. Ten Steps to Successful Breastfeeding *Protecting, promoting and supporting breastfeeding. The special role of maternity services.* WHO (1989)

### 6.4.5 Pressure on professionals

#### 6.4.5.1 Pressure on professionals: parents

Interviewees noted the pressures on staff which may impede their ability to give quality breastfeeding support. Introducing bottles is seen by many of the women as a solution to these pressures. Time pressures of busy staff and the short hospital stay is seen to result in less time to offer breastfeeding support to mothers. Women also felt that they couldn't ask questions because of these conditions (4.5).

'They're very busy. You know, they came in to check that he was latching on properly but that was it then. Once they were gone, they were gone.'  
(PFLFG2.5)

Observations of pressures on professional service providers included hospital overcrowding, rapid discharge policies, the diversity of mothers including multiple nationalities, language barriers, and the ease of providing bottles (0502.5).

'They are run off their feet like you know there is so much population there now. There are a lot more nationalities as well besides Travellers and I suppose, there is a language difference there as well. And, you know what I mean, so they haven't got the time.' (4.7)

#### 6.4.5.2 Pressure on professionals: service providers

Although the number of births has risen, staffing levels have remained the same (B18). Providers recognise that supporting breastfeeding is resource-intensive and argue that they do not have the time to show mothers practical breastfeeding steps (B6, 20, 34, 35). Providers, in particular midwives and PHNs, aspire to support women who wish to breastfeed (B29, 34, 36).

'There's not much time allotted for that (breastfeeding) in my post. I'm just one full time post to cover the entire hospital including kind of the paediatrics.' (B31)

Maintaining staff knowledge relating to breastfeeding is challenging. The cultural diversity amongst staff members presents difficulties in ensuring awareness and practice of recommendations (B36). Course attendance is negatively impacted by lack of staff resources and high staff turn-over. Providers argue that breastfeeding courses are attended by 'only the truly committed' (B2, 22). Not all providers of breastfeeding support have received standardised training. Community resource constraints are evident in the rationing of home visits (B6, 10). PHNs describe how during their annual, maternity or parental leave, no extra help is provided for their colleagues. It is 'literally a skeletal service' and 'we do everything as you know from the birth to the grave.' (B41).

Providers request the support of round the clock Lactation Consultant cover particularly on high-risk or neo-natal units as the patient turnover is quick and the work is intense (B26, 27, 33).

### **6.4.6 Community experience and continuity of care**

#### 6.4.6.1 Community experience and continuity of care: parents

Women reported leaving the hospital and the continued support they received when at home (6.4).

'The midwife who visited us for the first week, every day, she was also really supportive.' (0502.5)

Breastfeeding initiation and continuity is buffered by a supportive individual professional and in many instances coupled with a personal initiative to seek breastfeeding information. According to many of the interviewees these support structures and systems should be clearly identified, in contrast to the current ad hoc, patchy provision that exists within and between hospitals and between the hospitals and the community.

Many interviewees experienced little or no support in the home. Women were asked whether or not they were breast or bottle-feeding which was the only mention of breastfeeding. Women taught themselves to breastfeed and some were left without support e.g. up to 3 days on return from hospital, by which time they'd stopped trying to breastfeed and didn't know where to obtain information or support. The clinics were mentioned as being supportive in general but not specifically about breastfeeding.

'Just the usual (visit) once when I came home and that but they weren't, em, I had to learn about breastfeeding myself.' (0502.7)

'She (PHN) made that clear to us as well, d'ye know, ring any time, be day or night, be it the middle of the night, if I'm worried, if it happens again or anything. So it was lovely, great support.' (6.5)

Positive aspects of the support women received included the HSE, Public Health Nurses and the clinics, the HSE Community Mothers Scheme and the Traveller Primary Health Care Projects (4.3). The support was beneficial as women felt they were given more time, their questions were answered and techniques were learnt (PFLFG2.4). However most of the mothers interviewed did not attend any mother and baby/toddler groups.

'My first (clinic) experience, I just found it very em, it was all like technical like, weighing the baby and, you know, well if you feed them and then we weigh them we'll know how much.' (0502.7)

'So there was information like that, that I heard that was more clearly from the Primary Health Care Projects that the Traveller women are involved in. I got a lot of my information from that.' (4.3)

Other interviewees experience poor quality of information from the professionals consulted resulting in women being misinformed and ceasing to breastfeed.

'The nurses telling people to do, and its just, or give her a bottle in between feeds, that's the classic one...It was very misinformed or something or, just trying to solve a problem instantly without kind of getting any real information.' (0502.7)

Many women also sought support from acquaintances to reassure them on best practices (0502.1). Support from family was recognised as a necessary form of information and support to continue breastfeeding. Many women arrive home and depending on their circumstances may or may not have the support of family. Women made comparisons with other communities, families and friends on the level of support available to continue to breastfeed (PFL1.2). Experienced breastfeeding mothers were more confident with breastfeeding their subsequent children as they could draw on their previous experiences (6.3).

#### 6.4.6.2 Community experience and continuity of care: service providers

'All health professionals have a role and a responsibility to promote and educate...(breastfeeding) should be encouraged from every opportunity...consistent information, consistent encouragement...answering questions and dispelling myths...antenatal classes...including the partners.'  
(B31)

Mothers are being discharged from the hospital into the community early. This practice impacts on hospital and community providers in terms of the time available with mothers to establish breastfeeding. The importance of getting breastfeeding established in the hospital is noted by hospital and community providers alike (B10,

15). The difficulty is providing hospital support and information in this shorter length of time (B6, 11, 12, 22, 23). Mothers are being transferred home and in some cases their milk hasn't come in (B10, 30, 36, 41). This is cited as the greatest barrier to PHNs working in the community (B41).

'By the time she goes to the breastfeeding group she'll be on the bottle.'  
(B25)

Community providers recognise that breastfeeding is also challenged by the lack of continuity of care between the hospital and community. Community midwives argue that the majority of their mothers are breastfeeding when leaving the hospital and continue to do so with community and on-call support up to at least 5 days (B1, 2, 25, 26). Some community midwives offer the support of a post-natal group and hand over to the PHN in the community with a list of post-natal groups and breastfeeding supports in the area (B01, 40). Midwives are credited with being supportive in breastfeeding (B25, 40). Community midwives provide support on call 24/7 and a mother knows she can ring and someone may be able to call out and support her – 'can save her from giving a bottle...leaving it will have escalated and it may be too late.' (B01)

'We have a "never give up" approach to breastfeeding. Never give up on someone who wants to breastfeed' (B35, 25).

Mothers require breastfeeding support from the time the baby is born and in particular when difficulties arise. Providers recognise that they must identify what the particular difficulties are and whether they are internal or external factors. Time is required with the mother watching and encouraging feeds while acknowledging and solving her difficulties (23). Knowledge and support from every professional group is to be encouraged and activated (B9, 15, 22, 23, 25, 31, 35). More accessible supports are recommended and mothers encouraged to ring in and avail of them at any time (B1, 2, 22, 25). Rest, fluids and a good diet is to be encouraged (B27, 40). Hospital support is a key time to establish breastfeeding

before mothers are discharged into the community - 'If we send her home confident breastfeeding then she's much more likely to.' (B25)

'Consistent information to be given by all staff members and continuation of that support then when she goes home, by the PHN and (by) attendance of breastfeeding support groups.' (B20)

The challenge with lack of continuity of care is that community providers find it difficult to actually turn the negative information around that mothers have received (B08, 38). PHNs understand that hospital staff are busy but continue to point out that mothers need support in hospital as by the time they reach the PHN in the community - 'they come home failing, you've nearly lost them, it's hard to fight back, but we do try' (B41). The hospital staff have a perspective on this too. 'PHNs, hard and all as they try to get in as quick as they can, sometimes they miss the boat...the thing goes 'pear-shaped' (B02, 36). The apparent lack of community support including family, health visiting and breastfeeding solutions is a challenge as mothers are perceived 'on the day of discharge she is almost is like on her own.' (B40, 20, 35, 38)

'A lot of our children have grown up in a bottle feeding culture - that is all they have known so breastfeeding is alien to them and we have to try and re-educate them around that.' (B23)

The influence of the mother's social network including family and friends is seen as both an advantage and a challenge to breastfeeding. The difficulty exists when bottle-feeding is the family norm. 'Bottle-feeding was fine for them' (B 23, 27). Providers remark that the influence of the infant's grandmother is greatest and she needs to be encouraged to support breastfeeding or expressing (B3, 10, 18, 20, 21, 23). The restriction of family visits, which was previously a barrier, is seen to be advantageous (B39).

### **Community experience and continuity of care**

- **Providers knowledgeable of and co-facilitators in mothers' engagement in breastfeeding supports.**

**Source:** Steps 1,2,10 Ten Steps to Successful Breastfeeding *Protecting, promoting and supporting breastfeeding. The special role of maternity services.* WHO (1989)

### **6.4.7 Stopping breastfeeding**

#### 6.4.7.1 Stopping breastfeeding: parents

There are many reasons women stop breastfeeding. The reasons given included ill health, concerns for baby, returning to work, sleep deprivation, hungry baby, embarrassment, age of child, body consciousness, old-fashioned values and lack of support. Information and supports for women who wish to stop breastfeeding are needed (PFLFG2.4).

Women did have knowledge of breastfeeding policies at work and perceived their workplace to be supportive but argued that it isn't always practical to do (0502.5).

Due to exhaustion women stopped breastfeeding and introduced bottles. The reason to introduce bottles was to encourage the child to sleep through the night (1.4).

A hungry baby is often referred to and mothers are not sure if their baby is getting enough food. Some women introduce artificial food at first to 'top-up' the baby which led to the introduction of the bottle for each feed (3.4).

Expressing was suggested as a means to enable a mother to continue breastfeeding on return to work; the convenience of letting a partner give a night feed to enable the mother to sleep, to enable a mother go out, to give to a baby in special care and to avoid breastfeeding in public (1.4). Expressing milk is not always convenient some women found expressing demanding in terms of the time it takes to express after a feed and the cleaning up afterwards.

When to wean is debated and women have differing opinions on when to wean the baby off the breast. There were some strong objections made about women breastfeeding 'older' children. Many mothers weaned their children before this became an issue (1.1).

#### 6.4.7.2 Stopping breastfeeding: service providers

'Getting to the bottom of why she's decided to quit or to stop and ...try to pin-point those barriers and maybe again try to overcome them.' (B31)

There is a consensus amongst providers that they listen, acknowledge and explore the reasons a mother is deciding to stop breastfeeding and that she is comfortable with her decision (B18). If there are difficulties/problems, supports are addressed and breastfeeding solutions to be suggested and tried. Hospital providers, on discharge, are to encourage families to link in with community supports and to seek information about weaning (B1, 2, 20, 22, 23, 38). Providers should support a slower weaning process, so the mother may continue breastfeeding if she is given the opportunity (B18, 22). For mothers to make an informed choice they need to be able to access reliable, non-judgemental, problem-solving information (B20,31). Mothers who stop breastfeeding to return to work need to be provided with information about expressing and their legal rights in the workplace (B10,35,38). Links with Cuidiu, La Leche League, Lactation Consultant or PHN are recommended (B02).

Providers note that many women feel 'guilty' for stopping breastfeeding and this needs to be avoided (B4, 25, 33, 36). Also women are seen by providers who are 'pretending' to breastfeed due to presumed social pressure as 'it's the in-thing to do, you've to be seen to do it.' (B38).

'Go to the wrong person and get the wrong advice ... and then there are lots of regrets and recriminations.' (B04)



The 6 month breastfeeding target is a realistic achievement as stated by the majority of providers (B18). Many providers qualified this by remarking that this can be supported through the extended maternity leave. However others thought this to be too aspirational, given Ireland's current breastfeeding rates (B9, 15). A few however argued that the six month target is a fairly low target to achieve and that the WHO recommends feeding to two years and beyond (B19).

'Whether it is realistic or unrealistic, that is what the evidence is.' (B18)

The main reason for stopping breastfeeding is to return to work. Returning to work causes anxiety for mothers who need to establish the baby on formula – despite the laws supporting breastfeeding in the work place (B17, 38). Other reasons to stop are due to the perceived difficulties in establishing breastfeeding without support. Difficulties resulted in subsequent development of soreness, infection, insufficient milk supply, tiredness, disability, demands of larger family, poor delivery outcomes and embarrassment (B20, 22).

The following quote summarises the view of many:

'The longer you breastfeed the better, but I think partial is better than nothing at all. But I think exclusive I would say is a WHO recommendation and I would just recommend that.' (B03, and similar in B04, 12, 15, 18, 20)

Professionals promote exclusive breastfeeding as a model of good practice. Exclusive is best but this needs to be balanced with the best interests of the mother and the child (B27). Providers are less supportive of this recommendation than the achievement of breastfeeding for 6 months. In the initial stages exclusive breastfeeding is promoted until breastfeeding is established and the gut is mature (B9, 17, 23, 36). Partial breastfeeding is perceived to be a better outcome than stopping completely (B18, 25, 36). However providers' experiences have shown that 'when breastfeeding becomes partial, formula is introduced, it tends to be the end of breastfeeding' (B24). Expressing is an option but it is seen to be labour intensive.

'I think it's just about listening to the mothers and saying look you know, millions of babies around the world do very well on formula milk.' (B36)

Staff on the neo-natal units recommend breastmilk as the infant's sole nutrition. However, others perceive this to be idealistic, as premature babies' weight gain can be poor and may require one bottle of formula a day (B26, 36). Another group that is addressed but not so much amongst lower socio-economic groups are women who are exclusively breast milk feeding from a bottle. The cost factor of express pumps may inhibit mothers from lower socio-economic groups doing this (B28). Mothers with babies in neo-natal units may get pumps rent free, but this is currently at the discretion of the community welfare officer.

### **Stopping breastfeeding**

- **Providers show mothers how to breastfeed and maintain lactation and encourage breastfeeding on demand.**

**Source:** Steps 1, 2, 5, 6, 7, 8, 10. Ten Steps to Successful Breastfeeding *Protecting, promoting and supporting breastfeeding. The special role of maternity services.* WHO (1989)

### **6.4.8 Breastfeeding in public**

#### 6.4.8.1 Breastfeeding in public: parents

Embarrassment at the thought of breastfeeding in public, women were very expressive and vocal in their opinions that they would not breastfeed in public. Many women cited the embarrassment and mortification of doing so. For many it was the main reason they did not initiate breastfeeding, amongst young women in particular. A number of women stated that they wouldn't feel comfortable breastfeeding on the public ward or in front of their families either. Women perceived public opinion to have improved but that breastfeeding in public is still not accepted. Women are of the opinion that the public would rather women breastfeed in private as "it's disgusting", and this view was shared by some of the younger women (0502.3).

'I haven't really come across that situation ye know and I don't know if I'm just being managed to be kinda discreet, I don't know, but I haven't had any people staring or questioning.' (6.3)

It is important to emphasise that a lot more women referred to what is perceived to be negative public opinion, in comparison to the number of references to actual experiences. Most of the women, with some exceptions, are supportive of breastfeeding in public (1102.3).

'I would like to do it to be honest but I don't think I'd have the nerve. That's basically probably what's turning me off it you know. And then you get all this, you know, in public places, restaurants and stuff like that, when you hear all that.' (0502.3)

There were quite a few comments made in reference to these women's mothers old-fashioned values towards breastfeeding in public (3.2). Lack of privacy is especially noted amongst the Traveller community due to issues surrounding the home environment (4.6). A male audience prevents a lot of women breastfeeding. Although some women would breastfeed in front of anyone, most women were set against the idea. Women said that they would not breastfeed in front of their husbands due to embarrassment. Body consciousness is another reason women chose not to breastfeed. Many of the women felt very strongly about not wanting to show their breasts. Some women thought that the size of their breasts, particularly smaller breasts, would not enable them to breastfeed. Some women thought that breasts were seen to be sexual objects and not for feeding babies.

Many of the women stated that there should be more breastfeeding in public and some of them did breastfeed any and everywhere. Women also noted that they have the support of legislation in to breastfeed in public (1102.2; 4.1). Suggestions were raised by interviewees to avoid embarrassment in public including covering up using appropriate breastfeeding clothing; expressing milk into a bottle; using a blanket; using breastfeeding facilities and returning to the car or home to breastfeed privately.

## **6.4.9 Cultural differences**

### 6.4.9.1 Cultural differences: parents

Interviewees made many references to the influence of culture on breastfeeding practice. The Irish culture was mainly thought to have had an inhibiting effect on choice to and practice of breastfeeding.

'It's just our attitude; it's the way we were brought up really.' (PFLFG2.2)

All the women addressed the view that breastfeeding is not the norm in Ireland. Women addressed the fact that many Irish women do not breastfeed; many more do not feed in public; those who do breastfeed in public are isolated and the subject of breastfeeding is rarely spoken about (0502.7). Even though it used to be the norm in the past, as described by one woman Traveller (4.7), it has been displaced by a bottle-feeding culture in which it is acceptable to give bottles feeding equipment as gifts:

'I've seen two newborn grandchildren this year and they would be brought a present of this whole sterilising bottles, gadgets all like this...' (4.7)

Some references were made to class as a reason why women didn't breastfeed. Women perceive more educated women who come from breastfeeding families are more likely to breastfeed. But women said this was not necessarily the case (0502.1).

'I don't mean to like come across bad but it's not a done thing in more lower class areas, I've noticed. But I think kind of the more educated you are about it...they kind of know that it is okay to do it like.' (0502.2)

### 6.4.9.2 Culture differences: service providers

'A mother who is truly committed to breastfeeding whatever her social class background will continue.' (B22)

The culture in Ireland is not supportive of breastfeeding, and breastfeeding is taboo particularly amongst lower socioeconomic groups (B2, 13, 15, 20, 29, 32, 38). Providers argue that more women bottle-feed than breastfeed so there is no

particular type of mother that can be categorised as more or less likely to breastfeed (B8, 38, 39). Although there are exceptions, the following groups are specified by the service providers as least likely to breastfeed: mothers who are lacking support; younger women; lower levels of education including early school leavers; no breast-feeding contact; smokers; mothers living in vulnerable, overcrowded areas; mothers who have had a difficult delivery; Travellers; unmarried mothers; uptight and nervous mothers; drug-users; mothers with little or no antenatal education; and mothers with many children.

In contrast mothers are perceived to be more likely to breastfeed when: educated and supported. Other key factors taken into consideration are: straight-forward deliveries; non-Irish national mothers; middle to higher income bracket mothers; married women; mothers who previously breastfed; mothers who come from a family who breastfeed; women with a supportive mother/partner; mothers who attend antenatal education; mothers of premature babies; older women; and women who are more reflective and relaxed.

'If mothers come from a culture where everybody breastfeeds then they are more likely to automatically commence breastfeeding' (B22).

Providers touch on the fact that breastfeeding did have associations with poverty but now breastfeeding appears to be a middle-class issue (B24, 40). The middle-class distinction is perceived to cause access barriers in terms of class distinction between middle class professionals and lower socio-economic groups. Providers may also label women as likely or least likely to breastfeed which may impact on the level of support provided –'it was just assumed that they (lower socioeconomic groups) were not going to breastfeed and there's the bottles for you' (B32).

Publicly accessible local health centres are poorly attended by lower-socioeconomic groups who may come if they have problems (B10). Providers perceive that mothers from lower socio-economic groups, particularly younger mothers, fear accessing services or support groups for fear that asking for help could mean that they are not able to care for their baby (B21, 28).

Differences in attendance between public and private patients are described. Private patients make sure that they get antenatal classes; 'they try to find private antenatal classes which are quite expensive as well.' (B40) Antenatal classes are perceived to involve middle class thirty-somethings – which is an issue for a younger mum from a lower socioeconomic group.

'...the lower socio-economic groups don't tend to breastfeed even though you do try and encourage them.' (B26)

Some of the voluntary groups recognise that they are sometimes perceived to be for the middle class families only, 'which is very unfortunate, because we aren't reaching those that need it the most' (B14). More supports for mothers in the community are requested that are all inclusive and act as a forum to share correct information (B34). The Teen Parents Programme is a support programme for young mothers between the hospital and community setting and home visits are offered but not often enough to support the needs of a breastfeeding mother (B37).

The HSE Community Mothers Programme has experience working with young mums, but few breastfeed as they are "shy, embarrassed, uncomfortable, body conscious and don't think breasts are for breastfeeding" (B14, 30, 37). Practical reasons are also explained, including the fact that young mothers are often living at home and have the convenience of leaving the baby with their mother (B19).

The hospitals are pro-breastfeeding, and providers are sensitive around the fact that they are seen to be pushy and insisting on breastfeeding (B23). Younger mothers are more likely to breastfeed if someone in their social circle breastfed e.g. their mother or sister (B19). On a positive note, younger girls are perceived to be relaxed, successful breast-feeders (B39, B23, 33). One school made arrangements for a student to provide an area where she could express her milk (B37).

The neo-natal units have a culture of using expressed breast milk, more so than in the general hospital population. On the neo-natal ward the medical team are

enthusiastic that pre-term babies are supported with breast-milk. Mothers of premature babies are more likely to breastfeed as they are motivated to do it for the baby and are aware of the benefits; this makes them determined to do it (B21, 26, 27, 36). Providers are aware that research shows that higher-socioeconomic groups are more likely to breastfeed, but on the neo-natal ward it is different - 'some of them do actually quite well in that (lower socio-economic) group (B36). Some providers report however that these mothers will rarely continue to breastfeed after they leave the ward (B21, 36).

#### **6.4.10 Cultural differences with specific reference to Traveller Community**

##### 6.4.10.1 Cultural differences with specific reference to Traveller Community: parents

The women from the Traveller community raised some issues that were specific to Travellers. They describe how in the past, it was thought to be easier to breastfeed as they had no electricity or bottles, so breastfeeding was more convenient and they simply had no other choice. Also Traveller women dressed differently and wore big shawls which gave them privacy to breastfeed their baby.

'The women they even dressed different than we did in our days. They used to wear big rug around them, a shawl and they would carry the child in their arms. And when they'd be going out or walking or whatever that child would be there sucking away.' (4.1)

Traveller women today have other issues to contend with. Women have less privacy, sharing their home with many people, which they see as prohibiting them from breastfeeding. The accessibility to houses and electricity which were not available in the past makes bottle-feeding more convenient.

'If you look at it now, most of us are all living in houses, we have electricity, you can make the bottles...you have all these ready-made food and so it's all that kind of thing that I think myself is actually stopping people from breastfeeding.'(4.8)

Other issues raised specifically by Traveller women relate to the Beutler Test, specifically Traveller identification and postponement of feeding. Another concern raised was the negativity surrounding breastfeeding in public, a common theme throughout the report, but particularly amongst the Travelling community (4.3)

'We, being a Traveller, going into the hospital and being isolated, you know, and then this special food, and then this nurse all coming if you want to breastfeed but no encouragement like, no, they just walk away.' (4.6)

Some of the women stated that they would not be comfortable asking questions or seeking help in case they gave an impression that they weren't capable of looking after their baby (0502.3; 6.4).

#### 6.4.10.2 Cultural differences with specific reference to Traveller Community: service providers

Providers share a view that Traveller women like settled women share similar reasons for not breastfeeding- mainly lack of peer and professional support and breastfeeding information (B22). Members of the Travelling community are perceived to have specific cultural issues to address. One provider argues that Travellers are not a homogenous group: some Travellers would be more affluent and others less so, and this must be considered.

Travellers are perceived to be resistant to breastfeeding (B24, B29). 'Just won't do it, don't do it.' (B29, 35). Providers perceive Traveller families to be 'totally against' breastfeeding as a social taboo and insist mothers give up breastfeeding (B10, 12, 16, 19). It is important to target and educate the men: '...they respect those rules and each other...like dads would be very good hands on doing the feed and things like that' but will not interfere in breastfeeding as it would be seen as a taboo subject (B16,28). In the experience of the neo-natal midwives interviewed, it is more difficult to get women from the Traveller community to breastfeed (B26). Traveller mothers with babies in neo-natal care will express breastmilk, but 'they wouldn't dream of going home to the community and breastfeeding because that culturally is just too big a step' (B15). Yet if Traveller families have their babies



abroad the baby is breastfed until they return to Ireland because 'we don't do it here' (B30).

Other issues that prevent Travellers from breastfeeding is their lifestyle and issues of privacy, many children to mind, little time or space to sit down to breastfeed or express, distance from the hospital and also the issue of galactosaemia (Beutler Test) (B16,19, B21,26,28). Lack of privacy is a barrier to breastfeeding uptake (B28, 16). One mother chose to breastfeed her seventh child (but none previously) as her new house afforded her some privacy (B23). Another breastfed her premature baby for two months, but never in front of her partner (B27).

'Traveller in a caravan in X who is the highest risk group possible for every infection known to mankind, and yet they will not breastfeed...those kids need our services and we're not getting to them.' (B35)

There is a level of frustration amongst service providers who face resistance from the Travelling community- but want them to breastfeed in the child's best interests. Mothers from the Travelling community are very relaxed, good mothers, but culturally are perceived to not breastfeed (B33, 35). 'I have never seen a Traveller mother breastfeed, but I do think it would be the best option for their babies.' (B33).

Providers recognise the need to promote breastfeeding amongst the Traveller group particularly to reduce gastroenteritis and respiratory illnesses 'these are the babies that most need breast-milk because of their (living) conditions.' (B15, 28, 33, 35) Targeted Traveller breastfeeding promotion is being delivered but more is needed (B28, 33). Women from the Travelling community are perceived to be experts at hiding their pregnancy which makes targeted antenatal support more difficult (B16). Postnatal support is also offered to try to encourage breastfeeding but some mothers seek to suppress their milk using medication (B16).

Testing for galactosaemia is not perceived to be the main barrier to breastfeeding prevention amongst Traveller women, however there needs to be clear evidence and guidelines in relation to the Beutler test. Beutler testing is perceived to be over-targeting a lot of Traveller families in Ireland (B16, 30, 23, 25). This is interfering with the promotion of breastfeeding and usually results in the introduction of formula (B12, 15, 16). Providers seek clarification around the Beutler Test particularly on the following issues: Identifying the Traveller ethnic group; Subsequent Traveller care while awaiting test results (B12,19); Time taken to establish results (B28,35); Subsequent breastfeeding support if the results allow; Ethics, evidence and practice of targeted Beutler Testing and prolonging breastfeeding initiation (B19, B28).

'For the small number of children with galactosemia, does this outweigh the risk for to say to all the Traveller children to not breastfeed?' (B28).

Providers working with Travellers do not think breastfeeding information is acceptable to Travellers due to basic literacy skills, and cite the fact that it is not inclusive of them (B16). It is recognised that verbal communication is strong within the community (B33). Providers suggest that the best approach to promotion is through peer promotion and television or waiting room advertising, DVDs or having a role model to promote breastfeeding (B23). The inclusion of men in the advertising is recommended (B16).

'...Very good about taking the information and nodding and saying yes but they don't want to take any literature home because they don't want 'him' to see it.' (B04)

#### **6.4.11 Cultural differences with specific reference to non-Irish national families**

##### **6.4.11.1 Cultural differences with specific reference to non-Irish national families: parents**

The women interviewed perceive breastfeeding to be more acceptable in other cultures in which breastfeeding is accepted and practical supports are provided.

'In Germany it's a big thing to breastfeed but in Ireland most people just find it easier to give them the bottle. In Germany it was much better than here for feeding because everybody did it, so it didn't really matter where you were.' (PFLFG2.1)

#### 6.4.11.2 Cultural differences with specific reference to non-Irish national families: service providers

There is the perception that the increase in non-national mothers has increased hospital breastfeeding rates (B7, 22, 38). It is hoped that the influence of foreign people breastfeeding will bring about a change in breastfeeding uptake (B37, 38). Foreign nationals (Polish, Latvian, Czech, African, Brazilian, Scandinavian, Dutch, and Australian persons) are perceived to be more relaxed and uninhibited about the practice of breastfeeding (B1, 7, 10, 22, 25, 26, 27, 38). Providers share a view that immigrant populations have an 'engrained communal sense of the importance of breastfeeding' (B19, 11). Examples are given of other cultures e.g. India, where the grandmother moves into the home and does all the necessary supports, chores, freeing up the mother to focus on feeding the baby (B01, 20, 28, 40). There is a custom among some African mothers not to breastfeed for the first 3-4 days, instead introducing formula until their milk 'comes in' (B1, 29, 33, 38).

Some providers did raise concerns at the fact that non-national populations are now showing signs of introducing formula rather than breastfeeding (B9, 12, 30). The reason for this is raised awareness that Irish people don't breastfeed (B30). Providers would also argue that non-nationals are losing out on breastfeeding support and cease breastfeeding even though their cultures would support breastfeeding (B22, 38).

The broader issue of valuing childhood and investing in children is raised as influencing better rates abroad (B28). In Australia, mothers breastfeed for six months. 'It's a different ballgame; you would be seen as being neglectful if you didn't do it' (B21, 40). Irish providers are concerned that promoting breastfeeding may make mothers feel guilty (B28).

## **Culture of breastfeeding**

- **Every facility providing maternity services and care for newborn infants should implement the 10 Steps to Successful Breastfeeding.**

**Source:** Steps 1-10 Ten Steps to Successful Breastfeeding *Protecting, promoting and supporting breastfeeding. The special role of maternity services.* WHO (1989)

## **6.5 Overall results: Supporting breastfeeding amongst lower socioeconomic groups**

A synopsis of interviewee's views in relation to supporting breastfeeding are summarised below:

- Cultural acceptance of breastfeeding as natural and normal
- Implementation of Guidelines, Recommendations and Policies
- National coordination of breastfeeding information and dissemination
- Standardised Breastfeeding Training mandated
- Continuity of care across hospital and community supports

Ireland continues to maintain a strong bottle-feeding culture. Women from lower-socioeconomic groups come from backgrounds in which bottle-feeding is the norm and breastfeeding is seldom seen or discussed. It is felt that families need greater exposure to breastfeeding, to normalise breastfeeding. Irish society has lost one if not two generations of mothers who breastfed resulting in a bottle-feeding culture. Breastfeeding is much more accessible to women who come from a family or community in which breastfeeding is practiced. Breastfeeding is perceived to be the best food for baby, with many health benefits for both the child and the mother. The interviewees suggest that breastfeeding is often initiated, but without knowledge and practical support, it is not maintained.

Women from lower socio-economic groups are very private, and do not actively engage in breastfeeding. The women interviewed perceived a negative attitude towards breastfeeding from their society, and expressed their own personal embarrassment regarding breastfeeding. However women from these groups, although noted as exceptions, do successfully breastfeed on neonatal wards, on general wards, at home and in the community. Women who receive social and professional support are more likely to breastfeed, however many women from lower-socioeconomic groups fear asking or accessing supports as an indication of their inability to cope.

Parents concurred that most of the professionals are too busy to give information and those that do give conflicting advice. Breastfeeding service providers describe a critical need to build the capacity of the Irish professionals and in turn the public to support breastfeeding. The theoretical emphasis on breastfeeding needs to be supported in practice to facilitate sustainability of breastfeeding.

Regardless of where in the country these women receive their care, the experiences and perceptions of the services are similar. The promotional breastfeeding material is thought to be widely available, particularly in the hospitals and GP surgeries. However the accessibility of this material in supporting women to breastfeed is challenged by the mothers. Women do not feel that they are provided with sufficient antenatal supports to inform their breastfeeding decision. Women experienced minimal breastfeeding information during their pregnancy. Many women reported that they did not attend antenatal classes, but did attend for antenatal visits.

Community breastfeeding supports tend to be provided on an ad hoc basis. Many services are run weekly or monthly and can be difficult for lower socio-economic groups to access. Some community supports such as the Traveller Primary Health Care Project and the HSE, PHN service are accessed for information and support. Voluntary groups are perceived to be for middle-class 30-somethings and are

avoided by this group. Grandmothers and family are to be targeted and encouraged to support breastfeeding. Traveller groups are to be supported through peer support and the Traveller Primary Health Care Projects.

Providers are to avoid categorising women as likely or least likely to breastfeed. Some provider labelling and attitude is not supporting breastfeeding initiation. All women are to be supported to breastfeed. Support women to initiate breastfeeding and follow through with the 10 Steps to successful breastfeeding. Immediate professional support and privacy on the wards is recommended. Staff are to be supported to deliver breastfeeding support. Lactation consultants provide breastfeeding support to both parents and providers – full-time access to lactation consultants is welcomed. Neonatal staff support breastfeeding and are more likely to have mothers initiate and establish breastfeeding until discharge – regardless of socio-economic group. Mothers discharged under the care of community midwives are more likely to sustain breastfeeding.

More women are being encouraged to initiate breastfeeding but are not supported in their endeavours and cease to continue. Some feel pressured to initiate breastfeeding, resulting in negative experiences. Women experience inconsistent messages and are not confident in their ability to breastfeed. Many cease breastfeeding within hours of hospital discharge. Women, whether or not they breastfeed, would like to receive more support. The importance of implementing quality supports and facilities, including consistency of information and promotion of breastfeeding is requested.

In summary, the key factors to supporting mothers to breastfeed begin with targeted, influential and accessible educational messages. Service providers require access to standardised training to deliver consistent breastfeeding support to lower socioeconomic groups, and this training should be made an active priority in the workplaces. Service providers describe current working models of antenatal and postnatal supports e.g. Community Midwives breastfeeding workshops and home visits; Primary Health Care Projects and Teen Support Programmes. Providers need

to be supported to provide dedicated time to mothers to establish breastfeeding and to support continuity of care after discharge. Community groups should be supported to deliver consistent messages and improve access to lower socioeconomic groups.

'The group we need to reach are the ones who are undecided or who are saying no and try to figure out why they're saying no to breastfeeding.' (B35)

## **7 DISCUSSION AND CONCLUSIONS**

### **7.1 Summary of the report**

This document has presented an overview of the cultural perceptions of breastfeeding and the barriers to same in vulnerable groups of mothers: in particular, mothers at socio economic disadvantage and Traveller mothers. Section 1 provides an overall summary of the study findings. Section 2 provides an introduction to the issue of groups who are at greatest risk of not breastfeeding and an overview of the issue in the Irish context.

Section 3 is comprised of a literature review, with a synthesis of information relating to barriers to breastfeeding in the international as well as the national literature, and examining the data on breastfeeding rates specific to Ireland. It is clear that within the low socio economic position groups world wide, similar factors are at play with regards to limiting breastfeeding initiation and duration: an anticipation of failure, cultural issues relating to modesty and shame, the lack of breastfeeding role models and a family culture of breastfeeding, and a lack of support and education to assist with the skill of breastfeeding. From the Irish experience, social embarrassment and the practicalities associated with breastfeeding have previously been shown to be factors important to women in the lower socio economic groups when making the decision on how to feed their infant. Whilst breastfeeding was seen as "natural", bottle feeding was perceived as the norm and the usual thing to do.

A review of the breastfeeding rates in multiple secondary data sources relating to Ireland is presented in Section 4. Breastfeeding initiation rates are seen to be lower than in a comparable UK study, although those Irish mothers who do initiate breastfeeding, tend to maintain it for longer than their UK contemporaries. Factors consistently associated with increased breastfeeding initiation and duration rates in these datasets were maternal education and maternal age, with a negative association with maternal smoking. Thus, it can be seen that in an Irish context,



the mothers at risk of not breastfeeding are likely to be younger, with poorer educational status, and are more likely to be smokers.

Section 5 examines the services available to mothers, and the practices within the maternity units which aim to promote breastfeeding in Ireland. Whilst a number of HSE and independent services exist to assist in breastfeeding education and support, many are run on an ad-hoc basis, and have variable availability across the country. Many services are manned by committed mothers who have breastfed themselves, but who can only provide services on a part time basis. Many PHNs run breastfeeding groups, but again, these are not universally available, and may be vulnerable to any cut backs in services which the PHNs are able to provide. Within the maternity hospitals, adherence to the WHO's "Ten Steps to successful breastfeeding" is broadly expressed in the breastfeeding policies, and the Baby Friendly Hospital Initiative is warmly welcomed, as an internationally recognised yardstick of the pro-breastfeeding measures undertaken by our maternity services. However, the stated adherence to the principles of the International Code of marketing for breast milk substitutes is less clear.

Section 6 provides an in-depth description of the qualitative studies undertaken to acquire the necessary richness of information on the barriers to breastfeeding as perceived by mothers at socio economic disadvantage, by breastfeeding service providers who have a specific remit within these "at-risk" groups, and by breastfeeding service providers who work with all societal groups. The mothers describe that breastfeeding is not a usual step for them. They lack community and family role models. They are supportive of breastfeeding in others, but may not consider it appropriate for them, seeing it as some thing "shameful" for themselves. There is an awareness that breastfeeding is best for babies, and some mothers feel guilty for not breastfeeding. The mothers feel that the education and support for breastfeeding was not available to them.

Multiple breastfeeding service providers in multiple roles and from multiple health and other disciplines were interviewed, allowing us to access a wide range of

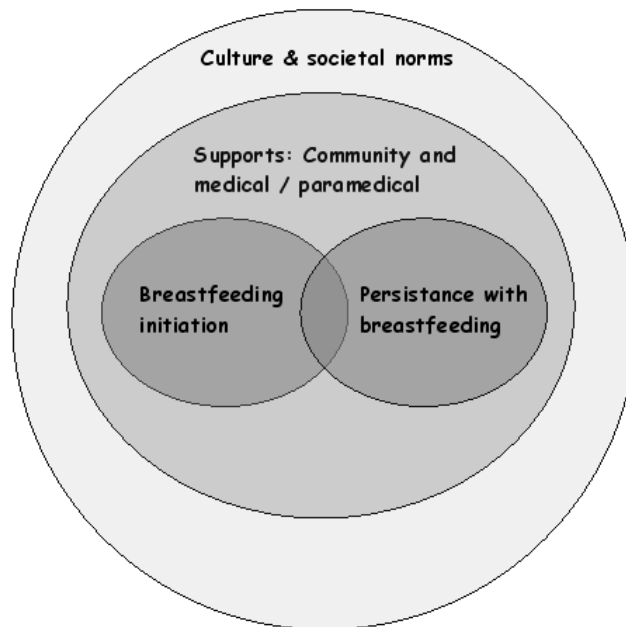
opinions and beliefs in this group. Providers displayed a range of opinions on best breastfeeding practice for mothers, with a different opinions being expressed relating to duration of breastfeeding and exclusivity of breastfeeding, even within the maternity ward staff. Service provider education on breastfeeding was not uniform, and pressures of time meant that providers felt they were unable to access educational materials and courses.

In summary, there is little doubt that despite gradual incremental improvements in breastfeeding initiation rates, breastfeeding still remains the minority way to feed infants in Ireland, and that the younger, less educated and economically disadvantaged mothers are least likely to initiate breastfeeding. Furthermore, breastfeeding duration remains very far from the ideal of “6 months exclusive breastfeeding” as espoused by the WHO. We have identified the women at most risk of not breastfeeding, and have collected data directly from both them and healthcare and breastfeeding service providers to acquire a rich insight into what factors are causing this risk.

## **7.2 Framing the Irish breastfeeding paradigm**

The factors identified which affect breastfeeding initiation and duration broadly fall under two main categories: the health service systems and providers which aim to support breastfeeding initiation and continuation, and the community and cultural norms, which affect the perceptions and actions of the women themselves. These categories are of course also interdependent: the health care providers are also influenced by the prevailing cultural attitudes and norms. In the next sections, we will summarise and discuss the findings of this report, within these categories, and ultimately make recommendations based on the evidence gathered in this report.

**Figure 7.1 Framing the paradigm of the influences on breastfeeding initiation and duration in Ireland**



### **7.3 Health service systems and providers: their role in supporting the initiation and continuation of breastfeeding in women in lower socio-economic settings**

#### **7.3.1 Breastfeeding initiation in the maternity units**

Apart from a small number of mothers who give birth at home, the vast majority of Irish women give birth in a hospital-affiliated maternity unit, and therefore initiation of breastfeeding will be considered in terms of the practices of these units. Maternity units in Ireland have been taking steps to promote breastfeeding initiation. Adherence to many of the principles of the WHO “Ten steps to successful breastfeeding” is evident in our review of the breastfeeding policies of 19 Irish units, and the activities of the Baby Friendly Hospital Initiative team are welcomed

in triangulating the adherence to these principles. These are substantial advances. However, initiation rates are poor, and when it comes to adherence to the principles of the International Code of Marketing of Breastmilk Substitutes, the majority of the hospitals' policies do not explicitly confirm adherence in this regard. From the interviews with mothers, it would appear that in at least some units, premade bottles of formula milk are readily available on the ward, and even may be purchased in the hospital at discharge. This provision of what is clearly a "second-best" for infant nutrition underlines the two-sided message that mothers perceive: "breast is best, but formula milks are alright too". This message may also be understood by mothers from the behaviour of staff in the maternity wards. From our data, such staff have expressed an opinion that "common sense" has to inform breastfeeding practice at a ward level, implying that breastfeeding advice is tailored to the mother, allowing potential for individual bias in the provision of support and education. Mothers describe that staff are very busy, and that they cannot consistently access the services that they would wish to have available on the post natal wards: emotional support, practical education, and consistent advice. The issue of formula "top ups" on the maternity wards is controversial. Both the mothers and the health service providers suggest that these could act as a barrier to continuation of breastfeeding, and that an alternative approach could sometimes be used by hospital staff.

A paradigm of successful breastfeeding initiation in the hospital setting, which the health service provider interviews highlighted, was the mother who has a newborn who requires care in the neonatal unit. Especially with regard to mothers with premature infants, the message from the health care teams in these cases is unequivocal. Breastmilk is lifesaving in such infants, particularly with respect to the avoidance of such potentially devastating infections as necrotising enterocolitis – to the extent that, should a mother not be able to produce breast milk for these sick infants, donor breast milk may be requested from the breastmilk bank. Health workers describe that these mothers almost all initiate expression of breastmilk, and may continue to either express or breastfeed breastmilk to these infants. It would appear that the difference between the rates of initiation of breastfeeding in

these mothers of ill or premature infants, and infants on the general post natal wards, relates to the unequivocal message that is given to the mothers of the infants on the neonatal units: that breastmilk is vital, and that providing breastmilk is the single best thing that such mothers can do for their infant. Furthermore, the need for breastmilk for these infants means that hospital staff will make time to provide the mother with a suitable electrical breast pump and support them in the use of this device. A multidisciplinary approach is taken, with involvement of midwives, doctors, lactation consultants and dieticians. Meanwhile the experience of the mother on the general post natal ward is that health care staff are short of time, and provide support only when asked. The unequivocal message that breast is best is not being communicated in this setting.

One specific situation in which maternity staff may discourage breastfeeding, is when a Traveller mother gives birth. Because of the greater incidence of galactosaemia in Traveller women than in the general population, standard practice now in Irish hospitals is to restrict all Traveller women from breastfeeding, until the results of the Buetler test "are declared normal". However, since this test is subject to delays in processing, and since the "normal" results are delivered by post, this effectively bars Traveller women from establishing breastfeeding, as the regular infant suckling needed to establish lactation in the early post partum days will not have occurred. From the health service provider interviews, it is interesting to note that although the health care workers recognised that the Buetler test and the practices surrounding it were detrimental to breastfeeding in Travellers, only one felt that it was having a substantial effect of Traveller breastfeeding rates. The Traveller women, on the other hand, spoke of how this practice made them feel that they were being discriminated against – that there was something "wrong" with them. They disliked having to use a different infant formula (a galactose-free formula) to other mothers, and expressed a lack of understanding as to why these practices were in place. Furthermore, Traveller women tend to dislike being in hospital, and will discharge themselves as soon as possible. Therefore, any opportunity to teach them interim ways of supporting lactation to commence breastfeeding or bottle feeding with expressed breastmilk, for whenever the Buetler

test may be reported, is minimal. From a breastfeeding promotion point of view, there is no doubt that this practice of preventing Traveller women from initiating breastfeeding is effectively eliminating the possibility of breastfeeding amongst many Traveller women and infants. The evidence is not well established that providing a baby with galactosaemia with 1 to 2 days of colostrum is detrimental to long term health and development. Meanwhile, failing to support breastfeeding in a vulnerable subpopulation, who in the longer term have an already-existing predisposition to suffer higher rates of chronic ill health and diabetes than the general population, cannot be seen as good clinical practice.

### **7.3.2 The role of the maternity units in promoting breastfeeding after discharge**

Women who access maternity services in Ireland rely absolutely on these services to look after their antenatal health, to ensure that their baby is growing safely in utero, and to ensure a safe delivery for both mother and baby. The pregnant mother who attends these services is largely highly motivated to preserve the health of her unborn baby, and will modify her own health behaviours to do so.

Maternity units are therefore ideally positioned to promote breastfeeding education and initiation, but they should also have a role in breastfeeding continuation post discharge. It was perhaps surprising that so few maternity unit breastfeeding policies mentioned continuation of breastfeeding to at least 6 months as a long term goal. All maternity units specified that they informed mothers of the community supports available on discharge. However, mothers describe a gap in care, between their discharge home, and the scheduled visits of the PHN. With most mothers who have had uncomplicated births being discharged from the maternity units within 48 hours of delivery, breastfeeding may not have been well established. It is during those first few days at home, with no family support or knowledge of breastfeeding available, that breastfeeding mothers may experience problems. The PHNs in this study described that bottles have often been introduced

by the time they get to see the mother. There is a knowledge gap here: whilst the maternity services describe providing the support information; the mothers do not access it in a timely manner.

### **7.3.3 Community services to support mothers who have initiated breastfeeding**

Community services include those provided by the HSE (PHNs, GPs), those which may be accessed privately (GPs, private lactation consultants and private maternity nurses), and those which are run by voluntary organisations (La Leche League, Cuidiu). Many community services are well established and run vital support services for breastfeeding mothers, but their availability varies by geographic area. Periods can occur when no support may be available, such as over holidays or long weekends. Furthermore, the lower socio economic mothers did not typically express information seeking behaviours, such as would lead them to services such as La Leche League and Cuidiu. Programmes such as the Community Mothers' Programme and the Traveller Liason PHN service generated good feedback, and such health care workers can be a force for change in isolated societies, by engaging with the populations and acting as a reputable and accessible source of health and breastfeeding information.

### **7.3.4 Training and education of health care workers in good breastfeeding practice**

A recurrent theme is the lack of consistency of advice that mothers receive about breastfeeding. Whilst the message that the mothers should breastfeed is being conveyed, practical advice about the specifics of breastfeeding practice can vary between caregivers, leaving the mother unsure what is truly best practice.

Feedback from the general practitioners interviewed suggested to us that such professionals were basing their information and knowledge of breastfeeding on their own personal experiences, or those of their wife in the case of male GPs. In fact, information on breastfeeding practice is now available to all GPs through the Irish College of General Practitioners website, in the form of a core curriculum for Irish

GP training, which was launched by the ICGP in May 2007. This represents a significant educational advance. Furthermore, post graduate vocational training programmes in general practice, as run by the various medical schools in the State, have expanded their programmes to allow for two years of training with dedicated teaching sessions in general practice, instead of one year as was previously the case. Breastfeeding practice is a standard part of the curriculum for GPs in training, however the depth in which trainees focus on this area is not standardized, and much of the trainees' learning is self directed. An emphasis on skills-based learning is to be welcomed, as it is particularly valuable in the case of breastfeeding knowledge. For established GPs, "Forum" magazine, published by the ICGP, has featured articles on breastfeeding at least biannually in recent years. Meanwhile, lactation counsellors are undergo the International Board Certification for Lactation Counsellors examination, and are expected to participate in continued education; while for PHNs, the 20-hour WHO and UNICEF approved breastfeeding course is now a mandatory requirement for registration (An Bord Altranais, 2005).

#### **7.4 Cultural and societal norms relating to breastfeeding in Ireland**

Within the Republic of Ireland, the mothers who are most likely to breastfeed are those who have higher educational status, those who do not smoke, those with larger families and those who are older when they have their families. Conversely, the socio economically disadvantaged mothers, the younger mothers and mothers from the Travelling community are less likely to breast feed, and these mothers were targeted in this study. Therefore, there is a gap between the social classes with respect to breastfeeding initiation and duration. Since breastfeeding is so dependent on having a positive role model and a family or friend to provide encouragement, advice and support, the longer this gap persists, the more it is likely to widen.

Breastfeeding is seen as an unusual thing to do in these groups. As already stated, the women interviewed saw breastfeeding as a "natural" way to feed an infant. There is however a subtext to this. It was felt that it should therefore be a skill which is automatic to all mothers. This is clearly a flawed concept. Breastfeeding is an acquired skill, which must be learnt through mentoring either by health workers,



or by knowledgeable family members or friends. Not only must the mechanics of putting baby to the breast be understood, to prevent immediate complications for the mother and failure to thrive in the infant, but there need to be an awareness of the potential medium- term complications in both mother and infant, so that help can be sought quickly should any complication arise. The occurrence of a breast abscess is an unpleasant and mostly avoidable complication in breastfeeding mothers. Mothers who have not sought information on achieving a good “latch” may find it difficult to persist in breastfeeding, despite their best efforts. This lack of understanding of the practicalities of breastfeeding is directly related to the fact that mothers interviewed have little if any experience of breastfeeding in their immediate friends or family. The knowledge of these skills, which would heretofore have been passed down in families, has been lost to the current generation, and therefore whilst breastfeeding appears natural, it does not appear to be normal to the mothers. Women are not unaware of the benefits of breastfeeding, and some women express feelings of guilt that they were unable to provide these benefits for their children. Nevertheless, artificial breastmilk substitutes are the default for infant feeding. Breastfeeding does not even occur to many mothers as a possibility for them.

Women in the lower socioeconomic groups are usually adept at accessing community and HSE supports: yet, in relation to breastfeeding, this is not the case. This may relate to the underlying ambivalence to breastfeeding in the prevailing culture. Whilst the tacit knowledge from health service providers is that breastfeeding is the best way to feed an infant, the experience of the women is that bottle and formula feeding is the most socially acceptable and normal behaviour. Bottlefeeding is measurable and provides reassurance as to baby’s food intake. Without appropriate support, mothers fear that their breastmilk “will not be enough for baby”, and that they will be perceived as a bad mother with an infant who does not thrive. Furthermore, they may be receiving negative feedback from family and friends regarding breastfeeding, and indeed have an expectation of failure. Mothers who do succeed in breastfeeding their infants often describe how they needed a strong will and determination to do so.

Traveller culture has also changed with respect to breastfeeding. Whereas substantially more of the older Traveller women describe having breastfed their children, only a tiny minority now achieve this. Traveller women cite a lack of privacy and being “ashamed” as factors in this change. In previous generations, the Traveller woman’s shawl was a useful aid to modesty while breastfeeding, but this has fallen out of fashion. There are also health service strategies which severely limit the ability of Traveller mothers to breastfeed, as we will discuss in the next chapter.

The effects of the Irish culture to bottlefeed artificial breastmilk substitutes to infants can also be seen on recent immigrants and asylum seekers in Ireland. The health service providers describe how recent immigrants have been seen to change to artificial breastmilk substitutes and bottlefeeding, in response to the culture of bottlefeeding that they perceive here in Ireland; the fact that, through their move to Ireland, they may have lost family support which may have facilitated breastfeeding; and the availability of artificial breastmilk substitutes through the free formula milk scheme. Factors which are specific to mothers resident in direct provision centres include the lack of culture-specific foodstuffs which the mothers would traditionally consume whilst breastfeeding, lack of availability of meals outside of prescribed mealtimes for mothers who may need extra caloric intake whilst breastfeeding, and the visibility of the free formula supplies within the centres. The direct provision centres, through the Department of Justice, Equality and Law Reform, have recognised these difficulties, and have outlined steps to counter their effects

## **7.5 Summary and recommendations**

There is no doubt that socio demographic factors continue to play a huge role in breastfeeding. There is a gap between the social classes with respect to breastfeeding initiation and duration. Since breastfeeding is so dependent on having a positive role model and a family or friend to provide encouragement, advice and support, the longer this gap persists, the more it is likely to widen. Based on the above report conclusions, we have identified a number of summary recommendations, which are listed in Table 7.1. Given the low rates of breastfeeding in Ireland, many of these recommendations would benefit all mothers intending to breastfeed their infants, not just those in the lower socio economic groups. However, some relate specifically to those populations at greatest disadvantage with regards to breastfeeding rates. It should be noted that most of these recommendations would also be effectively addressed by the implementation in full of the DOHC's Five Year Strategic Action Plan for Breastfeeding (DOHC 2005).

Within the biomedical services, a novel finding has been the equivocal feelings expressed by some healthcare providers on the importance of breastfeeding, and the variation in information relating to breastfeeding which healthcare workers provide to mothers. The paradigm of the neonatal care unit approach to breastfeeding initiation is informative: mothers who might otherwise not be expected to breastfeed are encouraged by an unequivocal attitude towards the importance of breastfeeding, and supported by multidisciplinary staff who are committed to helping her provide breastmilk to her infant.

In summary, women are not unaware of the benefits of breastfeeding. However despite all the pro-breastfeeding information that is distributed, women feel that they are not learning breastfeeding skills antenatally, and then are unable to take in the information post natally. Whilst rooming in is a breastfeeding-friendly step, new mothers can leave hospital exhausted and vulnerable. They return to a home where the family knowledge of the skills of establishing and maintaining breastfeeding, and of tackling any problems which might arise, has been lost over the last 40 years. These women are dependent on health professional and other agencies to provide timely and consistent support and advice, which heretofore

would have been available from other mothers. Therefore, the community breastfeeding networks, health professionals, and information on breastfeeding resources, are more important now than ever, and those mothers at lower socioeconomic status must be empowered to access these supports in a timely manner. By empowering mothers to breastfeed today, and by establishing the concept amongst women, currently at highest risk of not breastfeeding, that breastfeeding is truly a natural, normal way to feed one's infant, we take a positive step to promote the health of children and adults for generations to come.

**Table 7.1: Summary of recommendations based on the study of barriers to breastfeeding in lower socioeconomic groups.**

Issue identified	Recommendation	Specific recommendation
<b>1. Maternity unit and Healthcare and breastfeeding service provider policies</b>		
Promotion and support for breastfeeding in the maternity hospitals	Principles of the WHO Ten Steps to be adhered to, both in policy and in action	<p>Dissemination of standardised guidelines on breastfeeding principles and practice.</p> <p>The Breastfeeding policy for each unit to be available on the antenatal wards, and for each new staff member to receive a copy. Continue the roll-out of the Baby Friendly Hospital Initiative throughout the maternity units</p>
	Principles of the International Code of Marketing of Breastmilk substitutes to be adhered to	<p>Keep all baby formula out of sight on the hospital wards</p> <p>No formula to be sold through the maternity unit or hospital shop</p> <p>No free formula to be given to mothers on discharge.</p>
	Provision of a consistent breastfeeding message within the maternity hospitals	<p>Staff to assume that mothers will initiate breastfeeding unless otherwise stated.</p> <p>Staff to be trained in health promotion interventions regarding infant feeding, with due respect to individual mothers' choice. Individual staff policy to prioritise the promotion and facilitation of breastfeeding where a mother wishes to undertake same.</p>

	<p>Provision of adequate education on breastfeeding skills to new mothers</p>	<p>Hospital based midwives (and other relevant frontline staff) should have the expertise to provide best evidence based help to mothers to enable them to learn the skill of breastfeeding.</p> <p>Prioritise frontline staff to undergo training and refresher courses in breastfeeding practice as per WHO and UNICEF guidelines.</p> <p>Staff should enable and encourage new mothers to maintain breastfeeding with the provision of timely and appropriate support. Staff should support women using the principle of “showing, not doing”, and providing clear guidance through observation and instruction.</p> <p>Consideration should be given to appointing one midwife staff member, on every ward and at the commencement of every working shift, to take a primary role of breastfeeding support.</p>
	<p>Effectively utilise the antenatal period as the best time when expectant mothers can access and absorb information about breastfeeding.</p>	<p>Antenatal education classes to provide clear and supportive information about the benefits, practice and skills of breastfeeding. Ensure these classes are client-orientated: both accessible, and presented in a way which is relevant and understandable to a wide audience of women. Include practical information on ‘how to breastfeed’ as well as on</p>

		<p>‘why to breastfeed’ during the antenatal parenting classes.</p> <p>Utilise the antenatal clinic appointment time to provide ongoing breastfeeding information that gives a realistic picture of how breastfeeding is learnt and sustained. .</p> <p>Utilise the antenatal clinic appointment time to encourage pregnant women to attend local breastfeeding support groups so that they can learn from other mothers what breastfeeding involves.</p>
	Promote breastfeeding amongst mothers who may have bottlefed preceding children	<p>Promote awareness amongst staff that mothers who have previously bottle fed (or have had a previous bad experience) may wish to breast feed a subsequent child.</p> <p>Encourage education of such mothers, who do not typically reattend general antenatal classes by tailoring a breastfeeding information class to specifically meet their needs.</p>
	Promote breastfeeding amongst Traveller women	<p>Traveller women to be identified within the hospitals by direct questioning or self identification (rather than on an assumption by staff).</p> <p>A high priority should be given to the sending of galactosaemia tests (the Buetler test) to the National Metabolic Screening Laboratory in Temple Street, Dublin for analysis. This should involve, where possible, courier</p>

		<p>delivery of tests for hospitals in the Dublin area and priority posting from other centres to reduce delay.</p> <p>Provision to be made for all Beutler test results to be immediately faxed back to the relevant hospitals. Electronic dispatching of results should also be explored in the development of the new standard national IT systems pending for all maternity and neonatal units.</p> <p>If a Traveller woman is advised to defer breastfeeding while awaiting a Beutler test result, extra support to initiate and maintain lactation should be offered. Traveller mothers should then be taught how to breastfeed once a negative test result has been received.</p> <p>Consultation with Neonatal and Metabolic specialists with regard the appropriateness and evidence base underlying the policy that Traveller mothers cannot breastfeed until their babies have been tested for galactosaemia. As this may be functioning as a disincentive to breastfeeding among Traveller mothers, a risk benefit analysis should be undertaken to justify this policy.</p>
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<p>Continuity of care from hospital discharge to community services</p>	<p>Ensure that mothers at discharge have a full understanding of where they can access assistance with breastfeeding if needed, especially in the early days post discharge</p>	<p>Maternity units to provide all mothers with a comprehensive and up to date contact list of local support sources.</p> <p>Maternity units to hold regular open access breastfeeding clinics, for mothers recently discharged, in tandem with the access granted to all mothers and babies to return to the maternity unit with a maternity related problem up to 6 weeks post discharge (under the Maternity and Child Scheme).All breastfeeding mothers should be identified at discharge from hospital, and offered a PHN or GP visit within 48 hours of discharge, to assist in the early identification of any problems.</p> <p>Consideration should be given to a scheme similar to the Irish community midwives scheme or the UK Health Visitor scheme, where mothers who are breastfeeding at hospital discharge are provided with dailyphone calls and home support visits following postnatal discharge.</p>
<p>Provision of consistent advice regarding breastfeeding practices in the community</p>	<p>Promote breastfeeding support education amongst community health care workers</p>	<p>Roll out the WHO/UNICEF Baby Friendly Initiative to community health care settings. Provide access to such workers to attend the 20-hour breastfeeding course and such “refresher” courses as may be required.</p> <p>Consideration should be given to the appointing of PHNs with a lactation consultant qualification and given protected</p>

		time to advise colleagues and see patients with breastfeeding problems.
“Free Formula milk” scheme	Consideration of the equity and risk-benefit of the provision of free formula to certain groups	Provide an alternative to such schemes to remove the disincentive to breastfeeding mothers; alternatively offer a similar value aid to breastfeeding mothers to remove the disincentive to breastfeeding inherent in providing free formula only.
<b>2. Culture and community</b>		
Lack of knowledge of breastfeeding in the community	Promotion of general awareness of breastfeeding	Encourage positive role models of breastfeeding, in the community and in the public domain.
	Community healthcare workers to promote breastfeeding as a positive and proactive health care behaviour that mothers and families may wish to take	Consistent training (such as the 20-hour breastfeeding course) to be available to all HSE and community health care workers in the fields of antenatal care, postnatal care, and community health. Access to courses to be prioritised by employers.
	Families to be engaged in both the decision to breastfeed and the provision of breastfeeding support	Inclusion of partners and families (specifically targeting the woman’s own mother and the mother of her partner) in antenatal classes relating to breastfeeding Promotion of such activities as Fathers’ parenting groups, through the PHN networks and the maternity units Drop-in breastfeeding groups in the hospital or community

		<p>to have specific sessions which are “dad-friendly”</p> <p>Promote education of young people on the benefits and practicalities of breastfeeding; through the schools’ Transition Year programmes</p>
	Mentoring of new mothers by more experienced mothers	<p>Consider initiating breastfeeding peer support programmes, such as within a model like the community mothers’ scheme, in areas where breastfeeding rates are particularly low. Specific breastfeeding support may be accessed either from the community mother, or the PHN coordinator.</p>
	Exemplar of community breastfeeding services such as the PHN facilitated breastfeeding support clinic, community mothers schemes, voluntary breastfeeding support groups and community antenatal and postnatal groups.	<p>HSE to prioritise PHNs’ time to provide one-to-one community breastfeeding support and facilitate the holding of support groups</p> <p>Maternity units to specifically inform new mothers of the community supports available and their contact details.</p>
	Targeting young mothers, who are less likely to breastfeed	<p>Positive engagement with and identification of the breastfeeding needs of younger mothers at antenatal visits and adapt services to meet these needs.</p> <p>Engagement with such groups as Treoir, who support younger and single mothers.</p>

<p>Loss of breastfeeding skills amongst recent immigrants</p>	<p>Prioritise and value breastfeeding skills and culture in immigrant cultures and sub populations</p>	<p>Adherence to the best practice policy recommendations in the direct provisions centres' report</p> <p>Community workers and workers in direct provision centres to support breastfeeding among these populations</p> <p>An alternative to free formula to be provided to breastfeeding mothers in direct provision centres, thus removing the clear disincentive to breastfeeding that is present with the current practice.</p>
<p>Promotion of breastfeeding in the Travelling community</p>	<p>Prioritise and value breastfeeding skills and culture in the Travelling community</p>	<p>Positive engagement with such mothers at antenatal visits and tailor services to meet their breastfeeding needs.</p> <p>Engagement with such groups as Pavee Point and the Traveller Liason PHNs, to endorse breastfeeding and its benefits in this population</p> <p>Prioritise ongoing funding of such supports as the Traveller Primary Health Care Project</p>

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## **9 APPENDICES**

### **9.1 Appendix A: The data items used to collect breastfeeding information in the Lifeways, SLAN, Millenium Cohort and All-Ireland Traveller Health studies in Chapter 4**

#### **Lifeways:**

##### **WAVE 1**

1. For women with children only. Did you breastfeed your last child?
2. If Yes, how long did you breastfeed only for?
3. What age was your last child when (s)he stopped any breastfeeding?

##### **WAVE 2**

1. Was your Lifeways child ever breastfed (even just in the few hours after birth)?
2. If yes, how old was your Lifeways child when he/she completely stopped being breastfed? (including expressed milk)
3. If yes, how old was your Lifeways child when he/she first had any milk or drinks other than breastmilk? (not including water)

#### **SLAN 1998:**

Women with children only answer this section:

1. Did you breastfeed your last child?
2. If yes, how long did you breast feed only for?
3. Age at which last child stopped any breastfeeding?

#### **SLAN 2002:**

Women with children only answer this section:

1. Did you breastfeed any of your children?

2. Did you breastfeed your last child?
3. If yes, how long did you breast feed only for?
4. Age at which child stopped any breastfeeding?

**SLAN 2007:**

1. Can I ask you firstly if you have any children?
2. The following questions are about breastfeeding. Did you breastfeed any of your children?
3. Is your youngest child less than 5 years of age?
4. Did you/Are you breastfeeding that child?
5. [IF YES] How long did you breast feed exclusively for? (i.e. how long did the infant receive only breast milk and no other liquids, or solids with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines)

**Millennium Cohort Study- 9 month survey**

1. Did you ever try to breastfeed *^him*?
2. How old was *^Jack* when *^he* last had breast milk?
1. I'm now going to ask when *^Jack* first had (other) different types of milk. Please include any eaten with cereal.

**All-Ireland Traveller Health Study**

1. "Did you breastfeed any of your children?"

## **9.2 Appendix B: Information sheet and consent form for the mothers' qualitative interviews**



Study of Breastfeeding in Ireland

Professor Cecily Kelleher

UCD School of Public Health and Population Science

### **INFORMATION AND CONSENT FORM**

#### **What is our study about?**

This study is about mother's views towards breastfeeding in Ireland. We would like to ask mothers how best to make breastfeeding an easy choice for themselves and their peers. This study will help health professionals better understand why some women choose to breastfeed and others do not. This will allow them to develop new programmes to help families with breastfeeding.

#### **Why are we doing this study?**

Ireland has one of the lowest breastfeeding rates in Europe. We want to understand why this is the case and how we can improve breastfeeding promotion and support services in Ireland.

#### **How will you be involved in the study?**

You are one of several mothers being invited to join our study. We are asking you to join as you recently had a baby, or are an older mother who has can tell us how things have changes since you had your baby. To help us find out what how best we can make breastfeeding an easier choice for mothers, we will ask you to participate in a group meeting.

Families will be invited to meet with other parents to talk about ideas around breastfeeding. For example, "what would make breastfeeding easier in Ireland?". These meetings will take place in a local community venue and will last about 1 hour at most. With your permission, these meetings will be recorded using sound taping equipment.

### **What's good and not so good about helping us?**

Some things may concern you about being part of the study. There is a chance that you may not like answering some particular questions. Please remember that you are free to choose not to answer any questions if you do not wish. We will do our best to make sure you are happy with the study and we will listen to any concerns you may have at all times. While you may not benefit directly from this study, you will be helping us find out about breastfeeding in Ireland. If you agree to take part, you will be helping other parents and their children.

### **How will we keep your information safe?**

All information you give us in the group discussions will be kept private and confidential. This means your personal information will be safe and secure and not given to anyone outside of the UCD research team. The names of each participant will not be included in any report or file. Anyone else who sees the information collected during the group meetings will not see your name. Instead, numbers will replace your name and you will only be identified by a number. All information collected will be kept on computers in a safe and secure place in UCD. The researchers will need passwords to see this information.

If you agree to the sound taped recordings of the group discussions, while your name will not be used, people who know you may be able to recognise your voice. These recordings will not be heard by anyone outside the UCD research team and will be kept in a locked press in UCD.

### **What happens after the study ends?**

Once the study ends at the end all the information will be stored on a computer file. This file will not contain any of your personal details and names will be replaced by numbers so that any researcher will not be able to identify who provided the comments.

The report based on the study will be made available to you if you wish.

### **How do you join the study?**

Your decision to join the study is voluntary, this means you can say yes or no to us. You are free to leave at any time without giving a reason. If you decide to leave the study, you will still receive the usual healthcare and social services available to you.

You may want a little time to decide if you want to take part or not. Also, if you have any further questions about the study, please telephone.....

Your participation is highly valued and key to the success of this project. If you are now ready to join the study please complete the form below.

**Consent Form**

**DECLARATION**

**I have had the opportunity to read this consent form (or have it read to me) and I believe I understand what it says. I have also had time to consider whether to take part in this study. I have had the opportunity to ask questions about the information in this form and I believe that I have sufficient information to fill out this informed consent sheet.**

	YES	NO
<b>Do you agree to take part in the study described above?</b>		

**Name in block capitals.....**

**Signed.....**

**Date.....**

\*\*\*\*\*

**For parents under the age of 18 years, we require that your parents/legal guardians agree that you take part in this study. If you are under 18 years, the following must be signed by your parents/legal guardians:**

	YES	NO
<b>Do you agree to allow your daughter/child in your care to take part in this study?</b>		

**Guardian Name in block capitals.....**

**Signed.....**

**Date.....**



### **9.3 Appendix C: Information and consent form for the service providers' interviews**



#### **Assessment of Breastfeeding Service Needs in Ireland**

Principal Investigator: Professor Cecily Kelleher  
UCD School of Public Health and Population Science

#### **INFORMATION AND CONSENT FORM**

**Dear Sir/Madam,**

Researchers at the UCD School of Public Health and Population Science are conducting an in-depth analysis and report on the breastfeeding promotion and support services for groups identified as traditionally having low rates of breastfeeding. To achieve this, we are conducting semi-structured interviews with key stakeholder groups, such as health service providers and breastfeeding support groups. The purpose of the interviews are to ascertain your perspective on what is specifically required to better promote and support breastfeeding for those individuals identified as being least likely to initiate or sustain breastfeeding in Ireland.

This study has been commissioned as a national study by Ms. Maureen Fallon, National Breastfeeding Co-ordinator, HSE and full research approval has been obtained from the Research Ethics Committee at UCD.

This letter is an invitation for you to participate in one of these interviews. Each interview will be conducted via the telephone and will last about 20 minutes. If you agree to take part, an outline describing the main topics and questions to be covered in the interview will be emailed to you in advance, although the main topics vary depending on your role in breastfeeding promotion and support.

The interviews will be audio recorded and transcribed by a UCD researcher. All information you give us during the interviews and will be kept private and confidential. Your information will be safe and secure and not given to anyone outside of the research team. The data will be kept on a password protected file in UCD and deleted from the audio recording device. Anyone who sees the written records of your interview will not see your name. Additionally, your name will never be used in any reports of the research. If you agree to the audio recordings of the interview, while your name will not be used, people who know you may be able to recognise your voice. Therefore, these recordings will not be heard by anyone outside the research team.

The requirements of the Data Protection Acts (1988 and 2003) and the Statistics Act (1993) will be fully met in this project. The project approach is outlined in the context of the eight data protection rules enunciated by the Data Protection Commissioner (DPC) - that one should: 1) Obtain and process the information fairly; 2) Keep it only for one or more specified and lawful purposes; 3) Process it only in ways compatible with the purposes for which it was given to you initially; 4) Keep it safe and secure; 5) Keep it accurate and up-to-date; 6) Ensure that it is adequate, relevant and not excessive; 7) Retain it no longer than is necessary for the specified purpose or purposes; and 8) Give a copy of his/her personal data to any individual, on request.

Your participation in this interview is completely voluntary and you are free to not answer any question or withdraw from the interview at any stage without notice or reason. If you decide not to participate it will not have any effect on your relationship with UCD.

The report based on the study will be made available to you if you wish.

If you have any further questions about the study, please contact .....

Your participation is highly valued and key to the success of this project. If you decide that you would like to participate please complete the form on the next page and we will send a copy of this agreement to you.

Thank you in advance for your interest and support in this project and we look forward to working with you in the approaching weeks.

Regards,

UCD Research Team

**Consent**

I, \_\_\_\_\_, understand the nature and purpose of this study. I fully understand that the interview will be tape recorded and transcribed. I understand that the data from this study will be analysed and may be submitted for publication in a scientific journal.

I understand that all information that I provide will be kept confidential and that I may withdraw from the study at any time without prejudice.

I understand the data will be deleted from the audio recording device once the data are stored in a secure file on UCD research computers in accordance with the Data Protection Act (1988 and 2003) and the Statistical Act (1993) and that no-one outside of the research will be able to hear the tape recording.

I voluntarily consent to taking part in an interview with a UCD researcher on the topic of breastfeeding. I give consent for the recordings to be used for the purpose of this research only.

Name in Block Capitals: \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

**Please return this form by email to:** .....with Information Consent Form in the title and typing your name in the appropriate boxes - this indicates permission is given.

**Alternatively, please return by post to:**

.....

**Or by fax to:** .....

Telephone: .....

Code No:

## 9.4 Appendix D: Topic guide for the breastfeeding service provider interviews

### Questions

1. Can you describe your involvement in breastfeeding **support**?
2. Where do you get professional **information** on supporting breastfeeding?
  - a. Are there professional (or other) **barriers** to supporting breastfeeding?  
What are they, if so?
3. What advice do you think:
  - a. an **expectant** mother who is considering breastfeeding needs?
  - b. a mother who has just given **birth needs**?
  - c. a mother who is finding breastfeeding **difficult needs**?
  - d. a mother who is deciding to **stop** breastfeeding needs ?
4. What type of mother, in your view, is **most likely** to breastfeeding?
5. What type of mother, in your experience, is **least likely** to breastfeed?
6. How can mothers who are **least likely** to breastfeed be encouraged to do so?
7. What factors affect a mother's decision to **stop** breastfeeding before 6 months?
  - a. Is the target of 6 months realistic?
  - b. What is a model of good (breastfeeding) practice?
  - c. Exclusive versus partial breastfeeding?
8. Is there anything else you wish to add?

## **9.5 Appendix E: Interview guide for focus groups with urban and rural women**

### Interview guide for focus groups

1. Tell me about how the women you know normally feed their babies?
2. Some women choose to breastfeed and some women choose to bottlefeed, why do you think this is?
3. Where did you get your information about feeding your baby?
4. What do you think about support from health professionals for mothers around feeding their babies?
5. What do you think about support in the family for mothers around feeding their babies?
6. What do you think about support from other people outside the family?
7. Are there any others forms of support available for infant feeding? (Probe: Cuidiú, La Leche League)
8. What difficulties/problems do you think a mother might face if she chooses to breastfeed?
9. Breastfeeding was more common in the past? Why do you think it has declined?
10. What do you think about breastfeeding in public?
11. How do you feel about breastfeeding? Is it a good option or a bad option?
12. What could be done which would make it easier for women to breastfeed?
13. What would need to change in the future for more people to breastfeed?
14. Does anyone have any final comments?

## **9.6 Appendix F: Interview guide for individual semi-structured interviews**

### Interview guide for individual semi-structured interviews

#### **(A) You and your baby**

##### **1. How did you feed your children? Did you breastfeed or bottlefeed?**

###### Breastfed

- Why did you choose to breastfeed?
- For how long did you breastfeed?
- Why did you stop?
- Probe level of support:
  - o in the family
  - o at work
  - o from doctors/nurses/the hospital
- Did you attend a mother and baby group?
- Did you attend antenatal classes?

###### Bottlefed

- Why did you choose to bottlefeed?
- Why did you choose not to breastfeed?
- Probe level of support:
  - o in the family
  - o at work
  - o from doctors/nurses/the hospital
- Would you ever breastfeed? What would encourage you to do so?
- Did you attend a mother and baby group?
- Did you attend antenatal classes?

##### **2. When (at what stage) did you decide upon the way you were going to feed your child?**

**3.** Is there anyone/anything in particular that affected your decision about how you were going to feed your child?

- Anyone? (Probe: friends, family, health professionals)
- Anything? (Probe: knowledge, facilities, convenience, modesty, going back to work, embarrassment in public)

**4.** How did you feed your other children?

- Any differences - what are they?
- Did your experience of feeding your first baby affect your decision about feeding your other children?

**5.** Where did you get your information about breastfeeding? (the internet, baby books, health professionals)

**6.** Has anyone ever spoken to you about breastfeeding?

If yes, who spoke to you about it?

What did they say?

**7.** Do you think there is any difference between breastfeeding and bottlefeeding?

- for the child?
- for the mother?

**8.** How do you feel about breastfeeding?

### **(B) The Community**

**1.** Tell me about women (in your community/that you know) normally feed their babies?

**2.** Do you think they would ever breast feed? Would you encourage them to do so?

**3.** What do you think makes women decide to bottlefeed instead of breastfeeding?



4. What kind of difficulties/problems do you think a mother might face if she chooses to breastfeed her child?

**(C) Final comments**

Have you any final comments you would like to make/add about infant feeding?

## **9.7. Appendix G: Information Sources cited by Health Service providers during the qualitative interviews**

A list of named information sources are provided, which include:

- HSE website - [www.breastfeeding.ie](http://www.breastfeeding.ie) and Health Promotional literature e.g. Breastfeeding your baby.
- Breastfeeding Steering Committee (Representation includes voluntary organisations; PHNs; Hospitals)
- 18-20 hour breastfeeding course
- Conference, seminar, workshops e.g. Baby Friendly Initiative and study day attendance
- Breastfeeding coordinator (Hospital)
- Research, articles (Breastfeeding Review), professional journals (Human Lactation Journal), books, 'Caring for your baby' booklet; NHS 'promoting breastfeeding for health professionals' leaflet; internet websites (e.g. MIDIRS, Board Altranais) and hospital library
- Baby Friendly Hospital Initiative (10 Steps to Successful Breastfeeding) and Baby Friendly Link (quarterly) and website
- Neo-natal Nutrition Sub-group for neo-natal dieticians & European Society of Paediatric Gastroenterology Hepatology and Nutrition (ESPGHN) & British Dietetic Association and associated dietetic professional bodies.
- Lactation Midwives/Consultant/Specialist
- National Breastfeeding Strategic Implementation Committee
- 5 Year Strategy Action Plan
- Professional training, mainly by working on the wards and talking with the midwives
- Cuidiu e.g. e-list of shared experiences and opinions and references
- La Leche League e.g. Question and Answer Booklet
- Association of Lactation Consultants of Ireland (ALCI)
- Department of Health, National Breastfeeding Coordinator
- Local breastfeeding policy and committee e.g. Hospital Breastfeeding Committee
- Personal breastfeeding experience
- Observations of other women breastfeeding
- Colleagues