An Exploration of Health Professional Support for Breastfeeding

Barbara Whelan

Technological University Dublin

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An Exploration of Health Professional Support for Breastfeeding

A thesis submitted for the degree of Doctor of Philosophy

by

Barbara Whelan B.Sc., M.Sc. (Public Health Nutrition)

Supervisor

Dr. John M Kearney

School of Biological Sciences

Dublin Institute of Technology

June 2010
Abstract

Despite research consistently demonstrating the benefits of breastfeeding, Ireland has one of the lowest rates of breastfeeding in Europe with rates at discharge from hospital being 45% (Health Research and Information Division, 2009). Increasing emphasis is being placed on the role of health professionals in promoting and supporting breastfeeding (Sikorski et al., 2003). Little data are available in Ireland regarding health professionals’ perspectives on breastfeeding and women’s experience of professional support.

The research consisted of two phases, a mixed methods study exploring health professional support for breastfeeding and an evaluation of an intervention to raise awareness of breastfeeding amongst health professionals and the general public. The mixed methods study consisted of a quantitative cross-sectional survey which investigated different aspects of community health professionals’ (n=256), knowledge and attitudes towards breastfeeding, their self efficacy in dealing with breastfeeding issues and issues around breastfeeding education. This was followed by two qualitative studies, one of which explored the issues for health professionals, in both the community and hospital setting (n=58) in providing support for breastfeeding, and, the other of which examined women’s (n=22) experience of professional support for breastfeeding in the first year postnatally. Grounded theory methods (Strauss & Corbin, 1990) guided data collection and analysis in both qualitative studies. A cross-sectional mixed methods
study was also conducted to evaluate the role of forum theatre in creating awareness of breastfeeding.

In summary, the quantitative study identified significant differences ($p=0.001$) as to whether respondents felt they had sufficient skills to provide breastfeeding support, with 82% of PHNs, 54% of GPs and 32% of practice nurses agreeing with this. Interest in attending training about breastfeeding in the next year was assessed and GPs were the least likely to want to attend. The qualitative study with health professionals identified the key issues in professional support for breastfeeding. Health professionals were found to have different levels of ‘ownership’ towards breastfeeding and this affected their level of engagement with the subject. Barriers to providing support were also identified such as having a lack of time, conflicting information and lack of confidence in supporting breastfeeding. The qualitative study of women’s experience of professional support demonstrated that breastfeeding is not something that a woman simply decides to do or not but that instead she needs to navigate through ‘the world of breastfeeding’ which was defined by the woman’s own world, the medical world and the world of support. The evaluation provided preliminary evidence for the potential of using forum theatre to change attitudes to breastfeeding and also for its use in training health professionals.

This study has provided a greater understanding of professional support for breastfeeding. In order that women are adequately supported both in the antenatal and postnatal periods, health professional education around breastfeeding needs to be addressed and also alternative forms of support such as peer support on postnatal wards should be considered.
Declaration of Work

I certify that this thesis which I now submit for examination for the award of Doctor of Philosophy, is entirely my own work and has not been taken from the work of others, save and to the extent that such work has been cited and acknowledged within the text of my work.

This thesis was prepared according to the regulations for post graduate study by research of the Dublin Institute of Technology and has not been submitted in whole or in part for another award in any Institute.

The work reported on in this thesis conforms to the principles and requirements of the Institute’s guidelines for ethics in research.

The Institute has permission to keep, to lend or to copy this thesis in whole or in part, on condition that any such use of material of the thesis be duly acknowledged.

Signature _______________________________    Date ________________
Acknowledgments

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There is no such thing as a self-made man. We are made up of thousands of others.

Everyone who has ever done a kind deed for us, or spoken one word of encouragement to us, has entered into the makeup of our character and our thoughts as well as our success.

(George Matthew Adams)
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<td>AAP</td>
<td>American Academy of Pediatrics</td>
</tr>
<tr>
<td>ACOG</td>
<td>American College of Obstetricians and Gynecologists</td>
</tr>
<tr>
<td>ALL</td>
<td>Acute Lymphocytic Leukaemia</td>
</tr>
<tr>
<td>AML</td>
<td>Acute Myelogenous Leukaemia</td>
</tr>
<tr>
<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
</tr>
<tr>
<td>CAQDAS</td>
<td>Computer Assisted Qualitative Data Analysis Software</td>
</tr>
<tr>
<td>CI</td>
<td>Confidence Interval</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
</tr>
<tr>
<td>Code</td>
<td>International Code of Marketing of Breast milk Substitutes</td>
</tr>
<tr>
<td>CSO</td>
<td>Central Statistics Office</td>
</tr>
<tr>
<td>DPHN</td>
<td>Director of Public Health Nursing</td>
</tr>
<tr>
<td>FSAI</td>
<td>Food Safety Authority of Ireland</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Service</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>HSE</td>
<td>Health Service Executive</td>
</tr>
<tr>
<td>IBCLC</td>
<td>International Board Certified Lactation Consultant</td>
</tr>
<tr>
<td>ICGP</td>
<td>Irish College of General Practitioners</td>
</tr>
<tr>
<td>INDI</td>
<td>Irish Nutrition and Dietetic Institute</td>
</tr>
<tr>
<td>IPNA</td>
<td>Irish Practice Nurses Association</td>
</tr>
<tr>
<td>LHO</td>
<td>Local Health Office</td>
</tr>
<tr>
<td>LDL</td>
<td>Low density lipoprotein</td>
</tr>
<tr>
<td>mmHg</td>
<td>Millimetre of mercury</td>
</tr>
<tr>
<td>n</td>
<td>Sample size</td>
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<tr>
<td>NEC</td>
<td>Necrotising Enterocolitis</td>
</tr>
<tr>
<td>NPRS</td>
<td>National Perinatal Reporting System</td>
</tr>
<tr>
<td>OR</td>
<td>Odds Ratio</td>
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<tr>
<td>PHN</td>
<td>Public health nurse</td>
</tr>
<tr>
<td>PROBIT</td>
<td>Promotion of Breastfeeding Intervention Trial</td>
</tr>
<tr>
<td>PUFA</td>
<td>Polyunsaturated fatty acids</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>---------</td>
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<tr>
<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>WHO</td>
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CHAPTER 1

1 General Introduction

This chapter presents a background to the research and the aims and objectives. The structure of the study is also described. The review begins by addressing the question of why one should breastfeed, whereby the potential benefits of breastfeeding are outlined. Rates of breastfeeding initiation and duration in Ireland as well their principal determinants are given in order to highlight the extent of this public health issue. Breastfeeding policy initiatives in Ireland and Europe are discussed with particular emphasis being given to the role of health professionals in the promotion of breastfeeding.

1.1 Why breastfeeding is important

Breastfeeding is the superior form of feeding for the growth, development and health of infants. Breastfed infants are the reference against which all alternative feeding methods must be measured with regard to growth, health and development (Gartner et al., 2005). Breast milk provides all the nutrients that an infant needs in approximately the first six months of life (Fleischer-Michaelsen et al., 2000). The composition of breast milk changes throughout a feed depending on the time of day and during the course of lactation. Wagner et al., (1996) referred to the ‘dynamic’ nature of breast milk with it continuously evolving to meet the changing developmental needs of the infant. It
contains nutrients that serve the needs of infants such as essential polyunsaturated fatty acids (PUFAs), iron in a readily absorbable form and certain milk proteins (Fleischer-Michaelsen et al., 2000). Breast milk has a low protein content which presents a modest nitrogen load to immature kidneys and a low sodium content which keeps the renal solute load low (James & Lessen, 2009). In addition, it has a ratio of calcium to phosphorus of 2:1 which is ideal for the absorption of calcium (James & Lessen, 2009). With the exception of vitamin D, supplements are not necessary with breast milk. In Ireland and in more Northern latitudes where there could be insufficient vitamin D in breast milk, the Food Safety Authority of Ireland (FSAI) (Food Safety Authority of Ireland, 2007) recommend that all infants aged 0-12 months be supplemented with vitamin D (5µg/day). Mean intakes of breast milk provide sufficient energy and protein to meet the needs of infants up to six months old (Butte et al., 2002). In addition to the nutritional benefits, breast milk also contains immuno-protective and immuno-enhancing factors which provide protection against acute and chronic illness (Jackson & Nazar, 2006).

The American Academy of Pediatrics (AAP) summarised the advantages of breastfeeding in relation to health, nutrition, immunology, development, psychology, society, economy and the environment (Gartner et al., 2005). Breast milk contains numerous immunologic factors which both help to protect the infant against acute infection and also may influence the development of the infant’s immune system. Factors such as secretory immunoglobulin A (sIgA), lysozyme, lactoferrin and oligosaccharides have anti-microbial effects and protect the infant against potential pathogens by preventing adhesion of pathogens to mucosa in the upper respiratory
system and gastrointestinal tract (Jackson & Nazar, 2006). Appendix I summarises the immunologic factors in breast milk and their functions. There is also evidence that an infant’s immune system is influenced by breast milk. Hasselbach et al., (1996) found that the thymus of breastfed babies at four months was twice the size of that in formula-fed babies. The thymus is a central organ in the immune system. Breastfeeding has also been found to have a beneficial effect on vaccination response in children (Hawkes et al., 2007; Silfverdal et al., 2007; Dorea, 2009). Due to the protective effect of breast milk, Paracio Talayero et al., (2006) found that within an industrialised country exclusive breastfeeding reduced the risk of hospitalisation as a result of infections among infants less than one year of age. They found that 30% of hospital admissions would have been avoided for each additional month of exclusive breastfeeding. In addition, exclusive use of formula is associated with substantial costs to the health care system (estimated $331-$475 per infant never breastfed) based on the increased incidence of otitis media, lower respiratory tract infection and gastrointestinal infection (Ball & Wright, 1999).

In a review of the evidence on the effects of breastfeeding on short and long term infant and maternal health in developed countries, Ip et al., (2007) described the beneficial effects of breastfeeding on infant health. Horta et al., (2007) also conducted a review to assess the effects of breastfeeding on long term chronic diseases. The evidence for the health benefits of breastfeeding can be divided into strong, moderate and weak (Table 1.1), based on the findings of Ip et al., (2007) and Horta et al., (2007). Specific details regarding the findings of the two reviews, related to the effects of breastfeeding on infant health are available in Appendix II. The findings of these reviews, however,
should be interpreted with caution because many of the studies on which they are based are observational studies. There are limitations to the strength of evidence that observational studies can give due to selection bias, reverse causality and confounding effects of maternal and infant factors. Ip et al., (2007) have highlighted the need for further observational studies providing clear definitions for breastfeeding, proper quantifiable outcomes and controlling for potential confounders, in order to further elucidate and strengthen the evidence on the beneficial effects of breastfeeding compared with formula feeding.

It would be unethical to conduct a randomised controlled trial whereby infants would be either given breast milk or formula and so observational studies will remain one of the main sources of evidence on the health benefits of breastfeeding (Ip et al., 2007). However, the Promotion of Breastfeeding Intervention Trial (PROBIT) which was conducted in Belarus was a cluster-randomised trial of breastfeeding promotion based on the World Health Organisation (WHO) and United Nations International Children’s Emergency Fund (UNICEF) Baby Friendly Hospital Initiative (BFHI (Kramer et al., 2000). While the aim of PROBIT was not to determine the health outcome of infants who were breastfed or formula fed, it did provide the opportunity to compare the presence of acute infectious diseases amongst infants who were exclusively breastfed, partially breastfed and formula fed (Kramer et al., 2001). Data from PROBIT have provided evidence for a significant association between breastfeeding and reduced incidence of gastrointestinal infection and atopic eczema (Kramer et al., 2001) but not for respiratory tract infection (Kramer et al., 2001), child obesity or lower blood pressure (Kramer et al., 2009). Further cluster-randomised trials based on breastfeeding
promotion would provide further opportunity to investigate the association between breastfeeding and health outcomes (Ip et al., 2007).
Table 1.1. Strength of evidence and effect for the health benefits of breastfeeding on short and long term infant health in developed countries based on reviews by Ip et al., (2007)\(^1\) and Horta et al., (2007)\(^2\)

<table>
<thead>
<tr>
<th>Strong</th>
<th>Moderate</th>
<th>Weak</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced incidence of:</td>
<td>Reduced incidence of:</td>
<td>Beneficial effect on:</td>
</tr>
<tr>
<td><strong>Acute otitis media</strong> (50% reduction in risk amongst infants exclusively breastfed for three months or more)(^1)</td>
<td><strong>Obesity</strong> (24-7% reduction in obesity amongst those ever breastfed(^1,2))</td>
<td>Cognitive development (little or no beneficial effect(^1) and mean difference of 4.9 marks in intelligence tests amongst those breastfed(^2))</td>
</tr>
<tr>
<td><strong>Atopic dermatitis</strong> (Amongst those with a family history of atopy, breastfeeding for more than three months is associated with a 42% reduction in the risk of atopic dermatitis)(^1)</td>
<td><strong>Blood pressure</strong> (1.21-0.36mmHg(^1,2) reduction in systolic blood pressure and 1.41-0.49mmHg(^1,2) reduction in diastolic blood pressure amongst those who were breastfed in infancy compared with those formula fed)</td>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal infection</strong> (Any breastfeeding compared with no breastfeeding is associated with a 64% reduction)(^1)</td>
<td><strong>Cholesterol</strong> (in adulthood 0.18mmol/l(^1,2) reduction in total cholesterol and 0.2mmol/l(^1) in low density lipoprotein (LDL) cholesterol amongst those breastfed compared with those formula fed)</td>
<td></td>
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<tr>
<td><strong>Lower respiratory infection</strong> (72% reduction in hospitalisation for lower respiratory tract infection amongst those exclusively breastfed for four months or more)(^1)</td>
<td></td>
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</table>
Table 1.1. continued

<table>
<thead>
<tr>
<th>Strong</th>
<th>Moderate</th>
<th>Weak</th>
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<tbody>
<tr>
<td><strong>Asthma in children</strong> (in children with a family history of asthma who were breastfed for three months or more, exclusive breastfeeding is associated with a 48% reduction. The evidence for a continued protective effect in adolescence and adulthood is less conclusive)(^1)</td>
<td><strong>Type 1 diabetes</strong> (19-12% reduction in risk amongst those breastfed for more than three months compared with those breastfed for less than three months)(^1)</td>
<td></td>
</tr>
<tr>
<td><strong>Sudden infant death syndrome</strong> (reduced risk of 36% amongst infants ever breastfed compared with never breastfed)(^1)</td>
<td><strong>Type 2 diabetes</strong> (reduced risk of 39(^1)-37(^2) in later life amongst those with any breastfeeding compared with exclusive formula feeding)</td>
<td></td>
</tr>
<tr>
<td><strong>Childhood leukaemia</strong> (20% reduced risk of acute lymphocytic leukaemia and 15% reduced risk of acute myelogenous leukaemia amongst those breastfed for six months or more compared with those not)(^1)</td>
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</table>

(OR indicates Odds Ratio and CI Confidence Interval)
1.1.1 Benefits of breastfeeding for mothers

In addition to the health benefits which breastfeeding confers on babies, there are also benefits for mothers, with evidence for those who breastfeed having increased weight loss postpartum (Dewey et al., 1993; Kac et al., 2004), a decreased incidence of ovarian cancer (Rosenblatt & Thomas, 1993; Danforth et al., 2007) and premenopausal breast cancer (Newcomb et al., 1994; Marcus et al., 1999). The evidence for an association between breastfeeding and reduced incidence of breast cancer and ovarian cancer is strong (Ip et al., 2007). The Collaborative Group on Hormonal Factors in Breast Cancer (2002) re-analysed data from 47 epidemiological studies in 30 countries and found that for each year that a woman breastfeeds, the relative risk of breast cancer is reduced by 4.3%. More recently, Stuebe et al., (2009) found an inverse association between having ever breastfed and the incidence of pre-menopausal breast cancer in women who had a first degree family history of breast cancer.

Schwarz et al., (2009) found beneficial effects of breastfeeding on cardiovascular disease with duration of lactation being associated with a lower prevalence of hypertension, type 2 diabetes, hyperlipidemia and cardiovascular disease. However, with regards to type 2 diabetes, Ip et al., (2007) concluded that there was only an association between breastfeeding and reduced risk of type 2 diabetes in women who did not have a history of gestational diabetes. In addition to a reduced risk of some illnesses, women who exclusively breastfeed are also more likely to be amenorrhoeic at 6 months which reduces the risk of iron deficiency (Dewey et al., 2001). Breastfeeding while not giving supplementary feeds delays the return of fertility and menstruation, which in turn protects against pregnancy and helps to space out pregnancies (Van der Wijden et al.,...
Breastfeeding has also been associated with a significant decrease in the incidence of postmenopausal osteoporosis (Schnatz et al., 2010), however, the evidence is inconclusive (Ip et al., 2007). Finally, breastfeeding is associated with maternal infant bonding (Fergusson & Woodward, 1999; Britton et al., 2006) and lower levels of postpartum depression (Dennis & McQueen, 2009). The association between not breastfeeding or short duration of breastfeeding and reduced incidence of postpartum depression is, however, unclear as postpartum depression may lead to early cessation of breastfeeding, as opposed to breastfeeding altering the risk of depression (Ip et al., 2007).

1.2 **Breastfeeding recommendations**

1.2.1 **World Health Organisation recommendations**

Prior to 2001, the WHO recommended that infants be exclusively breastfed for 4-6 months, with the introduction of complementary foods (any fluid or food other than breast milk) thereafter (WHO, 1995). In 2001, following a report by a WHO Expert Consultation on the optimal duration of breastfeeding (WHO, 2001a), the WHO changed their recommendation to exclusive breastfeeding for the first six months of life (WHO, 2001b). This recommendation was further endorsed by a systematic review which was commissioned by the WHO and which assessed infant and maternal health outcomes with exclusive breastfeeding for six months versus exclusive breastfeeding for three to four months (Kramer & Kakuma, 2002). This led to a global recommendation for exclusive breastfeeding for the first six months of life with the introduction of
complementary food thereafter and continued breastfeeding for up to two years and beyond (WHO, 2003).

1.2.2 Irish recommendations

In 1999 the FSAI (1999) recommended exclusive breastfeeding for the first four to six months of life. However, in line with recommendations from the WHO (2001b), the Department of Health and Children (2003a) advocate exclusive breastfeeding of infants for the first six months, after which mothers are encouraged to continue feeding, in combination with suitably nutritious and safe complimentary foods until their children are 2 years of age or older. The new guidelines are recommended for the whole population and have been endorsed by the following professional organisations: The Institute of Obstetricians and Gynaecologists, The Faculty of Paediatrics, La Leche League of Ireland, The Midwifery Forum, The Institute of Community Health Nursing, Cuidiú – Irish Childbirth Trust, The Irish College of General Practitioners (ICGP), The Association of Lactation Consultants in Ireland, The BFHI in Ireland and The Irish Nutrition and Dietetic Institute (INDI).

1.3 Breastfeeding rates

1.3.1 Rates of breastfeeding in Europe

Feeding practices vary greatly within and between European countries, with some such as Sweden displaying high rates of initiation of breastfeeding and others such as the United Kingdom (UK) and France displaying low rates (Freeman et al., 2000; Yngve & Sjostrom, 2001). Historically, rates of breastfeeding have been low in Europe, however,
since the 1980s there has been an increase in many countries (Nicoll et al., 2002). Sweden has one of the highest rates of breastfeeding in the world (Brekke et al., 2005) with rates of ever breastfeeding of 98% (WHO, 2009). Rates of breastfeeding initiation\(^1\) are also over 90% in other European countries such as Germany (Dulon et al., 2001), Italy (Giovannini et al., 2004) and Switzerland (Merten & Ackermann-Liebrich, 2004). These compare with Northern Ireland and Scotland with initiation\(^2\) rates of breastfeeding of 63% and 70% respectively (Bolling et al., 2007). In 1992, a pan-European study, called the ‘Euro Growth’ study compared infant feeding practices across 22 European countries and found that Ireland had the lowest breastfeeding initiation rates in Europe (Freeman et al., 2000).

There has been criticism of the data on breastfeeding which are collected in Europe due to different countries using different breastfeeding indicators (exclusive breastfeeding, percent of children breastfed or partial breastfeeding etc.) and different data collection methods (Yngve & Sjostrom, 2001). This makes comparison of data between countries very difficult.

1.3.2 Rates of breastfeeding in Ireland

There is a lack of comprehensive national breastfeeding data available in Ireland (Food Safety Authority of Ireland, 1999). The National Perinatal Reporting System (NPRS) is at present the only regular Irish national infant feeding data source available. This system, however, only reports the rates of breastfeeding at discharge from hospital. In

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1 Initiation refers to mothers who ever tried to breastfeed post birth or the mother started breastfeeding within 48 hours after delivery
2 Initiation refers to all babies whose mothers put them to the breast, even if this was on one occasion only
addition, the system has been criticised for the length of time between data collection and dissemination of the results which is usually an average of two years (Department of Health and Children, 2003b). Other breastfeeding data have come from local studies which have looked at breastfeeding rates at different time points in the postnatal period.

Data available from 1975 indicate that a rapid decline in breastfeeding took place within a single generation from 64% in the 1950’s to 16% by 1975 (Kevany et al., 1975). Lowry & Lillis (1993) and Sayers et al., (1995) conducted surveys in Galway and Kildare respectively and found initiation\(^3\) rates of 36-38%. Loh et al., (1997) conducted a prospective randomised controlled trial amongst 193 women. Those in the intervention group (n=98) received a three minute talk and information from a health professional about breastfeeding. Those in the control group (n=95) received normal care. The rates of breastfeeding at discharge from hospital were 44% and 32% for the intervention group and control group respectively. Twomey et al., (2000) conducted a survey of breastfeeding rates from a random sample of infants in the Eastern Health Board (n=197) and found breastfeeding initiation of 51% and this dropped to 41% at one week, 16% at three months and the rate of any breastfeeding at six months was 8%.

Many of these studies had small sample sizes and in many cases did not specify the definition of breastfeeding (i.e. exclusive or partial breastfeeding), therefore making it difficult to generalise and compare the data nationally. More recently, studies have been conducted which have tried to overcome previous limitations and they have shed light on both rates of breastfeeding initiation and duration. Ward et al., (2004), Tarrant (2008) and Begley et al., (2009b) all used larger sample sizes and specific breastfeeding

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\(^3\) Initiation was not defined in these studies
definitions and found similar rates of breastfeeding initiation of between 47% and 51% for Irish women (Table 1.2). These are comparable to the most recent perinatal statistics report for 2007 (Health Research and Information Division, 2009) which identified exclusive breastfeeding of 45% at discharge from hospital. There has been a steady increase in rates of breastfeeding since the 1990s (Figure 1.1), however, rates still remain low. The perinatal statistics showed that the percentage of babies being breastfed varied by both maternal age (23% of mothers under 20 years breastfed compared with 49% of 35-39 year olds) and geographical location (<30% in Limerick and Clare compared with >50% in Dublin County and West-Meath). Similar discrepancies were found in the national infant feeding survey with rates of breastfeeding initiation highest in Dublin South-East (78%) and lowest in Waterford and Louth (38%) (Begley et al., 2009b). Both studies by Tarrant (2008) and Begley et al., (2009b) found great differences in the rates of breastfeeding between Irish women and women from other countries (Table 1.2) with initiation rates of ~50% for Irish nationals compared with >75% for non-Irish nationals. Because of the possible skewing affect of higher rates of breastfeeding amongst non-Irish nationals on national breastfeeding data, Tarrant et al., (2010) advise a separate analysis of breastfeeding rates by mother’s nationality. As can be seen from Table 1.2, the rates of breastfeeding in Ireland fall very short of the WHO recommendations (WHO, 2003).
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study details</th>
<th>Number</th>
<th>Initiation rate&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward et al., (2004)</td>
<td>Women resident in the North Eastern Health Board</td>
<td>247</td>
<td>51%</td>
<td>25% exclusive&lt;sup&gt;2&lt;/sup&gt; breastfeeding at 14 weeks</td>
</tr>
<tr>
<td>Tarrant (2008)</td>
<td>Coombe Women and Infants Hospital</td>
<td>450</td>
<td>47.1% (Irish nationals)</td>
<td>Rate of exclusive&lt;sup&gt;2&lt;/sup&gt; breastfeeding amongst Irish national/non-Irish nationals at discharge from hospital, 12 weeks and 6 months, 31.7/49%, 12.7/36.7%, 0/0.2% respectively</td>
</tr>
<tr>
<td>Begley et al., (2009)</td>
<td>National Infant Feeding Survey</td>
<td>2527</td>
<td>50% (Irish nationals)</td>
<td>Rate of exclusive&lt;sup&gt;2&lt;/sup&gt; breastfeeding at discharge from hospital, at 3-4 months and 6-7 months, 42%, 19%, 2.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>76% (non-Irish)</td>
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<sup>1</sup> defined as mothers who ever tried to breastfeed post birth including mothers who put their infants to the breast with the intention to breastfeed

<sup>2</sup> defined as the infant has received only breast milk from his/her mother or a wet nurse, or expressed breast milk, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, minerals, supplements or medicine
 Declining rates of breastfeeding worldwide in the twentieth century led to the WHO and UNICEF identifying a need for a global response to the protection, promotion and support of breastfeeding. The decline in breastfeeding was thought to be as a result of both socio-cultural reasons and also to the aggressive marketing strategies used by infant formula companies worldwide (UNICEF, 2005; Palmer, 2009). Initial recommendations to help stop the decline in breastfeeding were proposed to the World Health Assembly in 1981 by the WHO in the form of the International Code of Marketing of Breast-milk Substitutes (The Code) (WHO, 1981). The Code outlined a set of recommendations to regulate the marketing of breast milk substitutes, feeding bottles and teats (WHO, 2008). The adoption of the code, which is still in place, has been associated with major
reductions in some forms of advertising and promotion of breast milk substitutes around the globe.

In 1989 the WHO and UNICEF launched an official joint statement, protecting, promoting and supporting breastfeeding and recognised the important role of the maternity services in promoting breastfeeding. It acknowledged the need for leadership from health professionals in sustaining or re-establishing a “breastfeeding culture”. This statement also included the Ten Steps to Successful Breastfeeding (Appendix III). In 1990, representatives from thirty countries, world health leaders and technical advisors gathered in Florence, Italy to create a global action plan to reverse declining breastfeeding rates and this gave rise to the Innocenti Declaration and the Protection, Promotion and Support of Breastfeeding (WHO, 1990). It established four targets; By 1995, all governments were to have achieved the following:

1. Appointed a national breastfeeding coordinator and established a multisectoral national breastfeeding committee.

2. Ensured that every facility providing maternity services fully practices all ten of the ‘Ten Steps to Successful Breastfeeding’ set out in the joint WHO/UNICEF statement, ‘Protecting, Promoting and Supporting Breast-feeding: The special role of maternity services’.

3. Taken action to give effect to the principles of the International Code of Marketing of Breast-milk Substitutes.

4. Enacted imaginative legislation protecting the breastfeeding rights of working women and established means for its enforcement.
In 1991 the WHO and UNICEF launched the BFHI to promote implementation of the second target of the Innocenti Declaration. The Ten Steps to Successful Breastfeeding became the foundation of the BFHI. In 2005, once again in Florence, there was a meeting to assess the progress made since the original Innocenti Declaration and also to renew each member’s commitment to breastfeeding. While not all of the targets of the Innocenti Declaration had been met, there was progress, with the most promising indicator of success being a reversal in the decline in breastfeeding rates worldwide. The importance of countries reinforcing a ‘breastfeeding culture’ and vigorous reinforcement against a ‘bottlefeeding culture’ was highlighted (UNICEF, 2005). The vision put forward by the 2005 Innocenti Declaration, for the future, was ‘an environment that enables mothers, families and other caregivers to make informed choices about optimal feeding for infants and young children and to receive adequate support to implement them in order to achieve the highest attainable standard of health and development’.

In 2003 a Global Strategy for Infant and Young Child Feeding was launched (WHO, 2003). This strategy built on past and continuing achievements of policies to protect, promote and support breastfeeding. It emphasised the need for comprehensive national policies on infant and young child feeding. It was acknowledged that ‘no single intervention or group could succeed in meeting the challenge and so implementation of the strategy would need political will, public investment, awareness among health workers, involvement of families and communities and collaboration between governments, international organisations, and other concerned parties that would ultimately ensure that all necessary action was taken’. The WHO and UNICEF’s global recommendations for optimal infant feeding are set out in the global strategy: exclusive
breastfeeding for six months, followed by nutritionally adequate and safe complementary feeding starting from the age of six months with continued breastfeeding up to two years of age or beyond. In 2003, the WHO established a tool which countries could use to assess national practices and programmes in relation to targets set out by the Global Strategy for Infant and Young Child Feeding.

The BFHI has been found to be successful in increasing breastfeeding initiation rates in hospitals (Merten & Ackermann-Liebrich, 2004; Bartington et al., 2006). In Switzerland breastfeeding rates have generally increased since 1994 but infants born in baby friendly hospitals are more likely to be breastfed for a longer time than those born in non-baby friendly facilities (Merten & Ackermann-Liebrich, 2004). Mothers who deliver in maternity units holding the baby friendly award are 10% more likely to start breastfeeding than those who deliver in a non-accredited hospital (Bartington et al., 2006). There is an increased emphasis on the importance of establishing “baby friendly communities” in line with step ten of the Ten Steps, whereby community facilities would be given baby friendly accreditation in accordance with a Seven Point Plan for sustaining breastfeeding in the community (Appendix IV). Recently, the ‘Baby Friendly Hospital Initiative Revised, Updated and Expanded for Integrated Care’ was published (WHO & UNICEF, 2009). It included a recommendation that staff receive training on providing support for ‘non-breastfeeding’ mothers and it emphasised the importance of mother-friendly care so that practices are in place for mother-friendly labour and delivery.
1.4.2 The European Union and breastfeeding

While most of the WHO policy documents on breastfeeding (The Code, Innocenti Declaration, BFHI and Global Strategy on Infant and Young Child Feeding) were endorsed by European Union (EU) countries many were found not to comply with the policies and recommendations laid out in these documents (Cattaneo et al., 2005). In addition, there were great differences found between countries in how much they complied and also in actual breastfeeding rates. The heterogenous situation between EU countries with regards to breastfeeding has been noted (Cattaneo et al., 2010). In response to this situation an EU project ‘Protection, Promotion and Support for Breastfeeding in Europe: A Blueprint for Action’ was launched in Dublin in 2004. This blueprint outlined the actions a national or regional plan should contain and implement if effective protection, promotion and support of breastfeeding were to be achieved. In order to test the usefulness of the blueprint, a follow-on project was carried out in eight countries (including Ireland). It was found that the participant countries performed better than the remaining EU respondent countries in relation to implementing breastfeeding interventions (Cattaneo et al., 2010). Based on the experience gained from this project the original blueprint was revised and updated in 2008 (EU Project on Promotion of Breastfeeding in Europe, 2008). The revised document reaffirmed the EU’s commitment to protecting, promoting and supporting breastfeeding. It outlined six central components which it recommended should make up a national or regional breastfeeding policy. These are outlined below:

1. Policy and planning, management and financing recommended that a national policy should be based on the Global Strategy on Infant and Young Child Feeding (WHO, 2002) and that professional associations should issue recommendations and
practice guidelines based on the national policy. In addition, the designation of a suitably qualified co-ordinator was recommended.

2. **Communication for Behaviour and Social Change** highlighted the importance of communication for behaviour and social change, especially in countries where artificial feeding had become the norm. Such communication must be consistent with policies, recommendations and laws in that country. In addition, expectant and new parents should be able to receive full, correct and independent infant feeding information.

3. **Training** for all health worker groups and pre- and post-graduate groups was emphasised as needing improvement. Training materials should not be influenced by manufacturers of products that come under the scope of The Code.

4. **Protection, promotion and support** through reinforcement of The Code, promotion of breastfeeding at all policy levels so that breastfeeding is perceived as the norm and a commitment to establish best practice in all maternity and child-care institutions and provision of support at the individual level.

5. **Monitoring** of breastfeeding initiation, exclusivity and duration rates using standardised indicators, definitions and methods to ensure comparability across and within countries. While such definitions are not yet agreed upon within Europe, the need for this to be done quickly was highlighted in the Blueprint.

6. **Research** on many different aspects of breastfeeding is needed and the improvement of research within the EU, with regards to adequate study design, consistent use of standard definitions of feeding categories and appropriate qualitative research was highlighted.
1.4.3 Breastfeeding policy in Ireland

The first national breastfeeding policy for Ireland was published in 1994 (Department of Health, 1994) and it endorsed and advocated national implementation of the international breastfeeding initiatives of the WHO and UNICEF. The policy focused on breastfeeding in relation to five key areas: breastfeeding policy in hospitals, policy in communities, training of health professionals, promotion and support of breastfeeding in the wider community and setting of targets, implementation and monitoring of the policy. The policy set targets for improvement in rates of breastfeeding with breastfeeding initiation rates of 35% by 1996 and 50% by 2000 and amongst lower socio-economic groups rates of 20% and 30% respectively. It also set a target of 30% breastfeeding at four months by the year 2000.

In 1998 structures were put in place to establish the BFHI in Ireland. Currently there are twenty maternity units/hospitals in Ireland and nineteen of them participate in the BFHI. Depending on the degree of compliance and commitment to the BFHI, maternity units are awarded either Baby Friendly Status (hospital has fully implemented the Ten Steps to Successful Breastfeeding and the relevant articles of The Code), Certificate of Commitment (hospital has not met the global criteria for BFHI but is endeavouring to do so) or Membership level (hospital has identified and is beginning to put in place steps they need to take in order to begin the process of becoming baby friendly accredited). The Global Baby Friendly award is given when there is $\geq 75\%$ exclusive breastfeeding at discharge from the maternity hospital and the National Baby Friendly award is given when this criterion is not met but all other criteria are. In Ireland of the nineteen maternity units/hospitals which participate in the BFHI, six of them have been awarded
National Baby Friendly status\(^4\), three a Certificate of Commitment, seven Membership Level and three are in transition between levels or are in the process of renewal.

A National Breastfeeding Co-ordinator was appointed in 2001 and a National Committee on Breastfeeding was established in 2002. One of the main roles of this committee was to undertake a review of the Breastfeeding Policy for Ireland (Department of Health, 1994). They produced an interim report (Department of Health and Children, 2003b) and strategic action plan (Department of Health and Children, 2005). The Interim Report of the National Committee on Breastfeeding (Department of Health and Children, 2003b) found that as a result of the initial breastfeeding policy (Department of Health, 1994) breastfeeding promotion, protection and support in Ireland had improved and consequently there was a small increase in rates of breastfeeding. However, they also acknowledged that rates still fell far short of international recommendations. They found a lack of consistency in the training which was available for health professionals and while there was increased emphasis on training particular professions such as midwives, public health nurses (PHNs) and paediatric nurses, others such as doctors received little or no training.

The Interim Report facilitated the development of Breastfeeding in Ireland – A Five Year Strategic Action Plan (Department of Health and Children, 2005). The mission statement of this action plan is ‘to improve the nation’s health by ensuring that breastfeeding is the norm for infants and young children in Ireland’. The action plan was drawn up based on recommendations of The Global Strategy on Infant and Young

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\(^4\) Portumcula Hospital, Ballinasloe, St. Munchin’s Regional Maternity Hospital, Limerick, Rotunda Hospital, Dublin, Maternity Services, University College Hospital, Galway, Our Lady of Lourdes Hospital Drogheda and Cavan General Hospital, Cavan.
Child Feeding (WHO, 2002) and Protection, Promotion and Support for Breastfeeding in Europe: A Blueprint for Action’ (EU Project on Promotion of Breastfeeding in Europe, 2004). It draws on the five areas of health promotion as outlined in the Ottawa Charter (WHO, 1986). Each of the five goals of the action plan reflects one of the action areas of the Ottawa Charter and are based on the premise that a multi-faceted, cross-sectoral approach is more effective than stand-alone interventions to increase breastfeeding rates. Appendix V gives a summary of each of the goals and their objectives. The goals review breastfeeding in terms of the family, health sector, community, legislation and public policy and Irish society in general.

1.5 Maternity Care in Ireland

Women come to breastfeeding after encountering maternity services both before and after having a baby. They deal with different health professionals at different stages and these can include general practitioners (GPs), midwives, obstetricians, paediatricians, practice nurses and PHNs. Because of the different health professionals and disciplines involved in pregnancy, childcare and the postpartum period, fractured messages and support can be given for breastfeeding (Labbok, 2008). For this reason it has been suggested that synergy is needed between the different disciplines in their messages and protocols on breastfeeding (Labbok, 2008). One cannot, therefore, consider breastfeeding in Ireland without placing it within the context of the maternity services.

Under the Mother and Infant Care Scheme, all women in Ireland are entitled to maternity services free of charge until their babies are six weeks old (Department of Health, 1997b). One of the most common maternity care options which women choose
in Ireland is combined-care (Health Research and Information Division, 2009). This is where the woman’s GP provides about half of the antenatal care and the rest is provided by the maternity hospital/unit. This option of care can be chosen regardless of whether a woman decides on public, semi-private or private care. In 2007, the combined care option accounted for 77% of total births, hospital/obstetrician care accounted for 21% while a very small proportion of women delivered under other antenatal care schemes (midwifery-led units, early transfer home schemes, community and domino midwife schemes and home birth) (Health Research and Information Division, 2009). A description of each of the maternity care options available to women is described in Appendix VI. An illustration of the current pathway for maternity services, adapted from a report by KPMG (2008) can be seen in Figure 1.2.
Figure 1.2. Current pathway for maternity services. Boxes in pink indicate the model of care that most women receive (Adapted from KPMG, 2008)
In 2007 the average postnatal length of stay for spontaneous delivery for singleton births was 2.1 days and for a caesarean section 4.4 days (Health Research and Information Division, 2009). There has been a 30% increase in the number of live births in Ireland in the past ten years (Health Research and Information Division, 2009). In addition to this, maternity services are under increasing pressure with there being a shortage of nurses and midwives (Begley, 2008).

Maternity care in Ireland is mainly based on the medical/obstetric model of care (Wagner, 2001; Begley & Devane, 2003a). ‘Active management of labour’, which was pioneered in the National Maternity Hospital, Holles Street in 1969 reduces the length of active labour to less than 12 hours. Such management includes intervention in labour by direct involvement of the obstetrician in the care of women who are not progressing ‘normally’ in labour (Begley & Devane, 2003a). While such a practice is far from ideal, the reality in maternity hospitals in Dublin at the moment is that the current number of deliveries could not be provided without using active management (KPMG, 2008). In recent years Ireland has seen increasing use of interventions in childbirth with high rates of caesarean sections. Between 1999 and 2006 the prevalence of caesarean section delivery in Ireland increased by over a quarter (20.5% in 1999 to 25.5% in 2006) (Brick & Layte, 2009). The current rate is 10% - 15% higher than that recommended by the WHO (1985).

There has been criticism of maternity care from both health professionals and service users. Midwives have been found to be frustrated and disempowered with the obstetric led model of care (Keating & Fleming, 2008) because their own skills are not put to use nor valued within such a model. Nurses and midwives in Ireland have described general
dissatisfaction with their work due to staff shortages and increased turnover of senior staff which in turn resulted in ‘an immensely fragile working environment’ (McCarthy et al., 2002). Hyde & Roche-Reid (2004) found that midwives in Ireland felt undermined by the obstetric focus in childbirth and many described uses of technology which often did not enhance the health of the mother and baby but instead were used because they were preferred by the obstetrician, there was a need to accelerate deliveries because of staff shortages or the patient was private or public. Begley & Devane (2003b) proposed a midwifery-led model of care whereby normal childbirth is ‘endorsed, honoured and preserved’. They highlight the benefits of such care for both the women receiving the care and the midwives providing it. The ‘busyness’ of maternity units and the need for extra staff to improve the quality and continuity of care for all women using maternity services has been discussed in the literature (Lyons et al., 2008). There has also been a steady increase in the number of foreign staff in recent years with foreign staff accounting for roughly 8% of nursing and midwifery staff in Ireland (Aiken et al., 2004).

Recent reports and policy documents in Ireland have recommended that women should have access to a full range of maternity services which offer safe, evidence-based care (Kinder, 2001; Health Service Executive (HSE), 2004; Institute of Obstetricians & Gynaecologists, 2006). In particular, it has been recommended that women should have access to midwifery-led and community based care. Hatem et al., (2008) described the underlying philosophy of midwife-led care being normality and being cared for by a known and trusted midwife during labour. A report by KPMG (2008) of maternity and gynaecology services in the Greater Dublin Area, which was commissioned by the HSE,
discussed the issue of the current model of care (Figure 1.2) being, “by international standards, relatively hospital focused with a strong emphasis on medically-led (doctor) services”. The report also criticised primary care in general, including maternity services being ‘underdeveloped in terms of access, choice, equity and information’. They called for midwifery-led, community models of care being made available to women and they also highlighted the importance of developing primary care. The research by KPMG found staffing levels and internal infrastructure to be inadequate in each of the three maternity hospitals in Dublin city centre. The evidence for the success of midwifery-led units is strong both internationally and nationally. Begley et al., (2009a) evaluated the first ever midwifery-led units in the Republic of Ireland and found that such care resulted in less intervention, was as safe as consultant-led care and cost less. In addition, in some aspects of care it was viewed by women with greater satisfaction. Currently in Ireland there are two midwifery-led units: Our Lady of Lourdes, Drogheda and Cavan General Hospital.

Within the community, on discharge from hospital, postnatal care is provided by a PHN and GP. Under the Mother and Infant Care Scheme (Department of Health, 1997b) the GP does a two week check on the baby and a six week check on both the mother and baby. PHNs are nurses that are available within the community to individuals, families and population groups. PHNs are considered to be generalist nurses with the vast majority having responsibility to a range of different groups such as the elderly, terminally ill, psychiatric clients, school-going children and those requiring clinical care (Hanafin & Cowley, 2005). Up until 2007, registration as a PHN required a qualification in midwifery. Now instead, student PHNs are required to take a module in maternal and
child health nursing. In 2008, approximately two thirds of the student PHNs did not have a midwifery qualification (O'Dwyer, 2009). Because this happened only recently, the effect on postnatal care remains to be seen. PHNs are an important point of contact for mothers in the postnatal period with PHNs expected to visit mothers and their babies within 48 hours of discharge from hospital (National Children's Office, 2005). The average national compliance with this primary visit performance indicator is 72%. However, rates of compliance vary around the country with between 57.5% compliance in HSE Dubin North-East and 85% in HSE West (Department of Health and Children, 2008).

PHNs assess the needs of the mother and baby and on this basis they suggest further intervention if it is necessary or tell the mother about support groups in the area (O'Dwyer, 2009). Some PHNs run ‘well baby clinics’ and breastfeeding support groups (Leahy-Warren et al., 2009). In addition, there are PHN-led initiatives such as the Community Mothers Programme which involves non-professional volunteer community mothers delivering a child development programme to first time mothers and it has been found to be a successful programme (Johnson et al., 1993). While the remit within which PHNs operate is wide there is also inequity in the ratio of PHNs to population. The recommended ratio is 1:2,500 (Department of Health, 1997a), however, Hanafin & Cowley (2005) found that this varied between and within health boards with a mean population size of 4000 and a range of between 500 and 16,500 for one PHN. Such disparity and inequity had implications for the service which they could give clients and for the way in which their service was perceived by clients (Hanafin & Cowley, 2005).
In addition to PHNs and GPs, practice nurses may also play a role in promoting and supporting breastfeeding in the postnatal period. Shannon (2006) described the four main roles of the practice nurse in general practice as being in supporting the general practitioner in the care of acutely ill patients, monitoring patients with chronic illness, taking initiative in preventative medicine programmes and finally in promoting health amongst patients. The report of maternity and gynaecology services in the Greater Dublin Area (KPMG, 2008) recognised a range of health professionals such as obstetricians, midwives, GPs, PHNs and practice nurses, as being fundamental to high quality maternity care. Each of these professionals, therefore, play a lesser or greater role in promoting and supporting breastfeeding depending on their area of work and professional circumstances.

1.6 Determinants of breastfeeding initiation and duration

1.6.1 Determinants of breastfeeding initiation

The reasons why women decide to breastfeed or formula feed are often complex and multifactorial. Thulier and Mercer (2009) described breastfeeding as not being strictly physiological and they emphasised the social and emotional factors that play a role in breastfeeding. In general, women in developed countries who breastfeed tend to share similar socio-demographic features (Dyson et al., 2005). Breastfeeding initiation rates are positively correlated with higher socio-economic status and this has been noted in Australia (Scott & Binns, 1999), America (Singh et al., 2007), the UK (Wright et al., 2006; Bolling et al., 2007) and Ireland (Twomey et al., 2000; Ward et al., 2004; Tarrant, 2008; Begley et al., 2009b). In Ireland, 70% of professional workers initiate
breastfeeding compared with 37% of semi-skilled workers (Begley et al., 2009b). Increasing age is also positively associated with breastfeeding initiation, with older mothers tending to initiate breastfeeding more than younger ones (Scott et al., 2001; Gudnadottir et al., 2006; Begley et al., 2009b). Mothers who are more educated are also more likely to initiate breastfeeding (Ward et al., 2004; Gudnadottir et al., 2006; Tarrant et al., 2010). In addition, ethnicity is a factor amongst those who breastfeed. Tarrant et al., (2010) found that while only 47% of Irish women initiated breastfeeding, 80% of non-Irish women did. Such disparities have also been found in America with breastfeeding rates lowest amongst native women and highest amongst all immigrant women (Gibson-Davis & Brooks-Gunn, 2006; Singh et al., 2007).

Maternal factors play an important role in whether breastfeeding is initiated. Women who decide to breastfeed before becoming pregnant or in early pregnancy are more likely to initiate breastfeeding than those who do not (Scott et al., 2001; Ward et al., 2004; Kools et al., 2005; Tarrant et al., 2010). Bolling et al., (2007) found there was a high correlation between intention and actual feeding behaviour. In addition, having a previous positive experience of breastfeeding or knowing someone who has breastfed is also associated with breastfeeding initiation (Meyerink & Marquis, 2002; Bolling et al., 2007). Predictably, having a previous negative experience of breastfeeding is associated with not breastfeeding (Begley et al., 2009b).

A woman’s social circle influences whether she initiates breastfeeding (Swanson & Power, 2005) and women who receive positive encouragement from their partner and mother are more likely to initiate breastfeeding (Tarkka et al., 1999). Hearing about the benefits of breastfeeding from a range of people such as family, partner and health
professionals has been found to be positively correlated with breastfeeding intention (Humphreys et al., 1998). Women who have a positive attitude towards breastfeeding (Losch et al., 1995) and are aware of and appreciate the benefits of breastfeeding (Brodribb et al., 2007a; Begley et al., 2009b; Tarrant et al., 2010) are more likely to initiate breastfeeding than those who do not. Avery et al., (2009) described the importance of women having a “confident commitment” to breastfeed in order to breastfeed ‘successfully’.

Finally, health system factors such as the quality of the woman’s experience in hospital, receiving information about breastfeeding and being encouraged by a health professional to breastfeed are associated with breastfeeding initiation (Kuan et al., 1999; Lu et al., 2001; Bolling et al., 2007). Type of delivery can also affect breastfeeding initiation with women who have a caesarean section less likely to breastfeed (Ever-Hadani et al., 1994; Pechlivani et al., 2005) or to experience a significant delay in initiating breastfeeding (Rowe-Murray & Fisher, 2002).

### 1.6.2 Determinants of breastfeeding duration

The World Health Organisation recommends that infants be breastfed exclusively for the first six months followed by continued breastfeeding with complementary foods for up to two years (WHO, 2003). Many women do not, however, meet this recommendation and for a variety of reasons they discontinue breastfeeding. Thulier & Mercer (2009) identified multiple variables which influence breastfeeding duration and they divided these into four groups: demographic, biological, social and psychological. As with the reasons for initiating breastfeeding, reasons for discontinuing are also multifactorial.
**Demographic variables:** Socio-economic status, maternal age, maternal education level and ethnicity are all associated with breastfeeding duration. The older a woman is the more likely she is to breastfeed for longer (Scott & Binns, 1999; Susin *et al.*, 1999; Hodinott *et al.*, 2000; Dubois & Girard, 2003). Higher socio-economic status has been associated with longer duration of breastfeeding (Dennis *et al.*, 2002; Flacking *et al.*, 2007). A study in Canada found that a mother’s education level is the strongest factor of influence on breastfeeding from birth to three months (Dubois & Girard, 2003). Gibson-Davis & Brooks-Gunn (2006) found that immigrants in the US were significantly more likely to breastfeed than non-immigrants and for longer. However, they found a negative influence of living in the US on immigrants’ breastfeeding practices, with every additional year in the US associated with a 4% decrease in the odds of breastfeeding and a 3% decrease in the odds of breastfeeding at 6 months.

**Biological variables:** Maternal smoking, type of birth, mothers finding breastfeeding difficult and perceiving they have insufficient milk are all associated with women discontinuing breastfeeding. In a meta-analysis of breastfeeding duration amongst smoking and non-smoking mothers, Horta *et al.*, (2001) found maternal smoking increases the risk of early weaning. This association was also identified by Scott *et al.*, (2006). Tarrant *et al.*, (2010) found that the main reasons for women discontinuing breastfeeding at 6 weeks were maternal tiredness, the demands of feeding and perceiving inadequate milk supply. Perceiving insufficient milk is also a reason for women to discontinue breastfeeding (Wright *et al.*, 2006) and unfortunately, in response to women thinking that they are not giving their baby enough milk, they usually supplement with formula and this is also associated with a reduced milk supply and a shorter duration of
breastfeeding (Ekstrom et al., 2003; Li et al., 2004). Having a caesarean section is also associated with shorter duration of breastfeeding (Shawky & Abalkhail, 2003; Begley et al., 2009b). In addition, DiGirolamo et al., (2008) found that not giving pain medication to mothers during delivery was protective against breastfeeding termination.

**Social variables:** Support from significant others and also from health professionals contribute to breastfeeding success (Britton et al., 2007). Women who perceive their partner or mother to prefer breastfeeding have consistently higher breastfeeding rates than those who do not (Scott et al., 2006). On the contrary, women with moderate to poor support are less likely to be breastfeeding at three months (Hoddinott et al., 2000). Support in hospital is associated with increased duration and length of exclusive breastfeeding (Dennis et al., 2002). Women consider having support from healthcare professionals as being critical to their continued breastfeeding (Dillaway & Douma, 2004) and being satisfied with the help and support given in hospital is associated with longer duration of breastfeeding (Rajan, 1993; Tarkka et al., 1998; Kuan et al., 1999). Hospital practices and commitment to the Baby Friendly Initiative are also associated with longer duration of breastfeeding (Merten et al., 2005). A lack of professional support is associated with early weaning and decreased exclusivity of breastfeeding (Taveras et al., 2004b). While support in hospital is important, additionally support post-discharge also increases breastfeeding duration (Sikorski et al., 2003). Gill et al., (2007) found that women who received a home visit from a public health nurse within 2 weeks after birth had significantly longer duration of breastfeeding.

**Psychological variables:** Maternal self efficacy (Dennis, 1999; Dennis, 2006; Ekstrom & Nissen, 2006), intention to breastfeed (DiGirolamo et al., 2005; Scott et al., 2006) and
having a positive attitude towards breastfeeding (Scott et al., 2006) are important
determinants of breastfeeding duration.

1.7 Health professionals and breastfeeding

As previously discussed there are several factors that potentially influence the incidence
and success of breastfeeding and one of those factors is the provision of accurate
information and support to the breastfeeding mother during both breastfeeding initiation
and continuation. Studies have shown that women who receive skilled support and
advice on breastfeeding have a more positive breastfeeding experience and also
breastfeed for longer (Duffy et al., 1997; Ingram et al., 2002; Sikorski et al., 2003;
Renfrew, 2005). Interventions involving breastfeeding education of healthcare providers
improves breastfeeding initiation rates (Dyson et al., 2005) and additional professional
support, from medical, nursing and allied professionals, helps prolong exclusive
breastfeeding (Britton et al., 2007). However, inadequate or inappropriate support and
advice from health professionals can have negative consequences on breastfeeding
(Dennis et al., 2002; DiGirolamo et al., 2003; Sheehan et al., 2009; Montalto et al.,
2010). Women consistently recognise the importance of skilled supportive health
professionals in order to establish and maintain successful breastfeeding (Tarkka et al.,
1998; Hoddinott & Pill, 2000; Raisler, 2000; Simmons, 2002). Health professionals are,
however, ‘likely to have been socialised through the same culture as the women they
support’ (Dykes, 2005a) and so may not have the knowledge nor a positive attitude to
support breastfeeding. In addition, they often lack the confidence to support women and
recognise breastfeeding as a gap in their education (Smale et al., 2006). Despite this,
health professionals are sometimes considered to have the greatest knowledge of breastfeeding (Hauck & Irurita, 2003) but are often unable to provide appropriate counselling (Coreil et al., 1995).

1.7.1 **Health professionals and their role**

Health professionals differ in how they view their role in promoting breastfeeding, with some feeling that it is something they should promote, others feeling more neutral about it, others feeling obligated to promote it because of hospital policy and others expressing a primary focus on the bigger picture of the maternal experience (Nelson, 2007). In addition, there can be discrepancies between what health professionals think is their role in promoting and supporting breastfeeding and what their clients think, with health professionals playing down the importance of their role (Dillaway & Douma, 2004; Taveras et al., 2004a). Breastfeeding is sometimes considered by healthcare workers to be something that one either ‘believes in’ or not and having this belief then leads on to acquiring knowledge and supporting it (Smale et al., 2006). All healthcare workers need to be educated about breastfeeding and they all need to be able to support and promote it in order that they can inform on breastfeeding opportunistically (Zalkin & Jackson, 2009). Labbok (2008) discussed the fractured messages and support that can be given for breastfeeding because of the different health professionals and disciplines involved and she emphasised the need for synergy between the different disciplines in their messages on breastfeeding.

Doctors often do not see their role in supporting breastfeeding as they do not feel they are the most appropriate people to advise or assist with it (Brodribb et al., 2007b). In
Ireland, GPs are likely to be the first health professional a mother encounters in her pregnancy. They therefore have the opportunity to promote breastfeeding antenatally and also due to their role in the postnatal period, they can also support breastfeeding postnatally (Tarrant & Kearney, 2008). A recent study by O’Brien et al., (2008) indicated a lack of communication from GPs about feeding with nearly a half of those surveyed not recalling infant feeding being discussed at any of their antenatal visits. This research was a pilot study with a small sample size and so there are issues of the results not being generalisable, however, they indicate a lack of effort by GPs to promote breastfeeding. This is a pity as another study in Ireland found that a positive intervention by a doctor in the last month of pregnancy was associated with an increase in breastfeeding initiation and duration (Loh et al., 1997).

Apart from these two studies, very little research has been conducted in Ireland which has considered the role of health professionals in supporting breastfeeding. It is therefore necessary to look at studies from other countries, however, there is difficulty in doing this because of the lack of transferability of the research findings. The training which healthcare workers receive and their responsibilities in supporting breastfeeding differ between countries. In addition, some countries have high rates of breastfeeding and others low rates and so in the case of the former, health professionals are likely to deal with breastfeeding issues more than in the latter. While bearing these limitations in mind, research from other countries does help provide a better understanding of the role of health professionals in providing support for breastfeeding and also of their knowledge and attitudes towards breastfeeding.
The role of paediatricians in America in protecting, promoting and supporting breastfeeding has been clearly delineated by the AAP (Gartner et al., 2005). They have recommended that paediatricians and other healthcare professionals advocate breast milk for all babies unless it is contraindicated and that they provide parents with information on the benefits and techniques of breastfeeding so that women can make fully informed decisions. A study in the US of women who attended an early, routine, preventive, outpatient visit, with a paediatrician or family physician, providing breastfeeding support to women, resulted in significantly greater rates of exclusive breastfeeding at four weeks and longer breastfeeding duration, compared with those that had received usual care (Labarere et al., 2005). The role of obstetricians in promoting and encouraging women to breastfeed has also been emphasised in the US (Lawrence, 1982; Howard et al., 1993).

While the role of doctors in promoting breastfeeding is not well defined in Ireland, that of midwives and PHNs is and their role in the support and promotion of breastfeeding is well established. They are the main health professionals responsible for providing support for breastfeeding in hospital and the community. A recent review of breastfeeding support services provided by PHNs in Ireland found that PHNs had a positive attitude towards breastfeeding and expressed confidence in their provision of breastfeeding support (Leahy-Warren et al., 2009). Midwives have described a lack of resources as an obstacle to delivering care to breastfeeding mothers (Meaney, 2004). This has also been found to be the case in the UK where midwives have described deep dissatisfaction with the environment in which they work and the subsequent negative effect this has on the care that they can give women (Curtis et al., 2006).
1.7.2 Health professionals’ knowledge and attitudes towards breastfeeding

Health professionals having knowledge about breastfeeding has been found to be the greatest predictor of supportive behaviour for breastfeeding (Bernaix, 2000). Quite a lot of quantitative research has been conducted looking at the knowledge and attitudes of health professionals towards breastfeeding. Such research is of varied standard (Wallace & Kosmala-Anderson) with some having response bias (Register et al., 2000; Cantrill et al., 2003; Smale et al., 2006), low response rate (Cantrill et al., 2003) and the absence of tests of significance (Hellings & Howe, 2000). Despite these limitations, studies have focused on GPs, midwives, paediatricians, obstetricians, health visitors and paediatric nurses and have found knowledge deficits (Freed et al., 1995; Schanler et al., 1999; Bernaix, 2000; Guise & Freed, 2000; Hellings & Howe, 2000; Cantrill et al., 2003; Finneran & Murphy, 2004; Renfrew et al., 2006; Wallace & Kosmala-Anderson, 2006; Nakar et al., 2007; Wallace & Kosmala-Anderson, 2007; Leavitt et al., 2009). Knowledge about breastfeeding can vary between different health professional groups. In Northern Ireland, health visitors were found to have the highest level of knowledge and GPs the lowest (Bleakney & McErlain, 1996).

GPs in Ireland have been found to have knowledge deficits despite rating themselves confident in dealing with breastfeeding issues (Finneran & Murphy, 2004). This study also found, however, that those with formal training in breastfeeding had better knowledge. While GPs and paediatricians in the UK believe that they are at least competent in most of the skill areas of breastfeeding support, a sizeable minority admit to not being competent in key areas of breastfeeding management (Wallace & Kosmala-Anderson, 2006). Research in Australia has also found knowledge deficits amongst
midwives, in particular in knowing the immunological value of breast milk and in managing low milk supply and a breast abscess (Cantrill et al., 2003). Health professionals have been found to not only base their knowledge of breastfeeding on research based evidence but instead use a number of sources of knowledge: own personal experience of breastfeeding, formal evidence base, guidelines and policies, training courses, colleagues’ knowledge and knowledge of what has ‘worked’ for women in the past (Marshall et al., 2006).

Having personal experience of breastfeeding is often associated with health professionals feeling more knowledgeable about it. They sometimes look to their own personal experience of breastfeeding when giving advice (Simmons, 2002) or think they cannot advise on breastfeeding if they do not have personal experience (Dillaway & Douma, 2004). Doctors have reported having personal experience of breastfeeding as being their most useful source of breastfeeding knowledge (Brodribb et al., 2009). Arthur et al., (2003) found that female physicians that had breastfed were more comfortable diagnosing and treating some clinical issues related to breastfeeding compared to female physicians who did not have this experience. Health professionals who have personal experience of breastfeeding sometimes feel a special ‘connection’ with breastfeeding mothers and see themselves as being more committed to breastfeeding than those who have not breastfed (Nelson, 2007). In addition, those who have never breastfed tend to give more prescriptive advice and stick ‘by the book’ in relation to their breastfeeding recommendations (Marshall et al., 2006; Nelson, 2007). The definition of personal experience can, however, differ between studies with some defining it as ever breastfed (Freed et al., 1995; Patton et al., 1996), breastfed at least
three months (Cantrill et al., 2003) or comparing those who had children and breastfed with those who had children and did not breastfeed (Schanler et al., 1999). Caution must therefore be taken in interpreting results from previous research in this area.

Ekstrom et al., (2005b) discovered four different types of attitudes towards breastfeeding amongst midwives and nurses; facilitating, regulating, disempowering and breastfeeding antipathy. Those who facilitated were more likely to trust the mother baby unit to manage breastfeeding while those in regulating and disempowering were found not to be supportive of breastfeeding and did not consider mothers and babies as being very well able to manage their situation themselves. Those scoring high in the antipathy factor were found to have very little interest in breastfeeding and were in general ignorant of breastfeeding techniques. While most health professionals would not question the superiority of breast milk, they were less prepared to agree with specific reasons as to why this was the case (Beeken & Waterson, 1992). Health professionals can have ambivalent and negative attitudes towards breastfeeding (Kim, 1996; Schanler et al., 1999; DiGirolamo et al., 2003).

1.7.3 Barriers to promoting and supporting breastfeeding amongst health professionals

Research from other countries has found barriers which prevent or discourage health professionals from supporting breastfeeding. They include, healthcare professionals not feeling adequately trained (Smale et al., 2006; Brodribb et al., 2007b), not having personal experience of breastfeeding (Brodribb et al., 2007c), poor professional practice (Simmons, 2002), struggling not to appear like a 'breastfeeding bully' (Dillaway &
Douma, 2004; Tennant et al., 2006) and a lack of time to adequately support women (West & Topping, 2000; Lyons et al., 2008). There have been no studies conducted in Ireland looking at the issue around barriers for health professionals in providing breastfeeding support.

1.7.4 Health professionals and education around breastfeeding

Breastfeeding education for health professionals has been described as inadequate and fragmented (Smale et al., 2006). Spiby et al., (2009) described the preliminary breastfeeding education provided to health-care professionals as ‘varying in amount, scope, orientation and philosophical model’. Education around breastfeeding is, however, important as it has been found to improve health professionals’ knowledge of and attitudes towards breastfeeding (Rea et al., 1999; Dinwoodle et al., 2000; Wissett et al., 2000; Cattaneo & Buzzetti, 2001; Hillenbrand & Larsen, 2002; Durand et al., 2003; Ingram, 2006) and helps to increase breastfeeding initiation and duration rates (Martens, 2000; Taddei et al., 2000; Kramer et al., 2001). Education interventions have involved training based on the WHO and UNICEF Breastfeeding Management Course which was developed in support of the BFHI in 1993 (Dinwoodle et al., 2000; Cattaneo & Buzzetti, 2001; Kramer et al., 2001; Kronborg et al., 2008), interventions using multi-media (Hillenbrand & Larsen, 2002; Ingram, 2006) and short stand-alone informal courses (Martens, 2000; Abbott et al., 2006).

In Ireland, apart from specialist areas such as midwifery, public health and neonatal nursing, specific focused sessions on breastfeeding during undergraduate education are rare and instead it is incorporated into subjects such as biology, anatomy, behavioural
sciences and nutrition (Department of Health and Children, 2003b). In-service courses, such as the ‘18-hour breastfeeding management’ course or the ‘18-hour refresher’ course are generally offered to midwives, public health nurses and paediatric nurses and while hospital doctors and GPs are offered places on such courses, uptake is low (Department of Health and Children, 2003b). Most 18-hour breastfeeding management courses are based on the Ten Steps to Successful Breastfeeding with trainers adapting the course to suit their audience (Healy, 2004). There is no recognised content for the 18-hour breastfeeding management course and so the content may vary depending on the course facilitator. In addition, while in most cases courses are delivered by International Board Certified Lactation Consultants (IBCLC), there is no common standard for those providing breastfeeding training in Ireland (Department of Health and Children, 2003b). In a study of trainer’s reflections on the 18-hour breastfeeding course, Healy (2004) found that trainers wanted the course to be more standardised, the addition of a practical element to the course and also the development of modules based on adult education theories. Interestingly, at an international level, in 2009 the WHO and UNICEF revised and updated the BFHI and extended the 18 hour breastfeeding management course to 20 hours with at least three hours of supervised clinical experience (WHO & UNICEF, 2009). In training to be a GP, all doctors have to complete a compulsory module in women’s health. Breastfeeding, including its advantages, strategies to address with a pregnant woman and postnatal support are included in the syllabus for the module. There are also opportunities for GPs to update their skills around breastfeeding through continuing medical education (CME) small group activities.
1.8 Women and their experience of professional support for breastfeeding

While some health professionals feel that it would be best to have ‘breastfeeding-experts’, women feel that all health professionals should have some knowledge of breastfeeding and be able to give support (Dillaway & Douma, 2004). In addition, women have described the need for health professionals to have basic skills to support breastfeeding and also being able to communicate with them and understand their feelings (Smale et al., 2006). While healthcare workers are sometimes afraid of putting too much pressure on women to breastfeed (Frossell, 1998), women have been found to want encouragement and information about breastfeeding from their care providers in the antenatal period (Raisler, 2000). Nelson (2006) conducted a metasynthesis of qualitative breastfeeding studies and she found that mothers looked to health professionals for information, technical and emotional support. The availability and time that a health professional could offer a woman were considered the most important characteristic. Women have described good support as individual, clear, believable, gracious, caring, compassionate, positive and friendly (Nelson, 2006) and they feel that it is important that health professionals give them confidence in their ability to breastfeed (McInnes & Chambers, 2008; Sheehan et al., 2009).

Women have described frustration with hearing the benefits of breastfeeding from health professionals but not actually getting practical help with it (Hodginnott & Pill, 2000). This lack of practical information and help sometimes results in women discontinuing breastfeeding earlier than they had hoped (Lewallen et al., 2006). Women have also described not feeling prepared for breastfeeding (Graffy & Taylor, 2005) and despite
attending antenatal classes and seeking information, they still needed practical support and guidance (Sheehan et al., 2009). For many women the ‘reality of breastfeeding’ does not meet their expectations, namely of breastfeeding being natural and an innate skill (Bailey & Pain, 2001), and women have described wanting more realistic antenatal information whereby advice is given on how to overcome problems that may arise but with a positive spin that breastfeeding does get easier with time (Bailey et al., 2004).

Shakespeare et al., (2004) found that women did not appreciate health professionals giving advice ‘by the book’ and instead preferred more practical advice and support. They also found that some women thought that the advice from a health professional who had not breastfed herself was not authentic and would have preferred the healthcare provider to have had personal experience of it. In addition, women resented being told to just persevere with breastfeeding especially if this advice was given without additional practical and emotional support (Hoddinott & Pill, 2000).

1.9 **Interventions to promote and support breastfeeding**

Interventions to promote and support breastfeeding can be put in place both in the antenatal and postnatal stages and can involve a range of people. Because of the many determinants associated with both breastfeeding initiation and duration there is a need for multifaceted interventions to promote breastfeeding (Cattaneo, 2009). This approach has been adopted in Australia’s most recent National Breastfeeding Strategy, whereby breastfeeding is recognised as occurring on a continuum that starts well before the birth of a baby and continues on through several stages such as prenatal, immediate postnatal and medium postnatal stage (Australian Health Ministers' Conference, 2009). Specific
interventions to protect, promote and support breastfeeding are targeted at the different stages, in a multi-faceted approach. In Ireland, it has been recommended that interventions to improve rates of breastfeeding should focus on both encouraging women to breastfeed and also providing support for women once they leave hospital (Tarrant & Kearney, 2008). In addition, interventions are needed to address the negative cultural perceptions of breastfeeding through more creative breastfeeding campaigns (Tarrant & Kearney, 2008).

Media campaigns have been found to improve attitudes towards breastfeeding and in particular targeted media campaigns can improve initiation rates (Fairbank et al., 2000). The provision of leaflets explaining the benefits of breastfeeding is not beneficial in improving rates (Fairbank et al., 2000; Guise et al., 2003). However, promoting breastfeeding in the antenatal period combined with practical education improves breastfeeding initiation and duration rates (Guise et al., 2003). In particular, education which reviews the benefits of breastfeeding, myths and common lactation problems and skills training is beneficial to women who want to breastfeed. Also, tailored antenatal education combined with pro-active postnatal support in hospital and the community has been found to be beneficial for enhancing breastfeeding duration (Renfrew et al., 2005).

Professional and social support is an important determinant of breastfeeding initiation and duration. Research has shown that the availability of skilled peer and professional support in maternity hospitals and the community is associated with longer breastfeeding. Face-to-face support is more effective than support by telephone (Sikorski et al., 2003; Britton et al., 2007). Interventions involving the education of fathers about breastfeeding have resulted in them being more supportive of breastfeeding and this lead
to a subsequent increase in breastfeeding duration amongst their partners (Pisacane et al., 2005). Breastfeeding support groups are also effective ways of increasing breastfeeding prevalence (Alexander et al., 2003; Ingram et al., 2005).

A Cochrane Review by Dyson et al., (2005) found that health education in the form of one-to-one, informal sessions in the antenatal and postnatal period are effective at increasing breastfeeding initiation rates. In addition, peer support has been found to be a successful strategy for women who have decided to breastfeed (Renfrew et al., 2005). Changes to the health care system have been effective at increasing both breastfeeding initiation and duration rates (Dyson et al., 2005; Renfrew et al., 2005; Britton et al., 2007). These changes include employing some of the ‘Ten Steps to Successful Breastfeeding’ such as ‘rooming-in’ for mothers and their babies, reduced use of artificial milk and education of health professionals around breastfeeding. While lay support for breastfeeding has been found to increase breastfeeding duration rates (Britton et al., 2007), professional support was not found to be as effective. However, a combination of professional and lay support is more effective than either on their own (Britton et al., 2007). Providing women with consistent advice and support about breastfeeding technique and lactation management in the immediate post-natal period, increases exclusive breastfeeding at both two and six weeks (Ingram et al., 2002). In addition, teaching women positioning and attachment of the baby on the breast in antenatal classes improves their breastfeeding experience (Duffy et al., 1997).

1.10 Limitations of the current literature

As was mentioned previously, much of the data which are available on health
professionals and their knowledge and attitudes towards breastfeeding comes from other countries. While these data are useful in understanding the issues around professional support for breastfeeding it is not possible to generalise the findings to Ireland because the health system and cultural context is often not comparable to other countries. Equally, much of the data on interventions which have been put in place to promote and support breastfeeding come from studies abroad and may be specific to the culture and practices of those countries. It is important therefore that data specific to Ireland are recorded so that areas which need improvement can be identified. There is a paucity of information about professional support for breastfeeding in Ireland. In particular, there is no research which has looked at health professionals and their support of breastfeeding and women’s experience of professional support for breastfeeding.

1.11 Conclusions

Breastfeeding is the superior form of feeding for the growth, development and health of infants (Gartner et al., 2005). Breastfeeding also has health benefits for mothers, in addition to social, economical and environmental benefits (Gartner et al., 2005). Low rates of breastfeeding are, however, an important public health issue in Ireland (Begley et al., 2009b; Tarrant et al., 2010). The reasons why women decide to breastfeed or not are multi-factorial and so interventions to increase rates are needed at different levels of society. One such level is in the care that women receive from health professionals, before, during and after having their baby. Adequate promotion and support of breastfeeding by health professionals is an important determinant of breastfeeding initiation and duration (Sikorski et al., 2003; Renfrew et al., 2005), however, healthcare
workers often lack a positive attitude and knowledge about breastfeeding (Freed et al., 1995; Finneran & Murphy, 2004; Wallace & Kosmala-Anderson, 2006; Wallace & Kosmala-Anderson, 2007). There is currently a lack of information in Ireland on the issues for health professionals in protecting, promoting and supporting breastfeeding and women’s experience of professional support for breastfeeding. Such information would help identify areas for improvement around professional support for breastfeeding.

1.12 Aims and objectives of this research

The aim of this study was to understand health professionals’ perspectives on breastfeeding, their knowledge and attitudes towards breastfeeding and their self efficacy in dealing with breastfeeding issues, as well as perceived barriers to providing support and issues around breastfeeding education. A second part of the study looked at women’s experiences of professional support in the first year postnatally.

The specific objectives were as follows:

- To determine the knowledge and attitudes of health professionals towards breastfeeding
- To ascertain their self efficacy in dealing with certain breastfeeding issues
- To examine the barriers for health professionals in providing support
- To explore issues around breastfeeding education for health professionals
- To determine what the issues are for health professionals in supporting breastfeeding
- To investigate women’s experiences of professional support for breastfeeding in the first year postnatally.
These objectives are addressed in chapters three, four and five.

Finally, the last part of this study considered the possible role of using drama in promoting breastfeeding, amongst both health professionals and people in the community. This study is described in chapter six.
1.13 **Structure of the research**

The structure and the sequence of the research are described in Figure 1.3.

![Diagram of research structure](image)

**Figure 1.3. Structure of the Research**
CHAPTER TWO

2 Research Design and Methods

This chapter describes the general methods used in chapters three, four and five. A justification of the research approach is given along with an explanation of the methods used for both the quantitative and qualitative research.

2.1 Research design

The research design in this study incorporated a quantitative phase followed by two qualitative phases. Such a research design is known as mixed method methodology because both qualitative and quantitative methodologies were used. Mixed methods is relatively new to the research tradition and it has both its critics and supporters. Quantitative, qualitative and mixed methods methodology all approach research from different philosophies/paradigms, with that of quantitative methodology being post-positivist, qualitative methodology being constructivist and mixed method methodology being pragmatic (Teddlie & Tashakkori, 2009). The differences in the paradigms from which the methodologies originate have lead to criticism that these methodologies should not be mixed in the same study. Such criticism, while being valid, approaches research from a philosophical perspective and does not appreciate that mixed method methodology can provide a practical and pragmatic approach to research. Mixed method methodology has been described as an expansive and creative form of research which
allows research methods to follow research questions, offering the best chance to obtain useful answers (Burke Johnson & Onwuegbuzie, 2004). Patton (2002) described how ultimately in research a pragmatic approach must be taken and while accepting the value of intellectual, philosophical and theoretical approaches to qualitative research, he described how methods can be separated from the epistemology from which they originated. Mixed methods research incorporates the strengths of both methodologies (Burke Johnson & Onwuegbuzie, 2004). Patton (2002) described how quantitative data identify areas of focus within an area, while qualitative data give substance to those areas of focus adding depth and detail. Qualitative research is, however, not without its weaknesses and while it provides understanding and description of people’s own experience of phenomena, the knowledge produced may not be generalisable to other people or settings (Burke Johnson & Onwuegbuzie, 2004). In addition, the results are more easily influenced by the researcher’s personal biases (Burke Johnson & Onwuegbuzie, 2004). Grbich (2007) described one of the advantages of combining qualitative and quantitative methods as, ‘providing detail of individual experiences behind the statistics’. The findings of a qualitative study can add depth of understanding to quantitative data which can help by providing greater insight into the issue being studied. It was this for this reason that mixed methods were used in this research.

Teddlie & Tashakkori (2009) used the term sequential mixed designs to describe studies in which at least two strands occur chronologically and in which both have equal status. The studies can take the form of Quantitative → Qualitative or Qualitative → Quantitative. The conclusions of the first strand lead to the formulation of questions for the next strand. The final conclusions are based on the results of both strands of the
study. In my research such a research design was used whereby an initial quantitative study was followed by a qualitative study, which expanded on the results of the quantitative phase. In addition, a further qualitative study was conducted which complemented the first two studies (Figure 2.1).
Figure 2.1. Illustration of sequential mixed design where a quantitative study is followed by a qualitative study (Adapted from Teddlie & Tashakkori, 2009). The qualitative study is subsequently followed by another qualitative study, as can be seen on the right.
2.2 Setting

This study was conducted amongst health professionals in North Dublin. North Dublin comprises part of the larger HSE Administration Area of HSE Dublin North East which is made up of counties Louth, Meath, Cavan, Monaghan and Dublin City, north of the river Liffey. The HSE provides a wide range of community health services through a network of 32 Local Health Offices (LHO) and local health centres. North Dublin has three LHOs: Dublin North West, Dublin North Central and Dublin North. The population of North Dublin is 534,521, of which 72,834 are non-Irish, 39,325 of whom are European and 33,509 from the rest of the world (Central Statistics Office, 2006). Thirty two percent of the population are in social classes one and two (professional workers and managerial and technical positions) and 44% in social classes three, four and five (non-manual, skilled manual and semi-skilled positions) (Central Statistics Office, 2006). This distribution is the same as that of the general population in Ireland (Central Statistics Office, 2006). North Dublin has one maternity hospital, the Rotunda hospital. This hospital has seen a rise, in recent years, in the number of live births (Table 2.1). It achieved a National Baby Friendly award in 2006.

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2.3 Ethical approval

Ethical approval was obtained from Dublin Institute of Technology Ethics Committee for each of the three studies (references 06/07; 16/08; 20/09). In addition, the qualitative study which was conducted in the Rotunda Hospital received ethics approval from their Research Ethics Committee.

2.4 Quantitative study

The aim of the quantitative study was to establish health professional’s (GPs, PHNs and practice nurses) perspectives on breastfeeding from six different aspects: their knowledge and attitudes towards breastfeeding, self efficacy in dealing with breastfeeding issues, perceived barriers to providing support and issues around education. The quantitative phase of the study was carried out using a questionnaire.

2.4.1 Type of study

A quantitative cross-sectional study was conducted using a self-administered questionnaire. The questionnaire was distributed to PHNs, GPs and practice nurses in North Dublin.

2.4.2 Sample

A purposive convenience sample was used in this study. Purposive sampling involves selecting certain cases “based on a specific purpose rather than randomly” (Tashakkori & Teddlie, 2003). A list of the names and contact details of GPs in North Dublin was obtained from the ICGP. The ICGP is the body responsible for the education, training
and standards in general practice. Over 90% of GPs in the Republic of Ireland are members of the ICGP (O’Riordan, 2000). The contact details of the PHNs were obtained from the three Directors of Public Health Nursing (DPHN) in each of the three LHOs in North Dublin. DPHNs are responsible for the planning and delivery of the public health nursing staff and the overall service provided. The contact details of the practice nurses were sought from the Irish Practice Nurses Association (IPNA), the professional membership association of practice nurses in Ireland.

2.4.3 Questionnaire design

Questionnaires are often used for gathering data on knowledge, beliefs, attitudes and behaviours (Wall et al., 2002). They offer the advantage of being economical, relatively quick to complete and easy to analyse (Bowling, 2009). In addition, the use of questionnaires is appropriate when some information is already known on a subject or topic area (Rattray & Jones, 2007). The use of questionnaires, however, is not without criticism and Rattray & Jones (2007) have described such methods as assuming that the researcher and respondent interpret questions and language in the same way. In addition, closed questions which are often a common feature of questionnaires, can limit the depth of participant response and consequently the quality of data collected (Bowling, 2002). In compiling the questionnaire the study instruments used in similar and previous research were taken into account (Freed et al., 1995; Cantrill et al., 2003; Finneran & Murphy, 2004; Wallace & Kosmala-Anderson, 2006; Wallace & Kosmala-Anderson, 2007). Freed et al., (1995) developed the breastfeeding knowledge questionnaire to assess general attitudes to and knowledge of breastfeeding amongst health professionals. This has been adapted and validated (Cantrill et al., 2003) and so items from the
questionnaire were used to assess knowledge and attitudes. The original tool was modified to suit the Irish context. For example the statement ‘exclusive breastfeeding through the first four months is the most beneficial form of nutrition’ was changed to six months to suit Irish breastfeeding recommendations. The original questionnaire also had two questions on breastfeeding management, however, this was reduced to one to ensure that the questionnaire did not take too long to complete. In relation to assessing training around breastfeeding, items from a questionnaire developed by Wallace & Kosmala-Anderson (2006), were adapted to the Irish context and used to measure training needs and interest in attending training in the future. For example, specific questions were asked regarding breastfeeding policy and training in North Dublin. In order to establish content validity and ensure that the questions were measuring the concepts intended (Rattray & Jones, 2007) advice was sought from two lactation consultants, a GP, a PHN and a dietitian on the content of the questionnaire. Efforts were made to make the questionnaire as clear and concise as possible by explaining the study in an introductory letter, providing a clear and unambiguous title and making the questionnaire clear and legible with easy-to-follow instructions as to how to fill it in (Boynton & Greenhalgh, 2004).

The questionnaire was piloted amongst a group of health professionals (n=20) including GPs, paediatricians, PHNs, practice nurses, lactation consultants and midwives. This group was asked to complete the questionnaire and to comment on the content, how long it took to complete and whether there were items which were not needed or which should be included. Piloting of questionnaires ensures that questions are worded clearly, that they are appropriate for the target population and that there are no redundant
questions/items (Wall et al., 2002). Feedback from the piloting was incorporated and appropriate changes were made to the questionnaire. The changes made included adding a question about breastfeeding support groups and amending a question to suit the situation of PHNs.

The questionnaire was similar for all three groups of health professionals, however, there were some small differences between groups as some questions were not applicable to some health professionals (Appendix VII). The majority of questions were closed, however, some were open ended. While data from closed questions are easy to collect, code and analyse (Fink & Kosecoff, 1998), open questions can enable more accurate responses (McColl et al., 2001). Further details of the questionnaire are given in chapter three.

2.4.4 Maximising the response rate

Strategies to maximise the response rate were integrated into the study design (Wall et al., 2002; Boynton, 2004). These strategies included keeping the questionnaire as short as possible with a simple lay out, sending a personalised cover letter which emphasised the importance of the study and the confidentiality of the respondents and which was signed by the researcher and finally a pre-paid return envelope was included. In addition, each questionnaire was numbered so that respondents and non-respondents could be identified and so those that did not respond could be re-sent the questionnaire.

2.4.5 Validity

In survey research, the aim, in terms of quality, is to collect information that is valid,
reliable and unbiased (McColl et al., 2001). Validity refers to being able to measure the concept that is supposed to be measured, while reliability means that the concept is measured in a consistent manner (McColl et al., 2001). Face validity was established through the researcher subjectively assessing the presentation and relevance of the questionnaire (Bowling, 2009) and objectively considering instruments used in previous studies. Content validity, as previously discussed, was established by asking a panel of health professionals about the extent to which the content of the questionnaire comprehensively examined the characteristics it was intended to measure (Bowling, 2009).

2.4.6 Data analysis

2.4.6.1 Closed questions: Developing a coding frame

Bowling (2009) describes the basic rules for development of a coding scheme being, ‘that the codes must be mutually exclusive, coding formats for each item must be comprehensive and codes must be applied consistently’. The questionnaire was coded numerically. In cases whereby a reply fit more than one category, then each reply was coded separately. In cases whereby there were questions such as ‘other, please specify’ or ‘yes, which one’, code items to include all of the main themes in answer to these questions were included. Where possible, in order to avoid coding errors, the numerical codes for commonly occurring items were consistent (Bowling, 2009).

2.4.6.2 Open questions

Open questions in questionnaires have been described as ‘tending to fall between two stools, being neither strictly qualitative nor quantitative’, consequently making them
‘uncomfortable to work with’ (O’Cathain & Thomas, 2004). They can lack the conceptual richness, which is often associated with qualitative data. Open-ended questions were analysed based on the procedure outlined by (O’Cathain & Thomas, 2004), whereby responses were listed and a sub-set of the comments were read and grouped by theme. A coding frame was then developed and the codes were assigned to all the comments. The codes were entered into Statistical Package for the Social Sciences (SPSS) version 14.0 (14.0) (SPSS, Chicago, IL, USA) and were treated as variables (non-dichotomous) in a quantitative analysis, described using descriptive statistics.

2.4.6.3 Statistical Analysis

Data from the questionnaires were entered into SPSS (14.0).

2.4.6.4 Data handling

Questionnaires which were returned largely incomplete were not included in the analysis. In total there were eight such questionnaires: four GPs, two PHNs and two practice nurses. There were very few data missing from other questionnaires and so no substitutions were made for the missing data. The author was the only person who inputted the data into SPSS (14.0) and 25% of the questionnaires were randomly checked for any input errors. In addition, descriptive statistics and frequencies were used to check for consistency within the data and to highlight any outliers or data which may have been inputted incorrectly. Data which appeared spurious were checked against the corresponding questionnaire and changed if incorrect.
2.4.6.5 *Analysis*

Descriptive statistics in the form of frequencies and percentages were used for categorical variables.

2.4.6.5.1 *Pearson’s Chi-Square test for independence*

Pearson’s chi-square test for independence was used to investigate the relationship between categorical variables. The chi-square tests were performed using SPSS (14.0) and the procedures outlined in Field (2009). Statistical significance was set at 0.05. The chi-square test relies on one important assumption: the expected frequencies should be greater than five, or in the case of larger contingency tables, only up to 20% of expected frequencies are below five, and not fulfilling this assumption results in a loss of power (Field, 2009). In this situation Fisher’s exact test can be used instead of the chi-square test, however, this procedure is usually used with a 2x2 contingency table (Field, 2009). Therefore in analyses where the expected frequency was less than 5 and the chi-square test was not on a 2x2 contingency table, variables were collapsed in order to meet the assumption of the chi-square test.

2.4.6.5.2 *Binary logistic regression*

Binary logistic regression analyses were used to identify the independent contribution of certain variables which were statistically significant in univariate analysis, towards confidence in dealing with various skill areas. The forced entry method, whereby all predictor variables were tested in one block to assess their predictive ability while controlling for the effects of other predictors in the model, was performed (Pallant,
The procedure for the binary logistic analyses was performed using the procedure outlined by Pallant (2007).

The dichotomous dependent variable (confidence in dealing with the skill area) was coded as zero and one, with one being very confident/fairly confident and zero being not very confident/not at all confident. The independent variables were similarly coded with code zero being the reference category, as shown in Table 3.15 in chapter three. The output obtained from the analyses using SPSS (14.0), was checked and particular emphasis was placed on the table entitled ‘variables in the equation’. This table provided information regarding the variables that contributed significantly to the predictive ability of the model. Values which were less than 0.05 were considered significant. Both the odds ratio (indicated as Exp (B)) and the confidence interval values were reported in the results. If the confidence interval did not contain a value of 1 then the odds ratio was considered statistically significant at $p<0.05$ (Pallant, 2007).

### 2.5 Qualitative Studies

Two qualitative studies were conducted. The aim of the first study was to explore the issues for health professionals in providing support for breastfeeding. The aim of the second study was to explore women’s experience of professional support for infant feeding in the first year postnatally. This section describes the methods used for the qualitative studies.

#### 2.5.1 Introduction to qualitative research

Qualitative research has been described as using “a holistic perspective which preserves
the complexities of human behaviour” (Black, 1994). Denzin & Lincoln (2005) described qualitative researchers as ‘studying things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them’. Because of this, there is increasing recognition for using qualitative research in areas of health research and dietetics and nutrition (Holloway & Fulbrook, 2001; Harris et al., 2009). Qualitative research is a general term used to cover a range of philosophical traditions and methodological strategies (Thorne, 2000). There are five main traditions in qualitative research: narrative research, phenomenology, grounded theory, ethnography and case study (Creswell, 2007). In both qualitative studies, carried out as part of my research, grounded theory guided data collection and analysis.

2.5.2 Grounded theory

Grounded theory was developed in the 1960s by sociologists Barney Glaser and Anselm Strauss. It was developed as a result of their collaboration on a study of dying in hospitals. They published their first description of grounded theory in The Discovery of Grounded Theory (Glaser & Strauss, 1967), whereby they described strategies for developing theory grounded in data, rather than the traditional research approach of testing theory. Since then Glaser and Strauss have taken different directions in their approach to grounded theory with both developing two different strands to grounded theory methodology. The grounded theory methodology originally developed by Glaser & Strauss (1967) has therefore developed into different but similar methodologies according to Glaser (1978), Strauss & Corbin (1990) and others such as Charmaz (2006). As Dey (2007) has described, therefore, there is “no such thing as ‘grounded theory’ if we mean a single, unified methodology, tightly defined and clearly specified”.

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Corbin & Strauss (2008) explain, however, that despite the different versions of grounded theory, there are four elements which are consistent with all versions. These are the ‘constant comparative’ method of analysis, the use of concepts and their development, theoretical sampling and saturation.

Grounded theory encourages researchers to constantly interact with their data while also remaining involved with the emerging analysis (Bryant & Charmaz, 2007). Grounded theory has been described as being useful for beginner researchers (Kendall, 1999) and helpful for individual learners (Creswell, 2007) because of the concreteness it provides in advising on collecting and analysing data. Bailey et al., (1999) described grounded theory as “a robust and systematic method of designing, conducting, analysing and evaluating research, which at the same time facilitates and integrates the scientific and creative aspects of research”. Criticisms of grounded theory include there being too much of a focus on method and the use of complex terminology, which may take from the data, and result in the researcher coming away from the data to the extent that they lose a sense of what it is all about and what story the data is telling (Grbich, 2007).

Kendall (1999) described Strauss & Corbin’s approach to grounded theory as “a wonderful method of conceptual description”. She also emphasised that neither Glaser’s nor Strauss and Corbin’s version of grounded theory are more superior than the other and that deciding which one to use depends on whether the goal of the study is description or theory generation. McCallin (2003) maintains that although the aim of a grounded theory study is usually to develop a theory, the procedures and techniques, as outlined by Strauss & Corbin (1990), can also be a useful framework for guiding smaller studies, where theory is not generated. Grounded theory methodology can be drawn
upon as a strategy for qualitative analysis with the end product being qualitative description.

2.5.3 Grounded theory and descriptive studies

Sullivan-Bolyai et al., (2005) describe qualitative description as “a distinct method of naturalistic inquiry that uses low inference interpretation to present the facts using everyday language”. In an article on qualitative description, Neergaard et al., (2009) aptly question whether qualitative description is the “poor cousin” of health research. They do not think that this is the case and make a strong case for its use in mixed method studies. Sandelowski (2000) has described the value of qualitative descriptive studies and contends that in qualitative descriptive studies the researcher does not move far from the data and does not need to consider the data in an abstract format. Sandelowski (2000) also describes the importance of not describing a study as being grounded theory, if the study does not follow all the procedures of the methodology and instead suggests describing a study as a descriptive qualitative study with, for example, grounded theory “overtones”. This is a common criticism of grounded theory whereby ‘grounded theory’ studies sometimes do not result in theory being built and instead involve the generation of concepts (Grbich, 2007). Kennedy & Lingard (2006) warn against describing a study as being a ‘grounded theory’ study, when the only tenet of grounded theory used was constant comparison of data. They acknowledge the importance of calling a study as it is and so if aspects of grounded theory are used then this should be specified but the study should not be called a grounded theory study. It is with this warning in mind, that these qualitative studies are described as descriptive studies with grounded theory “overtones”. These overtones will be described in further
detail below. They include simultaneous collection and analysis of data using constant comparison technique, considering the use of the literature, continuing data collection until saturation is reached, the use of open coding and axial coding when analysing the data and finally, memoing and modelling.

2.5.3.1 Constant comparison of data

Constant comparison of data is where new information is constantly compared with previously identified information (Chiovitti & Piran, 2003). The constant comparison of data is one of the central tenets of data analysis in grounded theory studies (Kennedy & Lingard, 2006). Constant comparison means that issues of interest in the data are constantly compared with other data for similarities and differences. Emerging theory/description is therefore constantly refined as data collection and analyses proceed, producing a richness of theory/description. An important and vital part of constant comparison of data is that data collection and data analysis run concurrently so that new ideas and thoughts on data can be followed up in subsequent interviews.

2.5.3.2 Review of the literature

There is debate about how and when the literature should be used in qualitative studies. In the original “Discovery of Grounded Theory” (Glaser & Strauss, 1967), researchers are encouraged not to look at the literature on the area of interest but to formulate their own interpretations from the data which they collect. There was a fear that the researcher might impose their preconceived ideas on the data, resulting in the findings not being ‘grounded’ in the data. It is somewhat unrealistic to think that researchers would approach a study without any former knowledge of their area of interest, as researchers
are bound to have some prior knowledge of the subject. In addition, in order to comply with the demands of having to write a research proposal or apply for ethics approval, a literature review is often a pre-requisite to starting a study. This has led to a more pragmatic approach being taken with a literature review considered to be an inevitable part of the methods. Strauss & Corbin (1990) have suggested various uses for the literature review including using it to derive an interview guide, as supplementary validation when writing up findings, as secondary sources of data and to provide concepts and relationships which can be checked out against actual data. Bryant & Charmaz (2007) make an interesting point that the advice not to review the literature is often made by experienced researchers who already have extensive experience in the field and are already familiar with the literature. Using the literature is inevitable in any research project, including a grounded theory study (Schreiber, 2001).

2.5.3.3 Data collection and saturation

Strauss & Corbin (1990) explain how data collection and data analysis are tightly interwoven processes and they emphasise the importance of these occurring alternately, as analysis guides sampling of data. By collecting and analysing data in a cyclical process it enables the researcher to return to the field and establish strategies to help gather new and sometimes better information (Shin et al., 2009). In grounded theory, data collection continues until ‘saturation’ is reached. This means that there are no new concepts or categories appearing in interviews and that all categories are developed with some depth and variation. The objective of data collection in grounded theory is to gain a broad range of perspectives and experiences related to the research question (Kennedy & Lingard, 2006).
2.5.4 Analysing the data

Miles & Huberman (1994) outline six analytic methods that are common to all styles of qualitative analysis. These include strategies such as coding the data, reflecting on what is appearing in the data, finding similarities and differences within and between data from different sources, expanding on these through subsequent interviews, elaborating on a small set of generalisations found within the data and considering these generalisations from the point of view of theory/constructs. Corbin & Strauss (2008) describe analytic tools that can be used in data analysis. These include the use of questions, firstly asking ‘sensitizing questions’ of the data such as what is going on here, who are the actors involved and how do they define the situation. Then asking theoretical questions, trying to decipher the relationship between concepts and finally asking practical questions about where the direction of future interviews should go in order to help build concepts and reach saturation of themes.

2.5.4.1 Coding data

Coffey & Atkinson (1996) describe coding as both a process of reducing data and also expanding, transforming and reconceptualising data. Strauss & Corbin (1990) provide a systematic coding framework which gives the researcher a process through which to analyse and understand the data. They describe coding as ‘representing the operations by which data are broken down, conceptualized, and put back together in new ways’. Strauss & Corbin (1990) described three major types of coding: (a) open coding, (b) axial coding and (c) selective coding. They further emphasise that the different types of coding do not take place at different times but can intertwine, especially open and axial
coding. In addition, they stress that in providing a coding framework, they do not wish to imply rigid adherence to it.

Open coding is the part of the analysis where data are named and categorized through analysing the data word by word, line by line or paragraph by paragraph (Strauss & Corbin, 1990). The data are broken down and compared for similarities and differences. The researcher’s own assumptions about the topic are challenged which can lead to new discoveries. Categories can be named:

1. As “in vivo” codes whereby a word or phrase in the transcript is taken directly and used to name the category.
2. From concepts already discussed in the literature.
3. From reading through the data and capturing the concept by naming the particular phenomena.

LaRossa (2005) explains the importance of ensuring that a concept is neither too concrete nor abstract as both could lead to categories having too few or too many data, respectively. Balance and care, therefore are needed in coding data. Strauss & Corbin (1990) also provide techniques which can be used to “open up” the data and the researcher’s way of thinking about the phenomena under study. The techniques which were used in my research were:

- Asking questions of the data and of concepts using question words, who, what, why, where when etc. Strauss & Corbin (1990) describe how this technique is likely to lead to more questions which in turn can lead to the development of categories.
• Analysing a word, phrase or sentence to make the researcher question their assumptions about its meaning, enabling the researcher to validate possible meanings through further probing of the data or in interviews.

• “waving the red flag” whereby words or phrases such as “never”, “always”, “everyone knows…..” etc. make the researcher question if what is being said is always the case and encourage the researcher to take a closer look at the phenomena ensuring nothing is being taken for granted.

Strauss & Corbin (1990) describe axial coding as “putting data back together in new ways after open coding, by making connections between categories”. Negative or alternative cases add variation and deeper understanding to the particular phenomenon and should not be considered as negating hypotheses or description (Strauss & Corbin, 1990). They recommend stopping analysis at axial coding if the aim of the particular research is only theme analysis or concept development. For this reason analysis in my qualitative studies ceased at this level.

2.5.4.2 Memoing and modelling

Strauss & Corbin (1990) define memos as “written records of analysis related to the formulation of theory” and models as “visual representations of relationships between concepts”. They also highlight the absolute importance of both in the analysis of data. Schreiber (2001) describes how memos can be used for three reasons; (a) for the researcher to recognise their pre-existing assumptions, (b) to record methodological decisions while conducting the study and (c) to speculate on the data. Charmaz (2006) outlines some of ways in which memo writing can help in the whole process of
analysing and conceptualising data. These include sparking ideas to investigate in the field setting, demonstrating connections between categories, discovering gaps in data collection and linking data-gathering with data analysis and report writing. Memo writing also provides the researcher with the opportunity to stop and think about the data which in turn encourages reflexivity. The researcher is the research instrument in qualitative studies and so needs to be aware that they can have a lot of influence on a study (Holloway & Fulbrook, 2001). They bring their own thoughts and ideas to a study and so it is important that the researcher is reflexive and analyses their own preconceived ideas. In qualitative studies the researcher is encouraged to keep a reflexive journal which provides insights and reasons for methodological decisions and also information about the researcher’s own experience conducting the research.

Memo writing and drawing models are important steps in qualitative data analysis and can aid in providing a practical tool whereby there is a balance between rational and creative thinking (Bailey et al., 1999). Memos are written at each stage of coding, getting more analytical as coding moves from open coding to axial coding and eventually selective coding (if the aim of the study is to develop theory). Such is the case also with models. Ultimately the memos and models eventually aid in developing core categories and in understanding how the categories fit in relation to each other.

2.5.5 Sampling

One of the aims of sampling in qualitative research is to collect “rich” data (Daly et al., 2007). Purposive sampling is the sampling technique most often used in qualitative research. It is the intentional selection of participants based on them having particular
characteristics. While this would be seen as a source of bias in a quantitative study, it is considered beneficial in a qualitative study because it can lead to information “rich” cases, allowing for more in-depth study. Patton (2002) describes fifteen strategies of purposive sampling in qualitative studies. Strauss & Corbin (1990) acknowledge the difficulty in sampling purposefully and admit that it may be a matter of sampling on the basis of who is available and willing to participate in the research. Also, sometimes it can be difficult to access individuals or a study site and so a ‘gatekeeper’ may be used to help in this process. This can, however, result in gatekeeper bias, whereby the gatekeeper influences who participates in the study (Tuckett, 2004). In this situation care needs to be taken that the influence of the gatekeeper is taken into account and that this bias is reduced as much as possible.

Typically in a grounded theory study, sampling begins with convenience sampling if little is known about the topic and then theoretical sampling is used (Chiovitti & Piran, 2003). Charmaz (2006) describes theoretical sampling as ‘seeking pertinent data to develop emerging theory’. She explains that theoretical sampling involves ‘sampling to develop the properties of the categories which were built, until no new properties emerge’. Patton (2002) describes one form of purposive sampling being theory-based sampling, which is a conceptually oriented type sampling whereby the researcher samples incidents or people based on their potential for adding further insight into the developing theory/description. It is similar to theoretical sampling in grounded theory and based on the same premise of confirming conceptual relationships. As far as possible such sampling was used in this research as it was felt to be the most useful for understanding in more depth, the phenomena under study. The sample for both
qualitative studies (of health professionals and women who had experience of breastfeeding) was obtained from North Dublin.

2.5.6 Use of computer aided qualitative data analysis software

In the past twenty years there has been an increase in computer software for qualitative data analysis (Morison & Moir, 1998). The use of Computer Assisted Qualitative Data Analysis Software (CAQDAS) is well established in qualitative methodology and it has its proponents and critics (Kelle, 1995). Weitzman (2000) described how there can be an expectation that CAQDAS can enhance rigour and make analysis of qualitative data more systematic, however, he claims that this is not the case. In spite of this, he does concede that the tools available in CAQDAS, facilitate in organising data, checking for consistency in coding, keeping records and examining relationships. In this way CAQDAS can add to the systematic analysis of qualitative data as is needed in grounded theory. Morison & Moir (1998) demonstrated how software can facilitate analysis, however, “it cannot replace those moments of intuition when the relationships between concepts crystallise in the researcher’s imagination”. One of the misconceptions of using CAQDAS is that it will ‘do the analysis’, however, this is not true and as Bringer et al., (2004) explain, while the computer can assist in the analysis, ultimately it is the researcher that needs to interpret, examine relationships and document decisions in coding and analysis. Critics fear that using computers in analysing qualitative data will alienate researchers from their data (Seidel & Kelle, 1995). This does not, however, need to be the case and CAQDAS should be considered an additional hand in qualitative data analysis. When using CAQDAS there is never anything preventing a researcher from
taking out a pen and paper and for example jotting down ideas and making links between data, if it is felt that this will help the researcher be closer to the data.

While there is a range of software available to aid in the analysis of qualitative data, I chose to use NVivo (QSR International Pty Ltd, Doncaster, Victoria, Australia). NVivo is a product of QSR International and was developed from their original software NUD*IST. It has also been used successfully in the analysis of grounded theory studies, one of which was described by Bringer et al., (2006). I used one of the latest versions of NVivo which is NVivo 8 and it has different tools which aid in providing both efficiency and transparency in analysis. It allows for the storage and linking of both textual and nontextual data such as audio and picture files. It also enables open coding and axial coding, text searches, writing a journal and memos and linking data within the dataset. Finally NVivo allows for links to be made between the data and external sources such as articles, news items and website links.

2.5.7 Quality in qualitative research

Qualitative research is sometimes criticised for being subjective and for there being a lack of transparency in how results and conclusions are reached. Indeed, quality in qualitative research is a topic of much discussion and Miles & Huberman (1994) describe the potential problem with reporting on the analysis of qualitative data.

“Some qualitative researchers still consider analysis to be an art form and insist on intuitive approaches to it. We are left with the researcher telling us of classifications and patterns drawn from the welter of field data, in ways that are irreducible or even incommunicable. We do not really see how the
researcher got from 3600 pages of field notes to the final conclusions, as sprinkled with vivid illustrations as they may be”

Qualitative research has a lot of merit and can add significantly to the body of scientific and social research in a variety of areas. However, without sufficient rigour it loses its trustworthiness and authenticity. Terminology such as validity and reliability are often used to describe quality in quantitative research. However, there is debate as to whether it is appropriate to use such terms in qualitative research when they originally come from the quantitative tradition (Fade, 2003). Mays & Pope (2000) suggest that it is appropriate to judge qualitative and quantitative research by common quality criteria, in particular those of validity and relevance. They offer a complete and comprehensive list of strategies which can be used to address the issue of quality in qualitative research. They discuss quality from the point of validity and relevance and describe six strategies for improving validity (Table 2.2). Mays & Pope (2000) also discuss relevance and whether the research “adds to knowledge or increases the confidence with which existing knowledge is regarded”. In addition, they discuss relevance in terms of whether the findings can be generalised beyond the research setting and the importance of the researcher in giving sufficient detail about the research so that others can decide whether the findings are generalisable. Furthermore, they describe the sampling technique as being important for ensuring variation in those that are interviewed and full coverage of the concepts described in the results.
Table 2.2. **Assessing the validity of qualitative research** (Adapted from Mays & Pope, 2000)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Triangulation</strong></td>
<td>Comparing the results of two or more methods of data collection or data sources and therefore examining the same phenomenon from different perspectives.</td>
</tr>
<tr>
<td><strong>Respondent Validation</strong></td>
<td>Also known as member checking. The participants of the study are asked whether they think the results are an accurate account of their reality.</td>
</tr>
<tr>
<td><strong>Clear exposition of methods of</strong></td>
<td>A clear account of the process of data collection and analysis are given.</td>
</tr>
<tr>
<td><strong>data collection and analysis</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Reflexivity</strong></td>
<td>The researcher is aware of the way in which they and the research process have influenced the findings of the study.</td>
</tr>
<tr>
<td><strong>Attention to negative cases</strong></td>
<td>Perspectives which contradict the main findings are presented and discussed.</td>
</tr>
<tr>
<td><strong>Fair dealing</strong></td>
<td>The research design ensures that a wide range of perspectives are presented ensuring that the viewpoint of one group is not presented as the ultimate truth.</td>
</tr>
</tbody>
</table>

Fade (2003) argues that there is a risk of misinterpretation if the same language is used in assessing the quality of both research strategies and instead she offers quality strategies adapted from Whittemore *et al.*, (2001) which can be considered under four headings: credibility, criticality, authenticity and integrity. Most of these strategies
correspond with Mays & Pope (2000), with reflexivity, triangulation, member checking, providing a detailed description of the rationale of the analysis and sampling technique being used to assess credibility. In addition, consideration of a range of views, quoting significant blocks of raw narrative from the original data and ensuring participants are free to talk about issues that are important to them, can be used to assess criticality, authenticity and integrity. Fade (2003) emphasises that a study does not need to demonstrate all of the quality measures but that issues of quality are discussed so that readers can assess for themselves the findings of a study. The strategies used to address the issues of quality in the qualitative studies are described in chapter four and five.

2.5.7.1 Respondent validation

As discussed in the previous section, one of the strategies suggested by Mays & Pope (2000) for ensuring validity in qualitative research is respondent validation. They go on to explain, however, that this strategy should be considered more so as part of a process of error reduction rather than a check on validity because the account produced by the researcher will be a synthesis of what everyone said as opposed to individual accounts. Mays & Pope (2006) also recommend that further data, generated from member checking, should be considered data which can be used for further analysis. Member checking is also sometimes not practical as the findings may go beyond what the participants see and perceive and may be beyond their understanding of a situation. In addition, respondents may forget or regret what they said, feel obliged to agree with the researcher’s findings or want to present themselves in different ways at different times
(Sandelowski, 2002). Asking respondents to comment on the findings can also be time consuming and may be an additional burden on respondent’s time.

2.5.8 Interviews and use of an interview guide

Interviewing is one of the most common ways of collecting qualitative data (Holloway & Fulbrook, 2001). It enables participants to explain phenomena in their own words and time while also providing an opportunity for a researcher to understand a particular topic in more depth. Kvale (1996) has, however, described research using interviews as being ‘deceptively simple’. Kvale (1996) identified seven stages of an interview inquiry: thematizing, designing, interviewing, transcribing, analyzing, verifying and reporting. In order to conduct an interview that will gather ‘rich’ data it is important to reflect on and organise details prior to doing the interview. Initially the researcher needs to reconsider the research question and decide what questions will best obtain the information required. Schreiber (2001) advises that beginner researchers develop a draft interview schedule which will help guide the interview. However, she cautions not to use the interview guide prescriptively, as it may take from the spontaneity of the interview, allowing the participant to tell their story in their own words. Kvale & Brinkman (2009) also suggest developing an interview guide to aid in structuring the interview, while Rapley (2007) emphasises the importance of ‘following the interviewee’s talk, to work with them rather than sticking to the pre-determined agenda of the interviewer’. In the case of both qualitative studies which were conducted as part of this research an interview guide was developed for each study but it was not used prescriptively. The topic guides are provided in Appendices XI and XV. A pilot interview is not necessary
in qualitative research because of its developmental nature, but it can be useful for the interviewer as a practice run (Holloway & Fulbrook, 2001).

The actual setting and atmosphere of the interview are important and they should be such that the interviewee is encouraged to speak openly about themselves and their experiences Kvale & Brinkman (2009). Holloway & Fulbrook (2001) describe how the interviewer can establish trust with the participant using techniques such as 1. ensuring the participants that they are under no obligation to participate in the study 2. ensuring that the participants remain anonymous and that the data will not in any way allow them to be recognised 3. telling participants how the data will be used 4. the interviewer giving non-judgemental responses in the interview. Charmaz (2006) has described how a competent interviewer shapes questions to obtain rich data while at the same time avoids imposing preconceived concepts on it. She acknowledges how asking open ended questions while interviewing is helpful and also asking for additional information by questions such as “could you describe……… further”, not only aid in obtaining clarification on topics but also in getting richer data.

2.5.9 Ethical Considerations

Three ethical issues which are important to consider in qualitative research are anonymity, confidentiality and informed consent (Goodwin, 2006). Anonymity can sometimes be difficult to achieve if for example the context of what someone says makes them identifiable and if such text is quoted in the final report/thesis. Consideration needs to be taken on the part of the researcher of the degree of anonymity which can be given in the study and no false promises should be made to participants.
Confidentiality is another issue that needs to be addressed and Goodwin (2006) suggests it is a good idea to clarify the limits of confidentiality for example that the response of a participant will not be relayed to their manager but that it may appear as a verbatim quote in a final report. In qualitative research it is sometimes not possible to know how the study will proceed, as data collected may change the direction of the study, and so it can be difficult to specify in advance which data will be collected and how they will be used. This can, therefore, lead to difficulty with informed consent. Goodwin (2006) explains that in the case where the study is prolonged and the aims and objectives change along the way, then it is important to keep the participants informed so that they know what the study is about in full.

2.6 Conclusions

A mixed methods study was conducted which incorporated a quantitative phase and two qualitative phases. Quantitative data, relating to health professional support for breastfeeding, were collected through a cross sectional study using a self-administered questionnaire. Two qualitative descriptive studies with grounded theory ‘overtones’ were also conducted. The aspects of grounded theory which were used were mainly based on Strauss & Corbin’s (1990) approach whereby data collection and analysis occurred simultaneously. In addition, open and axial coding and memoing and modelling were used in the analyses of the data. The three studies were conducted in North Dublin.
CHAPTER 3

3 The Knowledge, Attitudes, Self-efficacy and Training of Health Professionals towards Breastfeeding and the Perceived Barriers in Providing Support

This chapter describes a quantitative study exploring health professional’s perspectives on breastfeeding from the point of view of their knowledge and attitudes towards breastfeeding, their self efficacy in dealing with breastfeeding issues, perceived barriers to providing support and issues around education.

3.1 Introduction

Despite breastfeeding being the preferred method of infant feeding, rates in Ireland remain one of the lowest in Europe (Freeman et al., 2000). The current rate of exclusive breastfeeding in Ireland at discharge from hospital is 45% (Health Research and Information Division, 2009). Over the past few years there has been a drive by the Irish Government to ensure that breastfeeding becomes a social norm and efforts are being made to increase both initiation and duration rates. The mission statement of a strategic action plan for breastfeeding in Ireland is to “improve the nation’s health by ensuring that breastfeeding is the norm for infants and young children in Ireland”. One of the objectives of the policy is that “health care workers have the knowledge and skills necessary to protect, promote and support breastfeeding” (Department of Health and
Children, 2005). The Global Strategy for Infant and Young Child Feeding acknowledges that even though breastfeeding is a natural act, it is also a learned behaviour and that mothers should have access to skilled practical help from trained health workers who can help to build their confidence, improve feeding technique and prevent or resolve breastfeeding problems (WHO, 2003).

Women who receive skilled support and advice on breastfeeding have a more positive breastfeeding experience and also breastfeed for longer (Duffy et al., 1997; Ingram et al., 2002; Sikorski et al., 2003; Renfrew, 2005). In addition, women consistently recognise the importance of skilled supportive health professionals in order to establish and maintain successful breastfeeding (Tarkka et al., 1998; Hoddinott & Pill, 2000; Raisler, 2000; Simmons, 2002). A Cochrane Review concluded that additional professional support has been found to help prolong exclusive breastfeeding (Britton et al., 2007). However, health professionals with a lack of knowledge of breastfeeding can be a negative source of support if they give inaccurate and inconsistent advice (Dennis, 2002).

General messages on the benefits of breastfeeding in health promotion campaigns are sometimes not met with support and advice on techniques of lactation (Coreil et al., 1995; Dykes, 2006b), with women consistently reporting frustration with receiving conflicting advice from health professionals (Simmons, 2002; Smale et al., 2006). Studies to determine the knowledge and attitudes of health professionals with regards to breastfeeding have found knowledge deficits (Freed et al., 1995; Hellings & Howe, 2000; Finneran & Murphy, 2004; Wallace & Kosmala-Anderson, 2006; Wallace & Kosmala-Anderson, 2007). In a country such as Ireland where breastfeeding rates have
been low for the past two generations, it is likely there is what has been previously described as a ‘collective loss of knowledge and experience of breastfeeding women’ (Graffy & Taylor, 2005). A study of first-time mothers in Ireland found that two thirds of first-time mothers relied on health professionals for information, however, nearly half of these mothers would have liked more information (Leahy-Warren, 2007).

Any effort to increase rates of breastfeeding must take into account the knowledge and attitudes of health professionals and also their training needs. Information, among a sample of health professionals in Ireland, in these three areas is needed to identify gaps in knowledge and practice and also to highlight the main issues in providing breastfeeding care and support.

3.2 Aims and Objectives

The aim of this study was to explore the issues around health professional support for breastfeeding. The specific objectives were to:

- Determine the knowledge and attitudes of health professionals towards breastfeeding
- Ascertain their self efficacy in dealing with certain breastfeeding issues
- Examine the barriers for health professionals in providing support
- Explore issues around breastfeeding education for health professionals

3.3 Methods

This study was a quantitative cross-sectional survey of community health professionals which included GPs, PHNs and practice nurses in North Dublin.
3.3.1 Sample

The study was conducted in North Dublin. As described in chapter two a list of the names and contact details of GPs in North Dublin was obtained from the ICGP. The list included the names of 299 GPs, both General Medical Service (GMS) and Private GPs. Eight names were repeated on both lists and one name had an insufficient address. Questionnaires were, therefore, sent to 290 GPs. The contact details of the PHNs were obtained from the three DPHN in North Dublin. The total number of names received was 154 and so questionnaires were sent to all of these PHNs. The names and addresses of the practice nurses were obtained from the IPNA. Questionnaires were sent to 109 practice nurses.

3.3.2 Study Instrument and Measures

As described in chapter two a questionnaire was designed for distribution to each of the GPs, PHNs and practice nurses in North Dublin. In compiling the questionnaire the study instruments used in similar and previous research were taken into account (Freed et al., 1995; Cantrill et al., 2003; Finneran & Murphy, 2004; Wallace & Kosmala-Anderson, 2006; Wallace & Kosmala-Anderson, 2007). The questionnaire (Appendix VII) consisted of five parts:

- Demographic details and information regarding personal breastfeeding experience and formal breastfeeding qualifications were obtained in addition to current breastfeeding promotion practices.
- Six statements related to benefits and knowledge of breastfeeding and perceptions of one’s role in providing breastfeeding support. These were
measured using Likert scale questions ranging from one to five with one being ‘strongly agree’ and five being ‘strongly disagree’. In addition, six questions were used to investigate knowledge related to the advice the health professional would give in certain practice scenarios. Respondents indicated yes, no or unsure as to whether they would advise a woman to stop breastfeeding in these different situations. These two parts of the questionnaire were largely based on the breastfeeding knowledge questionnaire by Freed et al., (1995). An additional open-ended question was included asking what advice the health professional would give in a situation where the mother perceived that her baby is getting insufficient milk.

- To examine self-efficacy, respondents were asked to rate their confidence in dealing with certain skill areas with one being very confident and four not at all confident. For GPs there was an additional question to include their confidence in prescribing medicine to a breastfeeding woman. These questions were based on those asked by Wallace & Kosmala-Anderson (2006) and Wallace & Kosmala-Anderson (2007), however, some items were changed to suit the Irish context and the fact that it was community health professionals being surveyed. For example, one item was included to measure confidence in advising a woman about returning to work and another to measure confidence in encouraging breastfeeding antenatally.

- Respondents were asked about their level of agreement to eight statements regarding the perceived barriers to supporting breastfeeding. They were also asked about the training in relation to breastfeeding that they had received and
whether they would like to receive further training. These questions were again based on those asked by Wallace & Kosmala-Anderson (2006) and Wallace & Kosmala-Anderson (2007). However, they were adapted to the Irish context and to community health professionals. For example, questionnaire items related to breastfeeding training and policy in North Dublin and an open-ended question was included to determine areas of breastfeeding which respondents would like training on in the future. In addition, they were asked about breastfeeding support groups in their area and whether they would be able to put a mother in contact with a group.

3.3.3 Procedure

In June 2007 a questionnaire was sent by post with an accompanying cover letter (Appendix VIII) and a stamped addressed envelope and a number was placed on the first page of each to track respondents and non-respondents. A second questionnaire, cover letter and stamped addressed envelope were sent to all non-respondents after three weeks.

3.3.4 Quantitative Data Analysis

Data were analysed using Statistical Package for the Social Sciences (SPSS) version 14.0 (SPSS, Chicago, IL, USA). Details regarding the analyses of the survey data are described below. The background to the statistical tests (Pearson’s chi-square and binary logistic regression) which were used in the analyses are described in chapter two, however, specific detail relating to how the tests were used with these data is described here.
Categorical data (e.g. profession, categorises of age etc.) were described descriptively using frequencies and percentages. Pearson’s chi-square analyses and Fisher’s exact test (for a 2x2 contingency table) were used to test for significant differences between categorical variables. Some responses were collapsed into categories (e.g. Likert-scale questions were collapsed into strongly agree/agree, neither strongly agree nor disagree and strongly disagree/disagree) and Pearson’s chi-square analysis and Fisher’s exact test were used to compare responses between professions and to determine any associations between responses and personal and professional characteristics. Likert-scale data in the breastfeeding knowledge questionnaire (Freed *et al.*, 1995; Hellings & Howe, 2000) were analysed as nominal data and so analysis in this study was done in this way. There are, however, limitations in analysing likert-data as nominal data and these will be addressed in the discussion. In all analyses, results were deemed statistically significant when $p$ was $<0.05$.

Binary logistic regression was conducted to determine the independent contribution of the variables: profession, age and personal experience of breastfeeding, on confidence in dealing with four skill areas. These four skill areas were chosen because all of these variables were significantly associated with them in univariate analyses.

Responses to open ended questions were analysed using the technique described by O’Cathain & Thomas (2004) as explained in chapter two. The responses were coded and analysed descriptively in SPSS (14.0).
3.4 Results

3.4.1 Response rate

Questionnaires were sent to a total of 553 health professionals. The response rate for the total sample of health professionals was 46%. The response rate among the different health professionals varied with a 35% (n=101) response rate by GPs, 54% (n=59) by practice nurses and 62% (n=96) by PHNs.

3.4.2 Characteristics of respondents

The age profile and gender distribution of the three different health professional groups are shown in Table 3.1. All of the PHNs and practice nurses who responded were female while 49% of GP respondents were male and 51% female. Eighty-four percent of GPs (n=84), 49% (n=47) of PHNs and 57% (n=33) of practice nurses had children. Of those with children, 82% (n=67) of GPs, 86% (n=36) of PHNs and 88% (n=29) of practice nurses had at least one child that was breastfed (data not shown). Twenty-five percent of GPs (n=25), 18% (n=17) PHNs and 24% (n=14) of practice nurses had personal experience (either they or their partner) of breastfeeding one of their children for 6 months or more (Table 3.1). PHNs had the most exposure to dealing with breastfeeding issues in the course of their work in the past year (Table 3.1).
Table 3.1. Characteristics of respondents

<table>
<thead>
<tr>
<th></th>
<th>General Practitioner</th>
<th>Public health nurse</th>
<th>Practice nurse</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=101</td>
<td>n=96</td>
<td>n=59</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;30</td>
<td>-</td>
<td>3</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>30-40</td>
<td>30</td>
<td>48</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>41-50</td>
<td>34</td>
<td>22</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>&gt;50</td>
<td>35</td>
<td>27</td>
<td>12</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>49</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>51</td>
<td>100</td>
<td>100</td>
<td>≤0.001</td>
</tr>
<tr>
<td>Parental status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>84</td>
<td>49</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Non-parent</td>
<td>16</td>
<td>51</td>
<td>43</td>
<td>0.000</td>
</tr>
<tr>
<td>Experience of breastfeeding§</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No experience</td>
<td>37</td>
<td>62</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>&lt; 6 months</td>
<td>39</td>
<td>20</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>≥ 6 months</td>
<td>25</td>
<td>18</td>
<td>24</td>
<td>0.006</td>
</tr>
<tr>
<td>Number of times in the past year dealt with issues related to breastfeeding:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>1-10</td>
<td>45</td>
<td>2</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td>11-49</td>
<td>36</td>
<td>27</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>50 or more</td>
<td>14</td>
<td>70</td>
<td>17</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Percentages may not sum due to rounding
* Pearson’s chi-square test used to determine differences
§ Based on either they or their spouse/partner having breastfed one of their children

3.4.3 Experience of breastfeeding promotion and main source of knowledge

Forty three percent (n=43) of GPs, 38% (n=37) of PHNs and 34% (n=20) of practice nurses felt that they themselves have an influence on a woman’s decision to breastfeed (data not shown). The majority of respondents discussed feeding plans with women and promoted breastfeeding (Table 3.2). GPs mainly promoted breastfeeding verbally while
PHNs and practice nurses also gave leaflets (Table 3.2). The main sources of breastfeeding knowledge for GPs and practice nurses were personal experience and general practice experience. This was in contrast with PHNs who rated in-service training and undergraduate/postgraduate experience more highly (Table 3.2)

<table>
<thead>
<tr>
<th></th>
<th>General practitioner (n=101)</th>
<th>Public health nurse (n=96)</th>
<th>Practice nurse (n=59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss breastfeeding at antenatal visits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>91%</td>
<td>61%</td>
<td>64%</td>
</tr>
<tr>
<td>No</td>
<td>9%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Not involved antenatally</td>
<td>-</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>Promote breastfeeding:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>2%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Promote breastfeeding by providing information:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written</td>
<td>2%</td>
<td>-</td>
<td>3%</td>
</tr>
<tr>
<td>Verbal</td>
<td>71%</td>
<td>7%</td>
<td>39%</td>
</tr>
<tr>
<td>Both (written and verbal)</td>
<td>27%</td>
<td>92%</td>
<td>58%</td>
</tr>
<tr>
<td>Greatest source of breastfeeding knowledge:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>49%</td>
<td>36%</td>
<td>53%</td>
</tr>
<tr>
<td>General practice experience</td>
<td>48%</td>
<td>24%</td>
<td>33%</td>
</tr>
<tr>
<td>Undergraduate experience</td>
<td>6%</td>
<td>9%</td>
<td>13%</td>
</tr>
<tr>
<td>Postgraduate experience</td>
<td>16%</td>
<td>30%</td>
<td>11%</td>
</tr>
<tr>
<td>In-service training</td>
<td>-</td>
<td>53%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Percentages do not add up to 100 because some health professionals gave more than one answer
3.4.4 Benefits and knowledge of breastfeeding and perception of role in providing support

Responses differed significantly between the three groups of health professionals with regards to the benefits of breastfeeding and how they perceived their role in providing breastfeeding support (Table 3.3). There were significant differences between the response of PHNs with that of GPs and practice nurses. PHNs had more conviction in their response with over 85% ‘strongly agreeing’ that ‘exclusive breastfeeding is the most beneficial form of nutrition during the first six months of life’ and that ‘a breastfed infant has increased immune function compared with a bottle fed baby’. Equally over 90% (n=89) of PHNs ‘strongly agreed’ that it is their role as a health professional to promote breastfeeding while only 50% (n=50) of GPs and 58% (n=34) of practice nurses ‘strongly agreed’. No significant differences were seen between professional group’s responses to ‘mothers know instinctively how to breastfeed’ or ‘supplementing with formula in the first two weeks causes breastfeeding failure’ (Table 3.3).

Respondents were asked whether they would advise a mother to stop breastfeeding in six different situations. The correct response to all questions was no. The least understood issue was with regards to advising whether to stop breastfeeding if the woman had a breast abscess (Table 3.4). As many as 27% of practice nurses and GPs (n=16 and 27 respectively) and 13% (n=12) of PHNs would advise a woman to stop breastfeeding if she had a breast abscess. The most understood issues were with regards to the infant teething or having frequent loose stools, with very few advising against breastfeeding in these situations.
Table 3.3. Benefits and knowledge of breastfeeding and perception of role in providing breastfeeding support among general practitioners, public health nurses and practice nurses

<table>
<thead>
<tr>
<th>Statement</th>
<th>General Practitioners (n=101)</th>
<th>Public health nurse (n=96)</th>
<th>Practice nurse (n=59)</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breastfeeding is the most beneficial form of nutrition during the first six months of life</td>
<td>43 Strongly agree, 33 Agree</td>
<td>88 Strongly agree, 4 Agree</td>
<td>65 Strongly agree, 14 Agree</td>
<td>0.035</td>
</tr>
<tr>
<td>It is my role as a health professional to promote breastfeeding</td>
<td>50 Strongly agree, 31 Agree</td>
<td>93 Strongly agree, 5 Agree</td>
<td>58 Strongly agree, 32 Agree</td>
<td>0.001§</td>
</tr>
<tr>
<td>A breastfed infant has increased immune function compared with a bottlefed baby</td>
<td>59 Strongly agree, 28 Agree</td>
<td>85 Strongly agree, 11 Agree</td>
<td>75 Strongly agree, 14 Agree</td>
<td>0.037§</td>
</tr>
<tr>
<td>Mothers know instinctively how to breastfeed</td>
<td>1 Strongly agree, 10 Agree</td>
<td>1 Strongly agree, 8 Agree</td>
<td>3 Strongly agree, 2 Agree</td>
<td>0.379</td>
</tr>
<tr>
<td>Supplementing with formula in the first two weeks causes breastfeeding failure</td>
<td>9 Strongly agree, 26 Agree</td>
<td>15 Strongly agree, 27 Agree</td>
<td>12 Strongly agree, 19 Agree</td>
<td>0.331</td>
</tr>
<tr>
<td>Breastfeeding is not feasible for a working mother</td>
<td>0 Strongly agree, 11 Agree</td>
<td>2 Strongly agree, 3 Agree</td>
<td>3 Strongly agree, 0 Agree</td>
<td>0.011</td>
</tr>
</tbody>
</table>

* p-value indicates differences between health professional groups in terms of agreement to the statements. Value was calculated from collapsed categories (strongly agree/agree, neither strongly agree nor disagree and strongly disagree/disagree) and differences were assessed using Pearson’s chi-square test.

§ p-value was calculated from collapsed categories (strongly agree/agree and neither strongly agree nor disagree/strongly disagree/disagree).
Table 3.4. Percent of health professionals that would advise or would not advise a woman to stop breastfeeding in the following situations

<table>
<thead>
<tr>
<th></th>
<th>General Practitioners (n=101)</th>
<th>Public health nurse (n=96)</th>
<th>Practice nurse (n=59)</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes %</td>
<td>Yes %</td>
<td>Yes %</td>
<td></td>
</tr>
<tr>
<td>Mother has mastitis</td>
<td>9</td>
<td>3</td>
<td>8</td>
<td>0.133$</td>
</tr>
<tr>
<td>Mother has insufficient milk</td>
<td>13</td>
<td>7</td>
<td>8</td>
<td>0.008*</td>
</tr>
<tr>
<td>Mother has a breast abscess</td>
<td>27</td>
<td>13</td>
<td>27</td>
<td>0.000*</td>
</tr>
<tr>
<td>Infant is teething</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>0.656$</td>
</tr>
<tr>
<td>Infant has frequent loose stools</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>0.03$</td>
</tr>
<tr>
<td>Baby does not seem satiated</td>
<td>8</td>
<td>4</td>
<td>2</td>
<td>0.07$</td>
</tr>
</tbody>
</table>

* P-value indicates differences in responses between health professional groups, calculated using Pearson’s chi-square test

$ P-value was calculated but the assumption of the chi-square test was not met (up to 20% of expected frequencies were not below 5)
3.4.4.1 Associations between personal and professional experience and attitudes towards and knowledge of breastfeeding

Associations between the personal and professional experience of respondents and their response to statements regarding the benefits and knowledge of breastfeeding and perception of role in providing breastfeeding support were examined. The sample was split into those who had personal experience of breastfeeding (either they or their spouse/partner had breastfed) and those who had not. Having personal experience was not associated with having significantly more knowledge about breastfeeding or having a greater appreciation for the benefits of breastfeeding (Tables 3.5 and 3.6). Further analyses were conducted to see if there was an association between having no personal experience of breastfeeding, having less than 6 months and having 6 months or more experience of breastfeeding. Length of personal breastfeeding experience was not associated with having a greater appreciation for the benefits of breastfeeding or having more knowledge (data not shown).

With regards to there being an association between the sex of GPs and their responses, a significant difference ($p\leq0.001$) was only found in the response to ‘mothers know instinctively how to breastfeed’, with 32% (n=16) of male GPs and 69% (n=34) of female GPs disagreeing/strongly disagreeing with this statement (data not shown).
Table 3.5. Percent of health professionals with or without personal experience of breastfeeding that strongly agreed/agreed to the following statements

<table>
<thead>
<tr>
<th>Personal experience of breastfeeding(^*)</th>
<th>No personal experience of breastfeeding</th>
<th>p-value(^\S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breastfeeding is the most beneficial form of nutrition during the first six months of life</td>
<td>85</td>
<td>81</td>
</tr>
<tr>
<td>It is my role as a health professional to promote breastfeeding</td>
<td>91</td>
<td>88</td>
</tr>
<tr>
<td>A breastfed infant has increased immune function compared with a bottlefed baby</td>
<td>92</td>
<td>90</td>
</tr>
<tr>
<td>Mothers know instinctively how to breastfeed</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Supplementing with formula in the first two weeks causes breastfeeding failure</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>Breastfeeding is not feasible for a working mother</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

\(^*\) Based on either they or their spouse/partner had breastfed
\(^\S\) p-value was calculated from collapsed categories (strongly agree/agree, neither strongly agree nor disagree and strongly disagree/disagree) and differences were assessed using Pearson’s chi-square.
\(^\Omega\) Differences were assessed using Fisher’s exact (2x2 contingency table)
Table 3.6. Percent of health professionals with or without personal experience of breastfeeding that were unsure or would advise a woman to stop breastfeeding in the following situations

<table>
<thead>
<tr>
<th>Situation</th>
<th>Personal experience of breastfeeding*</th>
<th>No personal experience of breastfeeding</th>
<th>p-value§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother has mastitis</td>
<td>8/132 (6.1%)</td>
<td>14/124 (11.3%)</td>
<td>0.108</td>
</tr>
<tr>
<td>Mother has insufficient milk</td>
<td>17/132 (12.9%)</td>
<td>19/124 (15.3%)</td>
<td>0.745</td>
</tr>
<tr>
<td>Mother has a breast abscess</td>
<td>42/132 (31.8%)</td>
<td>42/124 (33.8%)</td>
<td>1.000</td>
</tr>
<tr>
<td>Infant is teething</td>
<td>5/132 (3.8%)</td>
<td>7/124 (5.6%)</td>
<td>0.610</td>
</tr>
<tr>
<td>Infant has frequent loose stools</td>
<td>2/132 (1.5%)</td>
<td>7/124 (5.6%)</td>
<td>0.078</td>
</tr>
<tr>
<td>Baby does not seem satiated</td>
<td>12/132 (9.1%)</td>
<td>15/124 (12.1%)</td>
<td>0.463</td>
</tr>
</tbody>
</table>

* Based on either they or their spouse/partner had breastfed
§p-value indicates differences in responses between health professional groups, calculated from collapsed categories yes/unsure and no and differences were assessed using Fisher’s exact (2x2 contingency table)

The association between the age of respondents and their responses to the statements regarding the benefits and knowledge of breastfeeding and perception of role in providing support were examined. Age was collapsed into three categories (≤40 years, 41-50 years and ≥51 years) and a significant difference was found between age categories and the response to ‘mothers know instinctively how to breastfeed’ (p=0.010) and ‘breastfeeding is not feasible for a working mother’ (p≤0.001). The older age group tended to strongly agree/agree with the former statement, while the 41-50 year olds were least likely to agree with the latter (Table 3.7). With regards to whether respondents would advise a woman to stop breastfeeding in certain situations, significantly more
older respondents were unsure or would advise a woman to stop breastfeeding, in the
case of the mother having mastitis ($p=0.033$) and perceiving insufficient milk supply
($p=0.007$) (Table 3.8).

Table 3.7. Percent of respondents divided by age group who strongly
agreed/agreed with the statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>≤40 years (n=108)</th>
<th>41-50 years (n=79)</th>
<th>≥51 years (n=69)</th>
<th>Significance p-value *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breastfeeding is the most beneficial form of nutrition during the first six months of life</td>
<td>86%</td>
<td>83%</td>
<td>80%</td>
<td>0.884</td>
</tr>
<tr>
<td>It is my role as a health professional to promote breastfeeding</td>
<td>92%</td>
<td>88%</td>
<td>88%</td>
<td>0.680</td>
</tr>
<tr>
<td>A breastfed infant has increased immune function compared with a bottlefed baby</td>
<td>90%</td>
<td>92%</td>
<td>93%</td>
<td>0.765</td>
</tr>
<tr>
<td>Mothers know instinctively how to breastfeed</td>
<td>6%</td>
<td>10%</td>
<td>14%</td>
<td>0.010</td>
</tr>
<tr>
<td>Supplementing with formula in the first two weeks causes breastfeeding failure</td>
<td>35%</td>
<td>37%</td>
<td>41%</td>
<td>0.235</td>
</tr>
<tr>
<td>Breastfeeding is not feasible for a working mother</td>
<td>8%</td>
<td>1%</td>
<td>12%</td>
<td>0.001</td>
</tr>
</tbody>
</table>

* p-value was calculated from collapsed categories (strongly agree/agree, neither strongly agree nor disagree and strongly disagree/disagree) and differences were assessed using Pearson’s chi-square
Table 3.8. Percent of respondents divided by age group who were unsure or would advise a woman to stop breastfeeding in the following situations

<table>
<thead>
<tr>
<th></th>
<th>≤40 years</th>
<th>41-50 years</th>
<th>≥51 years</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=108)</td>
<td>(n=79)</td>
<td>(n=69)</td>
<td>p-value*</td>
</tr>
<tr>
<td>Mother has mastitis</td>
<td>6%</td>
<td>10%</td>
<td>19%</td>
<td>0.033</td>
</tr>
<tr>
<td>Mother has insufficient milk supply</td>
<td>14%</td>
<td>13%</td>
<td>31%</td>
<td>0.007</td>
</tr>
<tr>
<td>Mother has a breast abscess</td>
<td>42%</td>
<td>34%</td>
<td>50%</td>
<td>0.139</td>
</tr>
<tr>
<td>Baby does not seem satiated</td>
<td>13%</td>
<td>9%</td>
<td>19%</td>
<td>0.195</td>
</tr>
</tbody>
</table>

* Based on Pearson’s chi-square cross-tabulation of age (≤40 years, 41-50 years and ≥51 years) with collapsed categories yes/unsure and no

3.4.4.2 Advice that respondents would give for perceived milk insufficiency

Respondents were asked what advice they would give a woman who was breastfeeding her baby but perceived that the baby was getting insufficient milk. This question was open-ended and so responses were coded and analysed using SPSS (14.0). The range and frequency of responses are shown in Table 3.8. Some of the respondents failed to answer this question and so responses are based on 86 GPs, 89 PHNs and 47 practice nurses.

As can be seen in Table 3.9, a variety of advice was proposed by each professional group and responses differed significantly between groups (p<0.005). The majority of respondents (53-74%) recommended checking the baby’s weight and many PHNs (71%) also recommended checking how many wet and dirty nappies the baby had per day. Practice nurses (49%) and PHNs (64%) also recommended providing the mother with support and encouragement.
### Table 3.9. The advice that respondents would give a breastfeeding woman who perceived that her baby was getting insufficient milk

<table>
<thead>
<tr>
<th>Advice</th>
<th>General practitioner (n=86) %</th>
<th>Public health nurse (n=89) %</th>
<th>Practice nurse (n=47) %</th>
<th>p-value *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide support and encouragement</td>
<td>37</td>
<td>64</td>
<td>49</td>
<td>0.002</td>
</tr>
<tr>
<td>Explain supply and demand</td>
<td>13</td>
<td>18</td>
<td>28</td>
<td>0.103</td>
</tr>
<tr>
<td>Encourage mother to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• feed on demand</td>
<td>29</td>
<td>37</td>
<td>40</td>
<td>0.349</td>
</tr>
<tr>
<td>• drink lots of fluid</td>
<td>14</td>
<td>15</td>
<td>13</td>
<td>0.958</td>
</tr>
<tr>
<td>• relax and get rest</td>
<td>7</td>
<td>28</td>
<td>15</td>
<td>0.010</td>
</tr>
<tr>
<td>• eat well</td>
<td>13</td>
<td>31</td>
<td>19</td>
<td>0.001</td>
</tr>
<tr>
<td>Advise mother to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• supplement with formula</td>
<td>24</td>
<td>2</td>
<td>9</td>
<td>0.001</td>
</tr>
<tr>
<td>• express milk</td>
<td>8</td>
<td>3</td>
<td>13</td>
<td>0.120</td>
</tr>
<tr>
<td>• attend a breastfeeding support group</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>0.344</td>
</tr>
<tr>
<td>• feed from one breast until empty and then from the other</td>
<td>3</td>
<td>9</td>
<td>6</td>
<td>0.326</td>
</tr>
</tbody>
</table>
Table 3.9.  Continued

<table>
<thead>
<tr>
<th>Check</th>
<th>General practitioner (n=86) %</th>
<th>Public health nurse (n=89) %</th>
<th>Practice nurse (n=47) %</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the baby’s weight</td>
<td>74</td>
<td>64</td>
<td>53</td>
<td>0.043</td>
</tr>
<tr>
<td>• if the baby seems happy and contented</td>
<td>19</td>
<td>39</td>
<td>36</td>
<td>0.008</td>
</tr>
<tr>
<td>• the baby’s position and attachment at the breast</td>
<td>19</td>
<td>44</td>
<td>17</td>
<td>0.001</td>
</tr>
<tr>
<td>• how many wet and dirty nappies the baby has per day</td>
<td>13</td>
<td>71</td>
<td>30</td>
<td>0.001</td>
</tr>
<tr>
<td>Discuss strategies to increase milk supply</td>
<td>1</td>
<td>11</td>
<td>2</td>
<td>0.007</td>
</tr>
<tr>
<td>Ask if breasts feel full before a feed and empty afterwards</td>
<td>3</td>
<td>17</td>
<td>6</td>
<td>0.008</td>
</tr>
</tbody>
</table>

* Pearson’s chi-square was used to assess differences
3.4.5  Issues around education

Respondents were asked about training around breastfeeding of which they were aware of and which they had attended. In addition, they were asked about training that they would like to receive. While few GPs and practice nurses were aware of courses on breastfeeding which are provided by the HSE Health Promotion Unit, the majority of public health nurses knew about such courses (Table 3.10). Equally few GPs and practice nurses had attended training in the past two years while over a half of PHN respondents had. Among those that had attended training the majority felt that it was adequate for their needs. While the majority of PHNs (82%, n=79) and practice nurses (81%, n=48) would like to attend training in the next year, a little less than half (44%, n=44) of GPs would.

Table 3.10.  Number of respondents who answered yes to the following questions about training

<table>
<thead>
<tr>
<th></th>
<th>General Practitioners (n=101)</th>
<th>Public health nurse (n=96)</th>
<th>Practice nurse (n=59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of training on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>breastfeeding which is provided by the HSE Health Promotion Unit</td>
<td>4 (4)</td>
<td>80 (90)*</td>
<td>10 (17)</td>
</tr>
<tr>
<td>Have attended training on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>breastfeeding in the past two years</td>
<td>2 (2)</td>
<td>58 (61)</td>
<td>6 (10)</td>
</tr>
<tr>
<td>Training was adequate for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>needs</td>
<td>2 (100)§</td>
<td>54 (93)§</td>
<td>4 (67)§</td>
</tr>
<tr>
<td>Would like to attend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>training in the next year</td>
<td>44 (44)</td>
<td>79 (82)</td>
<td>48 (81)</td>
</tr>
</tbody>
</table>

* This is based on responses from 89 respondents
§ Based on numbers in the previous row, of those who had attended training
Of those who had received training, the majority attended either a breastfeeding management course or a breastfeeding management refresher course. With regards to how much time respondents would be willing to spend on training, the majority of GPs (68%) would spend a half day or less, while the PHN and practice nurse respondents would spend ‘as much time as needed’ or 1-2 days (data not shown). Of those who responded to what kind of training they would like, the majority of GPs would prefer a forum whereby they could study in their own time, such as using self-study training packs (58%, n=45) or online information (39%, n=30). Like PHNs and practice nurses, GPs were also interested in skill-based workshops. The majority of PHNs (50%, n=46) and practice nurses (42%, n=23) favoured an 18-hour breastfeeding management and like GPs, practice nurses (36%, n=20) were also interested in self-study training packs (Table 3.11).

Table 3.11. Medium through which health professionals would like to receive education about breastfeeding

<table>
<thead>
<tr>
<th></th>
<th>General Practitioners (n=77)</th>
<th>Public health nurse (n=91)</th>
<th>Practice nurse (n=55)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-study training packs</td>
<td>58%</td>
<td>18%</td>
<td>36%</td>
</tr>
<tr>
<td>Skill-based workshops</td>
<td>42%</td>
<td>55%</td>
<td>53%</td>
</tr>
<tr>
<td>18-hour breastfeeding management course</td>
<td>6%</td>
<td>50%</td>
<td>42%</td>
</tr>
<tr>
<td>Practical observation</td>
<td>4%</td>
<td>29%</td>
<td>25%</td>
</tr>
<tr>
<td>Online information</td>
<td>39%</td>
<td>13%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Percentages do not add up to 100 because some health professionals gave more than one answer
3.4.6 Self-efficacy in dealing with skill areas

Health professionals rated their confidence in dealing with various breastfeeding support skills, on a scale of 1-4 with 1 being very confident and 4 not at all confident. An option for not applicable (N/A) was also provided. Levels of confidence differed significantly between groups of health professionals (Figures 3.1 and 3.2). In Figures 3.1 and 3.2 ‘being very confident’ and ‘fairly confident’ were combined to give an optimum level of confidence. Figure 3.1 illustrates skill areas related to advising and helping a mother with practical issues such as correct positioning of the baby to the breast, using a breast pump and weaning etc., while Figure 3.2 illustrates areas related to dealing with issues that can arise when breastfeeding, such as mastitis and engorgement. Self-efficacy was strongest amongst PHNs with the majority rating their confidence highly in dealing with different skill areas. GPs rated themselves as more confident in dealing with clinical areas of breastfeeding care than with practical areas. Ninety one percent (n=92) of GPs were confident/fairly confident with prescribing medicine to a breastfeeding woman (data not shown). Ninety percent (n=91) of GPs, 96% (n=91) of PHNs and 61% (n=36) of practice nurses were confident/fairly confident in understanding the physiology of lactation (data not shown). Practice nurses were the least confident in dealing with the different skill areas illustrated in Figures 3.1 and 3.2.

While there was the opportunity for respondents to choose a ‘not applicable’ option few chose this option which would indicate that health professionals felt that the skill areas applied to their area of work.
Figure 3.1. Percent of health professionals who were confident/fairly confident in their breastfeeding support skills in practical areas

- **Encouraging breastfeeding antenatally**
- **Showing a woman how to use a breast pump**
- **Helping a mother with correct positioning and attachment of the baby to the breast**
- **Advising a mother with gestational diabetes about breastfeeding**
- **Advising a mother about weaning from breast to formula and or solids**
- **Advising about returning to work**

**Skill areas**

- **GP (n=101)**
- **PHN (n=96)**
- **Practice nurse (n=59)**

* * p≤0.001

The *p*-value indicates differences in responses between health professional groups, calculated from collapsed categories very confident/fairly confident and not very confident/not at all confident.

^ based on n=80 for PHNs and n=53 for practice nurses

' based on n=98 for GPs and n=55 for practice nurses
Figure 3.2. Percent of health professionals who were confident/fairly confident in their breastfeeding support skills in issues that can arise when breastfeeding

*p-value indicates differences in responses between health professional groups, calculated from collapsed categories very confident/fairly confident and not very confident/not at all confident*
3.4.6.1 Associations between personal and professional characteristics of respondents and their self efficacy in dealing with different skill areas

Associations between a range of personal and professional characteristics and confidence in dealing with different skill areas were explored using cross tabulations and Pearson’s chi-square or Fisher’s exact (in the case of a 2x2 contingency table). Attendance at training on breastfeeding in the past two years was associated with having greater self efficacy in dealing with each of the skill areas (data not shown). This effect may have been due to the fact that it was mainly PHNs that had attended training and so further analysis was conducted on PHNs alone, whereby the association between attendance at training and confidence was assessed using Fisher’s exact. The level of self-assessed confidence was similar for both groups and no significant difference was found (Table 3.12).

Having personal experience of breastfeeding (either they or their partner breastfed) was associated with being more confident in helping a mother with correct positioning and attachment of the baby to the breast \( (p=0.017) \), advising about weaning from breast to formula and or solids \( (p=0.002) \), dealing with milk insufficiency \( (p=0.026) \) and engorgement \( (p=0.039) \) (Table 3.13). This association remained the same for those with less than 6 months personal breastfeeding experience and those with six months or more personal experience of breastfeeding (data not shown). Being more than 40 years of age was also associated with being more confident in advising about weaning from breast to formula and or solids \( (p \leq 0.001) \), dealing with milk insufficiency \( (p=0.004) \) and engorgement \( (p=0.002) \) (Table 3.14). Dealing with breastfeeding issues more than 50 times in the past year at work was associated with being more confident in each of the
skill areas, however, because PHNs were the profession that dealt with issues the most, the association was assessed for PHNs alone. Significant differences were not found between the level of confidence amongst PHNs who dealt with issues more than 50 times in the past year with those who did not (data not shown).

Finally, there was no significant difference between male GPs and female GPs in their self assessed confidence levels in dealing with breastfeeding issues (data not shown).
Table 3.12. Percent of public health nurses that had or had not received training on breastfeeding in the past two years that were very confident/fairly confident with each of the skill areas

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Attendance at training in the past two years</th>
<th>Non-attendance at training in the past two years</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the physiology of lactation</td>
<td>98 %</td>
<td>92 %</td>
<td>0.296</td>
</tr>
<tr>
<td>Encouraging breastfeeding antenatally (n=80)</td>
<td>98 %</td>
<td>97 %</td>
<td>1.000</td>
</tr>
<tr>
<td>Showing a woman how to use a breast pump</td>
<td>91 %</td>
<td>86 %</td>
<td>0.504</td>
</tr>
<tr>
<td>Helping a mother with correct positioning and attachment of the baby to the breast</td>
<td>100 %</td>
<td>95 %</td>
<td>0.149</td>
</tr>
<tr>
<td>Advising a mother with gestational diabetes about breastfeeding</td>
<td>75 %</td>
<td>78 %</td>
<td>0.807</td>
</tr>
<tr>
<td>Advising about weaning from breast to formula and or solids</td>
<td>98 %</td>
<td>97 %</td>
<td>1.000</td>
</tr>
<tr>
<td>Advising about returning to work</td>
<td>98 %</td>
<td>97 %</td>
<td>1.000</td>
</tr>
<tr>
<td>Milk insufficiency</td>
<td>96 %</td>
<td>92 %</td>
<td>0.379</td>
</tr>
<tr>
<td>Mastitis</td>
<td>98 %</td>
<td>92 %</td>
<td>0.296</td>
</tr>
<tr>
<td>Cracked/sore nipples</td>
<td>100 %</td>
<td>95 %</td>
<td>0.149</td>
</tr>
<tr>
<td>Slow weight gain in the baby</td>
<td>100 %</td>
<td>97 %</td>
<td>0.389</td>
</tr>
<tr>
<td>Thrush</td>
<td>97 %</td>
<td>97 %</td>
<td>1.000</td>
</tr>
<tr>
<td>Inverted nipples</td>
<td>93 %</td>
<td>92 %</td>
<td>1.000</td>
</tr>
<tr>
<td>Engorgement</td>
<td>100 %</td>
<td>95 %</td>
<td>0.149</td>
</tr>
</tbody>
</table>

*p-value was calculated from collapsed categories (very confident/fairly confident and not very confident/not at all confident) and differences were assessed using Fisher’s exact (2x2 contingency table)
Table 3.13. Percent of health professionals that had or did not have personal experience of breastfeeding that were very confident/fairly confident with each of the skill areas

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>Personal experience of breastfeeding</th>
<th>No personal experience of breastfeeding</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the physiology of lactation</td>
<td>86% (n=132)</td>
<td>85% (n=124)</td>
<td>1.000</td>
</tr>
<tr>
<td>Encouraging breastfeeding antenatally (n=234)</td>
<td>85%</td>
<td>80%</td>
<td>0.501</td>
</tr>
<tr>
<td>Showing a woman how to use a breast pump (n=249)</td>
<td>67%</td>
<td>55%</td>
<td>0.079</td>
</tr>
<tr>
<td>Helping a mother with correct positioning and attachment of the baby to the breast</td>
<td>81%</td>
<td>67%</td>
<td>0.017</td>
</tr>
<tr>
<td>Advising a mother with gestational diabetes about breastfeeding</td>
<td>65%</td>
<td>63%</td>
<td>0.789</td>
</tr>
<tr>
<td>Advising about weaning from breast to formula and or solids</td>
<td>92%</td>
<td>77%</td>
<td>0.002</td>
</tr>
<tr>
<td>Advising about returning to work</td>
<td>92%</td>
<td>85%</td>
<td>0.060</td>
</tr>
<tr>
<td>Milk insufficiency</td>
<td>81%</td>
<td>68%</td>
<td>0.026</td>
</tr>
<tr>
<td>Mastitis</td>
<td>88%</td>
<td>87%</td>
<td>0.701</td>
</tr>
<tr>
<td>Cracked/sore nipples</td>
<td>92%</td>
<td>89%</td>
<td>0.519</td>
</tr>
<tr>
<td>Slow weight gain in the baby</td>
<td>85%</td>
<td>84%</td>
<td>1.000</td>
</tr>
<tr>
<td>Thrush</td>
<td>88%</td>
<td>89%</td>
<td>0.841</td>
</tr>
<tr>
<td>Inverted nipples</td>
<td>78%</td>
<td>70%</td>
<td>0.188</td>
</tr>
<tr>
<td>Engorgement</td>
<td>91%</td>
<td>82%</td>
<td>0.039</td>
</tr>
</tbody>
</table>

* *p*-value was calculated from collapsed categories (very confident/fairly confident and not very confident/not at all confident) and differences were assessed using Fisher’s exact.
Table 3.14. Percent of health professionals by age range that were very confident/fairly confident with each of the skill areas

<table>
<thead>
<tr>
<th>Skill Area</th>
<th>≤40 years</th>
<th>41-50 years</th>
<th>≥51 years</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the physiology of lactation</td>
<td>82%</td>
<td>89%</td>
<td>91%</td>
<td>0.174</td>
</tr>
<tr>
<td>Encouraging breastfeeding antenatally (n=234)</td>
<td>88%</td>
<td>90%</td>
<td>95%</td>
<td>0.339</td>
</tr>
<tr>
<td>Showing a woman how to use a breast pump (n=249)</td>
<td>64%</td>
<td>67%</td>
<td>60%</td>
<td>0.725</td>
</tr>
<tr>
<td>Helping a mother with correct positioning and attachment of the baby to the breast</td>
<td>72%</td>
<td>80%</td>
<td>78%</td>
<td>0.353</td>
</tr>
<tr>
<td>Advising a mother with gestational diabetes about breastfeeding</td>
<td>62%</td>
<td>66%</td>
<td>69%</td>
<td>0.584</td>
</tr>
<tr>
<td>Advising about weaning from breast to formula and or solids</td>
<td>73%</td>
<td>94%</td>
<td>96%</td>
<td>0.001</td>
</tr>
<tr>
<td>Advising about returning to work</td>
<td>85%</td>
<td>92%</td>
<td>94%</td>
<td>0.109</td>
</tr>
<tr>
<td>Milk insufficiency</td>
<td>66%</td>
<td>82%</td>
<td>85%</td>
<td>0.004</td>
</tr>
<tr>
<td>Mastitis</td>
<td>85%</td>
<td>88%</td>
<td>92%</td>
<td>0.341</td>
</tr>
<tr>
<td>Cracked/sore nipples</td>
<td>88%</td>
<td>95%</td>
<td>90%</td>
<td>0.272</td>
</tr>
<tr>
<td>Slow weight gain in the baby</td>
<td>81%</td>
<td>85%</td>
<td>91%</td>
<td>0.212</td>
</tr>
<tr>
<td>Thrush</td>
<td>86%</td>
<td>90%</td>
<td>93%</td>
<td>0.390</td>
</tr>
<tr>
<td>Inverted nipples</td>
<td>68%</td>
<td>78%</td>
<td>82%</td>
<td>0.089</td>
</tr>
<tr>
<td>Engorgement</td>
<td>79%</td>
<td>91%</td>
<td>96%</td>
<td>0.002</td>
</tr>
</tbody>
</table>

* p-value was calculated from collapsed categories (very confident/fairly confident and not very confident/not at all confident) and differences were assessed using Pearson’s chi-square
Binary logistic regression was conducted to determine the independent contribution of profession, age and personal experience of breastfeeding, towards confidence in dealing with various skill areas. All of the variables (having personal experience of breastfeeding or not, profession, and age) were entered into the model as predictor variables and confidence in dealing with the specific skill areas as the outcome variables. The results are presented in Table 3.15. When each of the other variables were controlled for, being a PHN was associated with being more confident in dealing with each of the four skill areas. In addition, being older (≥41 years) was also associated with being more confident in dealing with each of the skill areas. Having personal experience of breastfeeding was associated with being four times more confident in advising a woman about weaning from breast to formula and or solids.
Table 3.15. Binary logistic regression model examining personal characteristics on predicting confidence in dealing with breastfeeding skill areas

<table>
<thead>
<tr>
<th>Variable in model</th>
<th>Advising a woman about weaning from breast to formula and or solids</th>
<th>Advising about correct positioning and attachment</th>
<th>Dealing with milk insufficiency</th>
<th>Dealing with engorgement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Profession</strong> (public health nurse)</td>
<td>OR                     (95% CI)                                    OR                     (95% CI)                      OR                     (95% CI)                      OR                     (95% CI)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td>0.057                  (0.012-0.272)                               0.019                  (0.004-0.084)                  0.114                  (0.039-0.332)                  0.185                  (0.036-0.946)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice nurse</td>
<td>0.029                  (0.006-0.135)                               0.025                  (0.005-0.115)                  0.031                  (0.010-0.094)                  0.024                  (0.005-0.113)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age (less than 40)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41-50 years</td>
<td>6.314                  (2.078-19.185)                                   *                       3.298                  (1.389-7.830)                  3.622                  (1.213-10.818)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greater than 50 years</td>
<td>7.449                  (1.999-27.758)                               2.721                  (1.104-6.711)                  4.144                  (1.045-16.426)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Experience of breastfeeding</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(do not have personal experience)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have personal experience</td>
<td>4.458                  (2.226-8.927)                               2.384                  (0.968-5.872)                  1.781                  (0.852-3.723)                  1.552                  (0.597-4.032)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OR = Odds Ratio                                          CI = Confidence Interval
The reference category is given in brackets in italic
*Variables not included in the model as they were not significantly associated with being confident in these skill areas, in univariate analysis
3.4.7 Perceived barriers to providing breastfeeding support

The majority of health professionals agreed that mothers were given conflicting advice about breastfeeding from health professionals, with 63% (n=161) of the total sample agreeing with this. Significantly more PHNs agreed with this than GPs or practice nurses ($p \leq 0.001$) (Table 3.16). The majority of each profession also agreed that mothers were given conflicting advice about breastfeeding from family members and friends (Table 3.16). About 40% of each profession agreed that there are problems keeping up to date with current infant feeding recommendations. While the majority of PHNs (82%, n=79) agreed that they have sufficient skills to provide breastfeeding support, only half of GPs (54%, n=54) and one third of practice nurses (32%, n=19) agreed with this.

Of those GPs that disagreed or were unsure that they had sufficient skills to provide breastfeeding support, 49% (n=23) would like to receive training on breastfeeding in the next year, while the other 51% (n=24) would not (data not shown). In the case of practice nurses, 92% (n=36) of those that disagreed or were unsure that they have sufficient skills, would like to attend training around breastfeeding in the next year (data not shown). The majority of PHNs (83%, n=79) agreed that ‘my colleagues in my organisation have sufficient skills to provide breastfeeding support’, with significantly more agreeing than GPs and practice nurses (Table 3.16). Thirty nine percent of GPs, 53% (n=51) of PHNs and 36% (n=21) of practice nurses agreed that staff levels in their organisation are too low to provide adequate support to breastfeeding mothers.
### Table 3.16. Percent of respondents who agreed with the following statements on breastfeeding support

<table>
<thead>
<tr>
<th>Statement</th>
<th>General Practitioners</th>
<th>Public health nurse</th>
<th>Practice nurse</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers are given conflicting advice from</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health professionals</td>
<td>55%</td>
<td>79%</td>
<td>56%</td>
<td>0.001</td>
</tr>
<tr>
<td>Family members</td>
<td>88%</td>
<td>89%</td>
<td>95%</td>
<td>0.367</td>
</tr>
<tr>
<td>Friends</td>
<td>85%</td>
<td>81%</td>
<td>86%</td>
<td>0.659</td>
</tr>
<tr>
<td>There are problems keeping up-to-date with current infant feeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>recommendations</td>
<td>44%</td>
<td>38%</td>
<td>45%</td>
<td>0.560</td>
</tr>
<tr>
<td>Staff levels in my organisation are too low to provide adequate support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>39%</td>
<td>53%</td>
<td>36%</td>
<td>0.076</td>
</tr>
<tr>
<td>I have sufficient skills to provide breastfeeding support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>54%</td>
<td>82%</td>
<td>32%</td>
<td>0.001</td>
</tr>
<tr>
<td>My colleagues in my organisation have sufficient skills to provide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>breastfeeding support</td>
<td>53%</td>
<td>83%</td>
<td>44%</td>
<td>0.001</td>
</tr>
</tbody>
</table>

* Pearson’s chi-square was used to assess differences

#### 3.4.8 Knowledge of breastfeeding support groups

Sixty five percent (n=65) of GPs, 96% (n=89) of PHNs and 75% (n=44) of practice nurses knew of a breastfeeding support group in their area. While all of the PHNs would know how to put a mother in contact with a breastfeeding support group only 85% (n=85) of the GPs and 81% (n=48) of the practice nurses would know how to do so (data not shown).
3.5 Discussion

This study had a sample size of 256 health professionals. The response rate was quite low with an overall rate of 46%. The response rate was lowest amongst GPs with only 35% answering the questionnaire. Non-response of GPs to surveys has been correlated with a lack of interest in the study area (Barclay et al., 2002) and so this may indicate that breastfeeding is not a topic of concern for GPs. There are also limitations to postal surveys and these include, not being sure that the person to whom the questionnaire is sent actually fills it in and a lack of control over checking incomplete responses and incomplete questionnaires (Oppenheim, 1992). While caution must therefore be taken in interpreting the results, owing to the possibility of response bias, the study nevertheless provides an insight into the knowledge and attitudes towards breastfeeding and the barriers to providing support among a group of health professionals in North Dublin. Assuming that those who were more interested and positive about breastfeeding were more likely to have responded to the questionnaires, the results regarding knowledge, attitudes and self-efficacy may indicate a best case scenario. The setting for the study was both a city centre and suburban area and so while the results cannot be generalised to the rest of Ireland, the study does help illustrate issues for health professionals around breastfeeding support which may be of concern to health professionals in other areas and which are important to address. This research is unique in Ireland because it considered concurrently three different professional groups and many different aspects of professional support for breastfeeding in a single study.

As has been found in other studies (Freed et al., 1995; Hellings & Howe, 2000; Simmons, 2002), personal experience was one of the main sources of breastfeeding
knowledge for GPs and practice nurses. This is not surprising as dedicated breastfeeding training is usually only taught to midwives, public health and neonatal nurses at undergraduate level in Ireland (Department of Health and Children, 2003b). For PHNs, in-service training was one of their main sources of breastfeeding knowledge. This is similar to a study of health visitors in Denmark where it was found that courses and literature were their main sources of knowledge (Kronborg et al., 2008).

While having personal experience of breastfeeding was associated with being four times more confident in advising about weaning, it was not, however, associated with having more knowledge or having a greater appreciation for the benefits of breastfeeding. Equally having personal experience of breastfeeding for longer than six months was not associated with improved knowledge or attitudes towards breastfeeding. Other studies have consistently found a positive contribution of personal breastfeeding experience towards knowledge and attitudes (Freed et al., 1995; Patton et al., 1996; Schanler et al., 1999; Cantrill et al., 2003). Studies do, however, vary in their definition of personal experience with some defining it as ever breastfed (Freed et al., 1995; Patton et al., 1996), breastfed at least 3 months (Cantrill et al., 2003), or comparing those who had children and breastfed with those who had children and did not breastfeed (Schanler et al., 1999). In contrast to my results, research from Australia found that increasing length of breastfeeding experience was associated with better knowledge, attitudes and confidence in dealing with breastfeeding issues amongst GP registrars (Brodribb et al., 2008). The difference between my results and others may be a reflection of the low breastfeeding rates in Ireland and the lack of a breastfeeding culture. This, along with a
lack of training may have a greater effect on the knowledge and attitudes of health professionals than actual personal experience.

Hellings & Howe (2000) contend that there is both an ‘art and a science’ in breastfeeding and that education in the science of breastfeeding is needed because experience alone is not enough. Health professionals’ main source of knowledge about breastfeeding should not be personal experience and this result indicates a need for improved breastfeeding education especially for GPs and practice nurses. An educational intervention delivered to GPs, health visitors and midwives in the UK was found to reduce the difference in knowledge post intervention between those with personal experience and those without, indicating the importance of training around breastfeeding for all disciplines (Ingram, 2006).

In spite of the widely acknowledged nutritional and immunological benefits of breastfeeding, about 25% of GPs and practice nurses were neutral or disagreed that exclusive breastfeeding is the best form of nutrition in the first six months of life. A study of paediatricians also found such disagreement for the nutritional benefits of breastfeeding, however, in that study nearly half of those surveyed believed that breastfeeding and formula feeding are equally acceptable forms of nutrition (Schanler et al., 1999). The immunological benefits of breast milk were appreciated more than the nutritional benefits by all three groups, however, still 11-13% of GPs and practice nurses disagreed or were neutral that a breastfed infant has increased immune function compared with an infant fed formula. This lack of appreciation is likely to affect the way health professionals discuss breastfeeding with women. Respondents also had different levels of agreement in whether it was their role as a health professional to promote
breastfeeding with only 50% of GPs and 58% of practice nurses strongly agreeing with this. This contrasted with PHNs of whom 93% strongly agreed. This indicates a degree of ambivalence amongst some healthcare workers towards breastfeeding. It is important that this is addressed because women who are encouraged to breastfeed by their healthcare provider are more likely to initiate breastfeeding than those who do not receive encouragement (Lu et al., 2001). In addition, such attitudes would seem to add to the list of conflicting advice that mothers report receiving from health professionals about breastfeeding (Rajan, 1993; Dykes et al., 2003). These negative/neutral attitudes towards breastfeeding may also indicate that, as Battersby (2006) has proposed, attitudes are influenced by the society in which we live and so healthcare workers are not immune to the culture of formula feeding in Ireland. While the attitude questions helped determine health professionals’ views on breastfeeding, these were measured using a likert-scale. It must, however, be acknowledged that there is a limitation to the way in which the items were analysed as nominal data instead of being summed to give an attitude ‘score’ and so the results are descriptive and based on percentage comparisons between groups and responses to individual items.

Although research has shown that supplementing with formula in the first few weeks of breastfeeding can lead to breastfeeding failure (Righard, 1998), 58-69% of all health professionals disagreed or were neutral that supplementation has this effect. Cessation of breastfeeding in the first few weeks postpartum is associated with mothers perceiving they have insufficient milk (Kirkland & Fein, 2003; Taveras et al., 2004b; Lewallen et al., 2006). Evidence indicates that less than five percent of women are physiologically incapable of producing adequate supply of breast milk (Renfrew et al., 2000). It is
therefore discouraging that 27%, 8% and 20% of GPs, PHNs and practice nurses respectively were unsure or would advise a woman to stop breastfeeding in the case of milk insufficiency. In response to what specific advice they would give a mother who perceived she had insufficient milk, 24% of GPs would recommend supplementing with formula. For low milk supply, advice such as feeding on demand, checking how many wet and dirty nappies a baby has, checking the baby’s weight and checking the position and attachment of the baby at the breast are all positive ways in which a health professional could help deal with this issue (Gatti, 2008). Most of these practices were mentioned by less than half of all respondents. The lack of consensus on how to deal with perceived insufficient milk demonstrates there may be a lack of consistency across the different group of health professionals in the advice they give a breastfeeding woman. Receiving conflicting advice from health professionals has been commonly cited as a frustration for women and for healthcare workers themselves (Rajan, 1993; Dykes et al., 2003; Tennant et al., 2006). Health professionals do, however, seem to be aware of the lack of consistency in the advice that breastfeeding women receive as over half of those surveyed agreed that mothers are given conflicting advice about breastfeeding from health professionals.

While knowledge was good overall, the area which all groups lacked knowledge the most was in treating a breast abscess. This has been found in other studies (Hellings & Howe, 2000; Cantrill et al., 2003; Finneran & Murphy, 2004). Amir & Ingram (2008) have suggested that when health professionals often do not know how to handle common breastfeeding problems such as mastitis, they cannot be expected to know how to handle less common conditions such as breast abscess. Approximately one in six
women are likely to experience one or more episodes of mastitis while breastfeeding (Scott et al., 2008). In this study, while the majority of respondents would not advise a mother to stop breastfeeding in the case of mastitis, still 9% of GPs would. In a study of the appropriateness of the support and management received by women from healthcare workers for mastitis, Scott et al., (2008) also found that 10% of women were inappropriately advised to stop breastfeeding. While these rates appear low, they are as Scott et al., (2008) have described clinically significant. If a mother approaches a GP for treatment for mastitis or a breast abscess, she should be sure of getting the appropriate correct advice.

This research found that PHNs were confident in most of the skill areas of breastfeeding support and in particular were very confident with all support skills needed postnatally. In binary logistic regression being a PHN was associated with being more confident than GPs or practice nurses in four different skill areas, when personal experience of breastfeeding and age were controlled for. Leahy-Warren et al., (2009) found similar levels of confidence in a national survey of PHNs in Ireland. GPs and practice nurses showed a particular lack of confidence in helping a mother with correct positioning and attachment of the baby to the breast with 39-40% of those surveyed being not very confident/not at all confident. A lack of formal instruction for medical practitioners in how to attach a baby to the breast has been highlighted in another study (Brodribb et al., 2007c). Yet this skill is important because in order to prevent complications with breastfeeding such as cracked/sore nipples and milk insufficiency, a baby needs to be attached to the breast correctly (Renfrew et al., 2000). Also, it is a skill that mothers need to be taught, it is not instinctual and women have reported that health professionals
having such skills were crucial but sometimes lacking (Graffy & Taylor, 2005; Smale et al., 2006). In binary logistic regression being older (≥41 years) was also associated with having more confidence in dealing with skill areas. Few studies have looked at the association between age and confidence, however, some have found a positive association between older healthcare workers and more knowledge about breastfeeding (Cantrill et al., 2003). A little over a half of GPs and a third of practice nurses agreed that they have sufficient skills to provide breastfeeding support, demonstrating low self efficacy which could be damaging to the support and advice they give a breastfeeding woman. Profession was one of the main predictors in determining self efficacy, with PHNs being more confident than GPs and practice nurses. This is not surprising as all of the PHNs would have received specific training in breastfeeding as part of their training as midwives. Until 2007, all PHNs needed to be registered midwives, as well as registered general nurses. This requirement no longer applies and applicants to the Postgraduate Diploma in Public Health Nursing who are not registered midwives, must undertake a specific maternal and child health nursing module.

While having received training in the past two years was not associated with being more confident in different skill areas, PHNs received the most training in breastfeeding management, with 62% having attended training in the past two years. Equally the majority of PHNs (90%) were aware of breastfeeding management courses run by the health promotion unit, while few GPs (4%) and practice nurses (17%) were aware of this. Despite the high self efficacy displayed by PHNs in dealing with issues around breastfeeding, the majority (82%) still indicated an interest in gaining or updating knowledge and skills through training. This was similar for practice nurses with 84%
wanting to attend training on breastfeeding in the next year. GPs were less inclined and this study did not examine why they would not like training. A qualitative study of rural GPs in Australia found that some male GPs believed they needed minimal breastfeeding knowledge because they were unlikely to see breastfeeding women and they felt they were not the most appropriate people to assist or advise on breastfeeding (Brodribb et al., 2007c). Another study of health professionals found that breastfeeding was seen as a minor health issue, and that many felt breastfeeding support should be provided by experts (Dillaway & Douma, 2004). In the UK, GPs have been found to be less likely to attend training on breastfeeding compared with midwives and health visitors (Abbott et al., 2006). Wallace and Kosmala-Anderson (2006) also identified that health professionals who considered themselves competent in key areas of breastfeeding support, were more likely to want breastfeeding training while for those less competent the opposite effect was seen.

Education of health professionals around breastfeeding is an important issue that needs to be addressed as studies have found that having knowledge of breastfeeding is associated with supportive breastfeeding behaviour amongst healthcare workers (Bernaix, 2000; Kronborg et al., 2008). Improved knowledge does not however mean there is a resultant improvement in attitudes (Brodribb et al., 2008) and so education around breastfeeding should address both knowledge and attitudes. The results indicate that training is not something that simply needs to be provided but that instead each profession needs to be considered separately and the issues around them providing support for breastfeeding need to be understood in more detail.
3.6 Conclusions

The health professionals that a woman meets both in the antenatal and postnatal period, can influence a woman positively (Duffy et al., 1997; Renfrew et al., 2000; Sikorski et al., 2003) or negatively (Dennis, 2002) in her decision to breastfeed or to continue breastfeeding. Health professionals are an important group to consider when wanting to improve the standard of support given to breastfeeding women. This study reveals discrepancies between the knowledge and attitudes of different health professional disciplines towards breastfeeding. The findings are consistent with studies from other developed countries (Freed et al., 1995; Hellings & Howe, 2000; Cantrill et al., 2003; Wallace & Kosmala-Anderson, 2006), indicating as McFadden et al., (2007) have highlighted that the issues identified here may be “endemic across countries where breastfeeding rates are low”. While the majority of healthcare workers felt that it was their role as a health professional to promote breastfeeding, there was some ambivalence shown in relation to professional responsibility and also their attitudes towards breastfeeding. Doctors who do not understand or believe the benefits of breastfeeding are unlikely to convey to women that breast milk is the preferred form of infant nutrition (Freed et al., 1995).

This study also points towards some gaps in healthcare workers’ knowledge in dealing with certain breastfeeding issues. This is not surprising as the study revealed a lack of formal education in breastfeeding for GPs and practice nurses, with many depending on their own personal experience of breastfeeding as their main source of knowledge. Health professionals should not, however, need to depend on their personal experience of breastfeeding to provide information and should instead be able to practice in a
competent and professional manner (Brodribb et al., 2008). The study exposed a lack of consistency in healthcare workers’ knowledge and self-efficacy in dealing with certain breastfeeding issues, indicating the potential for women to be given conflicting advice. Finally, while the study provides an insight into the training needs of health professionals it also indicates that some professional groups are not especially interested in receiving training and so further research is needed in this area to understand the issues for health professionals in providing support for breastfeeding.
CHAPTER 4

4 Issues for Health Professionals in Providing Support for Breastfeeding

This chapter describes a qualitative study, the aim of which was to address the issues for health professionals in providing support for breastfeeding. This qualitative study follows on from the quantitative study described in chapter three. The findings of the quantitative study indicated a need for a more in-depth analysis of health professionals’ experiences around providing support for breastfeeding.

4.1 Introduction

As discussed in chapter three, quite a lot of quantitative research has been conducted, looking at the knowledge and attitudes of health professionals towards breastfeeding. These studies have focused on general practitioners, midwives, paediatricians, obstetricians and health visitors and have found knowledge deficits and varying attitudes amongst the different groups (Freed et al., 1995; Hellings & Howe, 2000; Cantrill et al., 2003; Finneran & Murphy, 2004; Renfrew, 2006; Wallace & Kosmala-Anderson, 2006; Wallace & Kosmala-Anderson, 2007). Qualitative research has also been conducted in this area and has allowed for a more in-depth look at the issues around breastfeeding for healthcare professionals. These studies have identified barriers for health professionals in providing support for breastfeeding women and include healthcare workers not
feeling adequately trained (Smale et al., 2006; Brodribb et al., 2007b), not having personal experience of breastfeeding (Brodribb et al., 2007c), poor professional practice (Simmons, 2002), struggling not to appear like a ‘breastfeeding bully’ (Dillaway & Douma, 2004; Tennant et al., 2006) and a lack of time to adequately support women (West & Topping, 2000; Lyons et al., 2008). However, to date no such qualitative studies have been conducted in Ireland amongst health professionals.

4.2 Aims and objectives

The aim of this research was to better understand the issues for health professionals, in both the community and hospital setting, in providing support for breastfeeding. The objectives were to describe health professionals’ views on infant feeding, their perceived barriers to promoting and supporting breastfeeding and their experience of and thoughts on training around breastfeeding.

4.3 Methods

As described in chapter two, this study is a qualitative descriptive study with grounded theory ‘overtones’. While the ultimate aim of the study was not to generate theory, as is normally the case with grounded theory, specific aspects of that methodology were used in the research and these will be described in more detail below.

4.3.1 Research setting

As with the quantitative study described in chapter three, this study was also conducted in North Dublin. In addition to GPs, PHNs and practice nurses, midwives, obstetricians
and paediatricians in the maternity hospital in North Dublin (Rotunda Hospital) were also sought to participate in the study. The contact details of the GPs, PHNs and practice nurses had already been obtained for the quantitative study and so permission was sought and granted from the ICGP, DPHN and the IPNA to use these names again for the qualitative study. Before conducting any research in the maternity hospital, ethics approval was sought from the Research Ethics Committee in the hospital and this was granted on condition that a gatekeeper within the hospital acted as a go-between, between the researcher and potential study participants. One of the lactation consultants in the hospital was asked to be the gatekeeper and she then worked with the researcher in recruiting participants.

4.3.2 Sampling strategy

Purposive sampling whereby participants are selected based on them having particular characteristics, is the sampling technique most often used in qualitative research. As far as possible, sampling was based on one of the strategies of purposive sampling called theory-based sampling (Patton, 2002). This involved interviewing participants based on their potential for adding further insight into the developing description being built upon during data collection and analysis. Where possible this sampling technique was used, however, as Strauss & Corbin (1990) acknowledge, sampling was sometimes done on the basis of who was available and willing to participate in the research.

4.3.2.1 Recruiting participants

Initially, GPs, PHNs and practice nurses were selected purposively based on those that had responded and not responded to the questionnaire which was sent to them as part of
the quantitative study. A letter was sent inviting them to participate in the qualitative study (Appendix IX). Initial uptake of health professionals who were willing to participate was low due to the time element involved in doing an interview. However, once interviewing began and contact was made with participants, as far as possible, sampling proceeded based on people’s potential for adding insight into developing categories during data analysis. For instance, health professionals who had an IBCLC qualification, those who worked in a primary care centre and male doctors were sought.

Theory-based sampling was more difficult in the hospital because a gate-keeper was used as an intermediary between the researcher and potential participants. The ‘gate-keeper’ informed midwives, obstetricians and paediatricians in the hospital about the study and if they were interested in participating, permission was sought to give their contact details to the researcher who subsequently called them to arrange a time and place for the interview. The gatekeeper also introduced the researcher to healthcare providers while walking around the hospital, enabling her to explain the study herself. An information sheet about the study was given to potential participants (Appendix X). Initial sampling strategy was therefore based on whoever was available and willing to participate. However, as data were collected and categories emerged, the researcher was able to ask the gate-keeper for participants based on specific attributes, such as male doctors, midwives working on private wards and foreign staff. This enabled the researcher to develop categories and aided in providing a deeper understanding of the issues under study.
4.3.3 Data Collection

Data were collected through face-to-face, individual interviews.

4.3.3.1 Development of an interview guide

An interview guide (Appendix XI) was used in order to provide a framework around which the interview could be conducted. In developing the interview guide, questions were brainstormed onto paper and they were first organised according to those that were essentially the same, then into similar topics and lastly into their narrative sequence. This was done as suggested by Gillham (2005). Questions were based on the aims and objectives of the study and also on the literature. In addition, the key findings from the quantitative study were further explored. These included some health professionals having a lack of interest in attending training on breastfeeding and barriers for health professionals in providing support for breastfeeding. During the interviews care was taken to allow the participants to tell their story in their own words and to not use the interview guide prescriptively (Schreiber, 2001).

4.3.3.2 Interview process

In total 58 interviews were conducted. Interviews took place over a six month period, between May 2008 and October 2008. All interviews, except for one, took place in a room in the participant’s workplace. In the case of one interview, the participant preferred to be interviewed by phone. All interviews were recorded, with permission, using an Olympus VN-2100 Digital Recorder. Four of the interviews were not recorded because three participants preferred not to have the interview recorded and the telephone interview was not recorded either. In these cases, notes were taken during the interview.
and field notes were written up as soon as possible afterwards. The interviews lasted an average of twenty minutes.

Interviews followed guidelines described by Kvale (1996). These included, at the start, the interviewer describing the purpose of the interview, explaining the use of the voice recorder and asking if the interviewee had any questions before starting. The interviewees were also assured of the voluntary nature of participation in the research and that what they said would not be identifiable to them (Holloway & Fulbrook, 2001). All participants were asked to sign a consent form and to fill out a brief demographic questionnaire. These are both provided in Appendix XII. During the interview the questioning technique used was such that the participants were encouraged to speak as freely as possible. In this way the same technique as that of Furber (2004) was used at the beginning of the interview, with the first question being “what are your views on infant feeding?”, encouraging the participants to say what they experienced as the main aspects of the phenomena being investigated, yielding spontaneous, rich description. In addition, probing questions were used to encourage participants to expand on what they said with questions such as ‘what do you mean by……’ or ‘could you tell me more about that’. Each interview was concluded with the interviewer asking the participant if they had anything else they would like to bring up or ask before finishing, giving them the opportunity to discuss issues that had not been asked but that were of importance to the interviewee and they were also asked if they could recommend another person who might be a valuable source of information (Erlandson et al., 1993).
4.3.3.3 Transcription of interviews

In qualitative research it is recommended that the researcher should be the person who interviews and also transcribes (Easton et al., 2000). In this study this was the case and it provided the opportunity for me to familiarise myself with the data. In keeping with grounded theory and data collection and analysis running concurrently (Strauss & Corbin, 1990), interviews were transcribed and analysed, where possible, after each interview. In some cases two or three interviews took place on the same day and in these cases they were transcribed and analysed as soon as possible afterwards. Any interruptions during the interview were noted in the script between brackets and also if the tone in which a participant said something was important to the meaning of the sentence, a note was also made of this. Sometimes owing to background noise, or not being able to hear the recording accurately, words were missing in the transcript and this was indicated by dots (…..). In order to ensure that the form and style of participant’s expression was caught, incomplete sentences, repetitions and poor grammar were included in the transcripts (Bazeley, 2007). In addition, if any more information was given at the end of the interview when the voice recorder was turned off, a note of what was said was written down as soon as possible after the interview. Finally following transcription of each interview and prior to analysis, the script was checked for accuracy by listening to the recording again and comparing it with the scripts. All interviews were transcribed in Microsoft Word.

4.4 Data Analysis

As described in chapter two, the computer software NVivo 8 was used as an aid to data analysis. Corbin & Strauss (2008) described how ‘computers can be used to keep a
running log of concepts and a log of memos, helping the analyst shift concepts around, retrieve memos and provide easy access to what has already been done’. Using NVivo in this study aided the research in such a way and made data analysis more efficient and transparent. Prior to data analysis, transcripts from interviews were imported into NVivo 8. The process of data analysis was conducted in accordance with the features of grounded theory, outlined in section 2.5.4. While the different stages of coding are presented sequentially below, in reality the process was more cyclical with the different stages interwoven.

4.5 General approach to coding

4.5.1 Initial coding or ‘open coding’

The data were analysed line by line and were named or coded in one of two ways. This step corresponded with what is called ‘open coding’ in grounded theory method (Strauss & Corbin, 1990).

1. Reading through the data and capturing the concept by naming the particular phenomena (Corbin and Strauss, 1990). For example the following data were coded as ‘Frustration’:

   “You spend all the first day devoting and everything doing for that woman and next day she turns up and says I don’t want to breastfeed I want to bottle feed”

2. Concepts already discussed in the literature (Strauss & Corbin, 1990). For example the following data were coded as ‘Jack of all trades’ and this term was used before by Begley et al., (2004) in a study of the role and workload of the PHN in the Galway Community Area.
“Like we do some many different things, like we have that much knowledge (puts fingers together to show small amount) about a million things and it’s hard to be an expert about everything you know”

In order to ensure that there were not endless lists of codes and that they were neither too concrete nor abstract (LaRossa, 2005) each code’s properties were described and so these along with the content of the codes were regularly reviewed. An example of a code and its properties are shown in Appendix XIII(A). In addition NVivo has a function whereby coding stripes can be turned on and these show, at a glance, which codes a particular piece of data have been coded to. An example of coding stripes and their corresponding data are shown in Appendix XIII(B). Codes that were similar in definition and content were either merged or refined to demonstrate the differences between them.

While coding, I employed strategies described by Strauss & Corbin (1990) to ‘open-up’ the data. These included asking questions such as “what is happening here?” and “what is the event about?”. Also, analysing a word or phrase enabled further probing of the data already obtained or further enquiry in future interviews. For instance, during coding I noticed that some health professionals described themselves as ‘pro-breastfeeding’, I questioned what this meant and when I enquired into it further I found that there were different levels of being ‘pro-breastfeeding’. For example, in one sense it had a positive connotation whereby a person supported breastfeeding, while in another sense if someone was ‘very pro-breastfeeding’ it meant that the person verged on being a ‘bully’ about breastfeeding.
Finally, while coding, a technique described by Strauss & Corbin (1990) called ‘waving the red flag’ was employed. This means that when words such as ‘never’ or ‘always’ etc. are used it makes the researcher question if what is being said is always the case and encourages the researcher to take a closer look at the phenomena, ensuring that nothing is being taken for granted. An example of how I used this technique was when I was coding an interview with an obstetrician and I noticed that he had described how he “always” called the lactation consultant if one of his patients was having difficulty with breastfeeding. In the interview I never questioned what would happen if he could not reach the lactation consultant which was quite likely due to the reduced hours that the lactation consultant worked and also being too busy. By employing the technique of ‘waving the red flag’ it highlighted the need for me to probe further when interviewees expressed such explicit remarks.

4.5.2 Focused coding or ‘axial coding’

As outlined in chapter two, coding moved from ‘open-coding’ to more focused ‘axial coding’ which lead to the building of ‘tree nodes’, whereby a coding hierarchy was built upon with concepts and categories related to each other. This higher level of abstraction was aided by keeping a research journal, writing memos and using the modeller function in NVivo.

4.5.2.1 Research Journal

One important strategy in qualitative data analysis is that the researcher remains reflexive of the thoughts and ideas that she brings to a study and the influence of these on the research (Holloway & Fulbrook, 2001). For this reason a journal was kept in
which I could record my views on what was coming up in the data to ensure that I was not bringing my pre-conceived ideas to the findings but that instead the findings were grounded in the data collected. Keeping a journal also enabled me to think more creatively about the data and to jot down any ideas I had with regards to further ideas to investigate in the field. In addition, I used the journal for making connections between literature I had read and findings from data analysis. Finally, the journal was used to record any methodological decisions during the process of analysing and collecting the data. Because the journal was written within NVivo, it could also be coded into nodes. An excerpt from the journal is shown in Appendix XIII(C) and it illustrates how the reflective process aided in thinking about the data and in identifying ideas that needed further investigation.

4.5.2.2 Memos

Writing memos is an important step in qualitative data analysis. Memos were written at each stage of coding and they became more analytical as coding moved from open coding to axial coding. A memo was written after each interview and it was attached to each case. The memo recorded my thoughts and impressions of the interview. In addition, I compared each interview with data collected from other interviews and could make connections between data. I linked ideas that came up in interviews with the literature, where it was appropriate. Reading back through these memos at later stages in the analysis helped me move to a higher level of abstraction moving from open codes to axial codes. Two examples of this type of memo are provided in Appendix XIII(D).
As data collection and analysis progressed, I began to develop a coding hierarchy whereby concepts and categories were developed. As coding moved from initial ‘open coding’ to focused ‘axial coding’, memos were written for each category and concept. This helped to explore the relationship between the categories and where they fit into the overall concepts. Links were also made in the memos between codes and what was found in previous research. Strauss & Corbin (1990) describe how the literature can be used as supplementary validation when writing up findings. In some cases the literature validated findings and in other cases it added to my understanding of a particular phenomenon. An example of a memo describing the category “issue of time” is provided in Appendix XIII(E).

4.5.2.3 Modelling

I used the modelling function in NVivo at different stages throughout data collection and analysis to help think about the relationship between codes and categories and to help raise the level of abstraction in the analysis. By presenting the codes diagrammatically it helped me to visualise the organisation of the codes at different stages of data analysis which helped in moving from open coding to axial coding.

4.6 Text searches and attributes

NVivo has two additional functions which aided in data analysis. One of these was being able to search memos, transcripts and nodes for a particular word or phrase. I found this particularly useful when I wanted to check if topics that I thought had been mentioned a lot had actually been or whether it was a pre-conceived idea that let me think this. For
example I thought that issues around agency staff were discussed a lot, however, when I did a text search I realised this was not the case. In addition, text searches were useful to search previously coded documents for newly developed categories. Of course interviewees do not always use the same word to describe something and so I also used the synonyms of words to ensure that all cases were identified. Another function which proved useful was being able to record the attributes (such as profession) of interviewees in NVivo and so this allowed for data to be searched by attribute. For example a search was done on the node conflicting information by profession to indicate the level of response from each profession.

4.7 Completing data collection and analysis

While all of the above steps which were used in the collection and analysis of data are described in a linear fashion, it must be remembered that in reality they occurred in a more cyclical way and processes were interwoven with each other. Data collection and analysis continued until no new concepts or categories appeared in interviews and all categories were developed with some depth and variation. Flick (2002) describes how it is up to the researcher to be pragmatic in deciding when concepts and categories are sufficiently developed, such that the initial research questions are answered.

4.8 Quality in qualitative research

As outlined in chapter two, strategies identified by Mays & Pope (2000) were used to address the issue of quality in this qualitative study. These strategies included using triangulation, whereby data were collected from different data sources (in this case different health professionals) in order that issues around breastfeeding support were
examined from different professional’s perspectives. These different perspectives were then compared during data analysis. In addition, a clear account of the process of data collection and analysis were provided and the use of CAQDAS aided in keeping an ‘audit trail’ whereby the different steps of data analysis were recorded and could be easily audited. Because of the possible influence of the researcher on the research findings, I kept a research journal in NVivo to help remain reflexive of the thoughts and ideas that I was bringing to the study. Finally, Mays & Pope (2000) discuss the importance of the researcher maintaining ‘fair dealing’ whereby the research design ensures that a wide range of perspectives are presented ensuring that the viewpoint of one group is not presented as the ultimate truth. This was achieved through theory based sampling whereby a range of participants were sought to take part in the study and the different views of these participants were represented in the results.

4.9 Results

Fifty eight health professionals took part in this study, fifty five of whom were female and three male. There were eight general practitioners (GPs), fifteen public health nurses (PHNs), four practice nurses, nineteen midwives, one of which was a community midwife and two of which were Domino midwives\(^5\), six obstetricians and six paediatricians. The majority of participants were Irish (n=49) and between thirty and fifty years of age. Interviewees ranged from having only a few months of clinical

\(^5\) The Domino scheme is a scheme whereby women give birth in hospital but they are discharged home early and then receive home visits from a Domino midwife.
experience to having over thirty years. Table 4.1 describes demographic details of the health professionals that participated in the study.

4.9.1 Issues for health professionals in providing support for breastfeeding

The key issues which were identified for health professionals in providing support for breastfeeding are described in terms of four main concepts: barriers to providing support, commitment to breastfeeding, supporting women and training. These concepts are further explained in more detail within the context of each of its categories. Figure 4.1 provides a descriptive model of the categories and concepts.
Table 4.1. Demographic details of the health professionals that participated in the study

<table>
<thead>
<tr>
<th></th>
<th>General practitioner (n=8)</th>
<th>Public health nurse (n=15)</th>
<th>Practice nurse (n=4)</th>
<th>Obstetrician (n=6)</th>
<th>Paediatrician (n=6)</th>
<th>Midwife (n=19)</th>
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</table>
Figure 4.1. Descriptive model of issues for health professionals in providing support for breastfeeding

- **Barriers to providing support**
  - Barriers in the workplace
    - Issue of time
    - Conflicting information
    - Jack of all trades
    - Medicalisation of breastfeeding
  - Personal barriers
    - Confidence in providing support
    - Personal experience
  - Medicalisation of breastfeeding

- **Commitment to breastfeeding**
  - Being committed to breastfeeding

- **Supporting women**
  - Role of health professionals in promotion and support of breastfeeding
  - Breastfeeding perceived as difficult
  - Breastfeeding support groups
  - Supporting breastfeeding and bottle feeding

- **Training**
  - Attitude towards training
    - Training in the future
4.9.2 Barriers in providing support

Barriers in providing support are discussed in terms of barriers in the workplace, personal barriers and social barriers. Each of these in turn is discussed in further detail in relation to what specific type of barriers there are.

4.9.2.1 Barriers in the workplace

4.9.2.1.1 Issue of time

Health professionals discussed not having enough time to adequately support women with breastfeeding. This was especially the case for midwives, many of whom described a hectic work environment.

*I know the women need the help and you know sometimes if you’re frantically busy you can spend so much time and then you say look I’m really sorry but I have to go but I promise I’ll come back and because of ward workload, you may not end up getting back for three or four hours, which is frustrating* (Midwife 13)

One midwife described simply not having enough hours in the day to provide adequate support and she felt “pulled and dragged” with lots of people needing help. She also discussed how providing breastfeeding support was time consuming and this was also mentioned by other health professionals. A comment that I wrote after interviewing a PHN was as follows: *She discussed the amount of time that is needed to give quality care to mothers who are breastfeeding especially to those that have difficulties such as engorgement, cracked nipples, no sleep, no milk.*

This was highlighted by another PHN and can be seen in the following remark.

*I suppose really time is the big thing, it really is, like amm, you know the thing of going down to a house and doing a notification maybe then sitting*
for another half an hour going through breastfeeding, it’s just you know, it could mount up to like an hour and a half and you are just kind of conscious that you have all the other visits that you have to do (PHN6)

While interviewees commented on breastfeeding ‘being best’, some felt that the issue of insufficient time was sometimes the determining factor in whether breastfeeding succeeded.

Well I think breastfeeding is the best but it’s not really practical here because of time, the staff don’t have time to put enough effort into it and that’s why I think it fails a lot of the time (Paediatrician 3)

It is a very busy ward and you need to go out from the ward, get the discharges done, then you have a new mother who wants to breastfeed, you cannot concentrate on that mother, we feel we cannot justify, we cannot use our enough time to give enough support for that mother so we do find difficulty in giving time, that is the main factor (Midwife 1)

Health professionals in the community confirmed the lack of support in hospitals because of staff having insufficient time. One PHN commented on the experience of some of the women that she meets.

You will get a lot of mothers who will say that they wanted to breastfeed and they weren’t able to breastfeed straight away because it was too busy or that the wards were so busy and they didn’t have the help (PHN10)

There was also a sense of disjointed care in the hospital environment with the level of support given depending on the particular day and the amount of free time available to the particular health professional.

I would say really the encouragement for breastfeeding depends on the day you get that particular doctor or midwife or that nurse because if they’ve
got, if they're extremely busy and under pressure, they're not going to be able to give the same time (Paediatrician 6)

Finally, in contrast to the frustration described by midwives in not having enough time to give support, the Domino midwives, who mainly care for women in their homes, described the ease of having time to give to women and being able to support them as much as they wanted.

Like at home you can spend a lot of time and even if you've women who have specific problems you can go over morning and like we would go back in the evening you know if necessary to give them that support (Domino Midwife 6)

A community midwife expressed similar sentiments.

At home up in the community it is so different, when I go up to the houses I can be there as long as I like with that mother. It’s fantastic, it is and I love it and that is why I like it because I am allowed as much time as I like (Community midwife 1)

4.9.2.1.2 Conflicting information

Many midwives and public health nurses discussed the issue of conflicting advice and the importance of health professionals ‘singing from the same hymn sheet’.

I suppose the main thing is that we are all kind of, as you say, singing from the same hymn sheet. You know, because every so often it can happen, people will say oh well the other midwife told me to wake the baby up and then somebody else told me look leave the baby it’ll be fine (Midwife 13)

Some healthcare workers discussed the conflicting advice which women get from other professional groups.

I had one GP in particular who put a mother on a course of antibiotics for
a month as well as antacids which she really didn’t need and the mother was told she had to stop breastfeeding and she was devastated so I think there has to be a bit more information for GPs, on, you know, that they can actually breastfeed on certain medication. (PHN 10)

However, conflicting advice also occurred within professions and caused a dilemma as interviewees described wanting to remain loyal to their profession on becoming aware of wrong advice being given but also wanting to give the woman the correct information.

a mother yesterday told me she was told she didn’t need to breastfeed her baby at night, you know, something like that is difficult because you know, at night the hormone levels are higher so of course you need to breastfeed.

It was another public health nurse that told her that so that’s really difficult and you don’t want to get your colleague in trouble but at the same time you want the mother to have the right information (PHN 10)

Three different reasons were given for why conflicting information is an issue. One of the reasons being some health professionals having a lack of training and consequently lacking the skills to give proper advice.

It’s [conflicting information] probably lack of training and personal opinions which isn’t right, you know, we need factual stuff (GP 3)

Another reason was because health professionals were at odds in their approach to supporting and advising on breastfeeding, with some taking a medicalised view and others a more holistic approach. In particular, this was in relation to doctors recommending top ups while midwives and PHNs felt that this was unnecessary and harmful to breastfeeding.

I think the only time I’ve ever come across it [conflicting advice] is actually in the hospitals where paediatricians might say something different to the mum than what we would be saying about breastfeeding. Their main focus
was on the baby and on getting the weight up regardless and if that meant introducing formula then so be it whereas our main focus would be establishing breastfeeding (PHN 3)

The midwife meanwhile is behind the scenes working arduously to try and get this baby attached and get breastfeeding established and then the paediatrician comes a long and says your baby might be losing a bit of weight there now, maybe top it up (Midwife 9)

Finally, some health professionals felt that conflicting advice was as a result of women interpreting information from different health professionals in different ways and that while the advice was correct the problem was in the interpretation.

Unfortunately sometimes I might say something about breastfeeding and say Helen [other PHN in the clinic] might say something about breastfeeding but both of us are correct but the mother’s interpretation of what I say could be taken differently (PHN 7)

The conflict between midwives and paediatricians in recommending ‘top ups’ of formula for infants was explained by one of the paediatricians. She suggested that a certain mind shift was needed in order for paediatricians to ‘trust’ breastfeeding more.

This can be seen in the following comment.

I think probably the only big barrier is consistency and you speak to women time and time again, you go in and see them and they’ve got five different messages about what they’re supposed to do. Consistency and I think also probably a slight mind shift on the part of paediatricians accepting that there is a natural time lag for milk to come in and not to be, you see there’s a very fine line for us not to be, we see the dehydration or the jaundice in the very sick babies but accept the natural time lag and allow the women that time and not to be so worried about the rare medical complications that we don’t push the breastfeeding cause the women then
sense that we’re kind of relieved when they go on the bottle, even if it’s not said it’s picked up on so I think it’s important that as a group both junior and senior and doctors that we’re all really pushing for breastfeeding. And we all know the theory but it’s not done in practice (Paediatrician 6)

One paediatrician described the disparity between midwives and paediatricians in their approach to breastfeeding. For midwives the aim was to establish exclusive breastfeeding, while the paediatricians were anxious that the baby did not lose more than 10% of his/her weight. This highlights the different approach of the two professions with that of the paediatricians being medical and that of midwives more holistic.

They don’t believe in it. They don’t believe there has to be any mixture at all. It’s got to be breast all the way and they’re not really that particular or stressed about the 10% [weight loss] as we are because they feel that once the baby is thriving the baby is ok, things just start to roll just about that time, the time things start to get better. And that’s the time we are recommending a rescue top up (Paediatrician 4)

Suggestions were made as to how to limit conflicting advice with one way being to standardise information and advice on breastfeeding.

If there was a standardised advice, sort of you know, that was circulated widely that people could refer to I think it might improve the standardisation of advice (GP 2)

However, some interviewees felt that too many rules and regulations about breastfeeding could make it regimented and not suited to individual mothers and babies. In addition, it was felt that women put too much emphasis on what different health professionals advise about breastfeeding and that they are less inclined to trust their own instinct on what is right.

I think women are getting conflicting advice because some people are so
dogmatic and this is why I say it’s getting too technical that this is the way and this is what you do. And that like there’s no other way that’ll suit any woman whereas I feel it’s very important that the woman is treated as an individual and what will suit one may not suit another. (Midwife 4)

4.9.2.1.3 Medicalisation of breastfeeding

One source of conflicting advice, which was discussed in the previous section, was health professionals considering breastfeeding differently with some regarding it as a natural life event, while others criticised it for becoming too medicalised.

Having a baby and breastfeeding is as basic and natural a thing as there is and people try to medicalise and talk down to women and every woman’s fear is my baby being fed is my baby hungry. It’s her primal instinct (Midwife 2)

I think the frustration is that it is still medicalised and that would come from the top down, like the paediatricians, some paediatricians who actually advocate bottle and actually the comments made by a paediatrician to one of my mothers recently was it’s six weeks, well listen, I think she’s had enough, why don’t you give your baby a bottle and forget this lark with the breastfeeding (PHN1)

Some considered this divergence in the approach to breastfeeding being a consequence of maternity care being obstetric-led as opposed to midwife-led and this resulted in a more medical approach being taken.

I think one of the biggest barriers for those women in receiving support is that the model of midwifery care that we offer in this country, because really it’s obstetric led care (Midwife 8)

Interestingly, some GPs did not think that breastfeeding was a medical issue and so
consequently did not feel that it came into their remit of care. They had little sense of ‘ownership’ towards breastfeeding and felt that it was only of concern to them if it was associated with a clinical condition such as mastitis.

*That’s why I suppose there probably would be I think a resistance to start taking it on as a management issue like we have to manage diseases because it really is a natural life event you know. And it’s very debateable really whether it even should enter into the medical domain unless somebody’s having a medical problem like ah mastitis or you know, I mean mothers do come for advice but it’s certainly on the periphery, you know* (GP 2)

In contrast to the medical approach taken by some healthcare workers, other questioned whether something so natural as breastfeeding should even be discussed in terms of science and medicine and whether by doing that it made breastfeeding sound a lot more complicated than it actually is.

*You know for a very natural thing you wonder why there’s so much science involved. There shouldn’t really be an awful lot of science involved in something that’s so natural* (GP 8)

*I think maybe sometimes we talk too much about it because it’s a very natural thing. I think that’s a big problem. I think it’s gone that way. That it’s gone into something that’s very sort of maybe technical* (Midwife 4)

4.9.2.1.4 *Jack of all trades*

The issue of being a ‘Jack of all trades’ was only discussed by health professionals in the community and refers to the generalist nature of their work. Community healthcare workers described how their job involves many different facets of care with this affecting how much time they can dedicate towards one particular area, be it training in
that area or providing care. As can be seen in the following quotes, it was an issue that was mentioned by all three community professions.

We really do have to deal with a huge amount of information and there’s a huge number of disease management issues going on, chronic illnesses, diabetes, heart disease, you have to keep up with all of that and it does mean going out to meetings and study leave and you know breastfeeding isn’t seen to be, sort of priority really (GP 2)

It’s hard to have all the knowledge about breastfeeding, like we do so many different things, like we have that much knowledge (put her fingers together to show a small amount), about a million things and it’s hard to be an expert about everything you know (PHN 2)

Some healthcare workers prioritised their work by what issues were important in the community in which they practised and often breastfeeding was not an issue of significance.

Contraception or something here would be far more important, not far more important but higher up in the priority list I suppose because in general practice there are so many different areas you know, everything, any disease comes up here so you’re trying to prioritise all the time (Practice nurse 4)

4.9.2.2 Personal Barriers

4.9.2.2.1 Confidence in providing support

Health professionals differed in their confidence in providing support, with PHNs and midwives being generally confident, while doctors experienced a lack of confidence. Many PHNs and midwives described themselves as ‘confident’ and ‘happy in their knowledge’. Some GPs, especially those that had not breastfed themselves or had not had a very positive experience of breastfeeding were not particularly confident.
They probably do trust us but I don’t think we have any more knowledge [about breastfeeding] in general than most people (GP 4)

I suppose it’s a bit technical if you’ve never done it yourself (GP 6)

Equally, some paediatricians were not especially confident as seen from the following quote.

I have three or four times since I came here been in the position where the mother is putting it on for the first time and I’m just like, ohh I’ll just get a midwife cause I don’t know how to do it. So maybe it would be helpful if I knew (Paediatrician 3)

Paediatricians who were not so confident in their knowledge considered the midwives to be the experts and depended on them for help.

We get the advice from the midwives as well most of the time. Here in OPD [out patients department] I think I am quite confident in the sense that I can advise over the handling a little bit but still I get advice from like you know, the midwives here, they are really experts (Paediatrician 2)

For some, having personal experience of breastfeeding was associated with feeling more confident as can be seen in the following quote from a practice nurse.

I probably feel a lot more confident now in any case about it having done it myself but still I’m sure there’s lots more I could learn (Practice nurse 2)

The influence of personal experience of breastfeeding on practice is described in further detail below.

4.9.2.2.2 Personal experience of breastfeeding

Some of those who had children and had breastfed felt more assured in their knowledge about breastfeeding particularly the practical aspects. They also appreciated being able
to relate to women and the experience of breastfeeding.

*I think a person that has breastfed and has been successful in breastfeeding certainly has a lot more insight into it and I think the practical issues of you know positioning and you know that things settle down after a couple of weeks and how easy it is and practical to go places and all that can be related really well if you’ve breastfed yourself* (Practice nurse 1)

*You know sometimes when they’re going to feed, I kind of position the baby for them and everything. And little tricks that I’ve learned as well* (Paediatrician 1)

Others felt that while personal experience of breastfeeding was a bonus in supporting women, it was not essential.

*I did breastfeed my own and absolutely I suppose when you are involved in a breastfeeding group if you have breastfed yourself obviously you are relating to it and sometimes women are kind of sussing out well has this one, with all the answers done it however there are nurses on the breastfeeding group who don’t have children and don’t have experience of breastfeeding and it’s not an issue at all, it’s not a problem for them and I don’t think women, generally they accept any advice, they’re delighted with it* (PHN 1)

This comment also illustrates how some health professionals felt that it mattered to women whether their healthcare provider had breastfed themselves. Those who did not have personal experience of breastfeeding felt that while it may help with the practical side of things, it was not a problem not having this experience. This opinion was especially reflected by healthcare workers that had received training around breastfeeding and indicates that training may counteract feelings of inadequacy providing breastfeeding support as a result of not having personal experience.
It probably helps with the practical side of things, I’m sure it does, cause I don’t have children and I haven’t breastfed so I don’t know but I’d hate to think that I didn’t have knowledge about breastfeeding just because I don’t have children (PHN 3)

In contrast, one GP who did not have personal experience of breastfeeding felt that she was at a loss in giving practical advice about breastfeeding. This may reflect the lack of training for GPs compared with PHNs and may answer why personal experience would be important to GPs and not so much to PHNs.

I suppose it’s a bit technical if you’ve never done it yourself I would imagine, you know, especially like I’d be very confident with bigger things like mastitis or those kind of medical type ones but the kind of teething ones like it’s not properly latching on, I wouldn’t be great at explaining that now, I wouldn’t have got much hands on, here’s a baby, here’s a breast, this is how you do it type (GP 6)

For some, namely GPs, who had personal experience of breastfeeding, either through they or their wives having breastfed felt that this provided them with sufficient knowledge about breastfeeding.

Well I feel happy in my knowledge because I’ve had children myself and I’ve breastfed them myself so I would feel happy about my approach it’s a fairly, you know once you’ve done it yourself you have a fairly good grasp of what’s involved (GP 2)

I think most, as a dad of three, I kind of, I’d know a little bit about it (GP 7)

However, one GP who did not have a positive experience of breastfeeding, felt that she could pass on experience to women, leading one to wonder whether she would reflect positively or negatively on breastfeeding when giving support.

I had a baby myself and I tried to breastfeed but it didn’t really go very
well so I think really if you’ve done it yourself, you probably can pass on any experiences as a woman (GP 4)

4.9.3 Commitment to breastfeeding

4.9.3.1 Being committed to breastfeeding

Different health professionals had different levels of ‘commitment’ or ‘ownership’ towards breastfeeding. Being committed to breastfeeding manifested itself in health professionals seeking out training on breastfeeding, promoting it amongst colleagues, keeping up-to-date with the latest research and supporting women as best they could. Some PHNs described giving their mobile phone number to women so that they could call any time they needed help with breastfeeding. Another described organising clinical clubs in her area to promote and encourage staff on breastfeeding.

We decided in our area that we would run, you see I am a breastfeeding lactation consultant as well and that we’d maybe start some clinical clubs, because I have a great interest in breastfeeding just to help promote breastfeeding and encourage the staff on breastfeeding (PHN 7)

A paediatrician described encouraging women to express milk for their premature babies.

I tend not to say do you want to breastfeed, like I say, are you going to express, and give yourself today and then by tomorrow, end of tomorrow you’ll start trying to express and try to tell them that you’ll get just a couple of drops and I tell them that every little helps and these drops are very important (Paediatrician 1)

Some healthcare workers described needing to be committed to breastfeeding in order to
overcome working conditions that did not facilitate the promotion and support of breastfeeding.

We have 42 mothers and 42 babies and about 60-70% of them are breastfeeders so if you have to remain there you need some time and you need a staff ratio for that, you know, so you need a lot of commitment in breastfeeding which is a bit difficult in the very busy hours (Midwife 1)

In contrast to the display of commitment shown by some health professionals, some GPs were less fervent in their commitment to breastfeeding, as seen in the following comment.

I suppose it’s like a kind of an opinion thing about how much you are into it. Cause I would consider I support it but not the whole hog like, cause if people start getting into trouble and are all upset about it. Now the first time but more than once I start going myself I’m thinking oh what are they doing this for. I’d probably be more middle ground like you know (GP 6)

This also resulted in some acknowledging that they were not the best placed to provide support for breastfeeding and so instead called on PHNs to help.

I think there are other health professionals be they at the maternity end of things or ahh you know at the paediatric end of things or public health nurses that are better placed to take down the nitty gritty of it (GP 7)

A lot of the thing I think in relation to baby feeding in general, I think both breast and bottle, I think most GPs leave it up to the district nurses [public health nurses]. In relation to, even you know in relation to the mums come in, in relation to bottle feeding and she’s on cow and gate now and she’ll put her on extra steps, I really don’t think we have a clue (GP 8)

Professionals in both the community and hospital who were considered to be ‘committed’ and interested in breastfeeding were seen by others as an important
resource for information and help. In the hospital, these people were the lactation consultants or in some cases more senior members of staff who had more experience.

   So I would be consulting senior staff, you know, if the lactation midwives are not always available, so if there is that case, I would have to consult other staff members, I wouldn’t be always 100% and don’t forget there are always changes in policy so it’s up to us to keep up with that as well (Midwife 3)

In the community these people were more senior PHNs, PHNs who were trained as lactation consultants or lactation consultants within the maternity hospital.

   We are very lucky to have the support of the nurses there [in the maternity hospital] who are mostly fantastic and the lactation consultants who are a great resource to us particularly with difficult problems and you feel well maybe it is time to pass this back to someone else (PHN 1)

   As regards if I had to help someone with something like latching on or I can answer general questions about it but if you get down to the nitty gritty of it I probably wouldn’t be able for it but the public health nurses here are very good as well. We have a lot of public health nurses and a lot of interaction between us (Practice nurse 4)

4.9.4 Supporting women

4.9.4.1 Role of health professionals in promotion and support of breastfeeding

All health professionals discussed promoting and supporting breastfeeding in the context of their role, if any, in doing this and also in relation to how they did so. PHNs supported women in practical ways and in many cases took into account the culture and society within which the woman was breastfeeding. The following is an excerpt from field notes which were written after an interview with a PHN.
She mentioned how visitors to mothers can be really hard and mothers feel they should entertain while also having to breastfeed. She said that mothers need to be told that it is ok to leave the room if there are visitors to go out and breastfeed. She then remarked how this needs to be balanced with it is fine to breastfeed in public but she said that in the first few days women need to get used to breastfeeding and find it difficult to do it discretely and so for their own comfort should leave the room.

Midwives related the ways in which they promote and support breastfeeding and like PHNs they tried to be practical in their approach and emphasised the importance of letting the mother know that support was close at hand.

*I wouldn’t say it’s always going to be difficult but I would say to them well some of you have never held a baby before much less try and feed it you know, you’re going to be fingers and thumbs and you need help and the best way to sit and put the baby on. So that’s an angle I’d come from* (Midwife 4)

Some midwives discussed the importance of promoting breastfeeding and also of being balanced in their approach especially if the woman wanted to bottle feed. They felt, however, limited in the support that they could give women because of the baby friendly policy in the hospital and this meant that they could not offer advice about bottle feeding.

*You know with the baby friendly hospital initiative we’re not supposed to actually probably teach them about bottle feeding but I find that’s wrong, we should not be put under that pressure* (Midwife 17)

*Sometimes you feel that a woman doesn’t want to breastfeed at all and that you’re not allowed to recommend that she should bottle feed and that is sometimes really hard* (Midwife 15)
One midwife discussed the importance of not talking women into breastfeeding and she compared the situation in Ireland with that of Germany saying that in Germany the promotion of breastfeeding is backed up with support as women get a lot of support for breastfeeding from community midwives. However, she intimated that this is not the case in Ireland.

There was some disparity amongst paediatricians with regards to their role in supporting breastfeeding with some describing how they promote and support breastfeeding and others admitting to not putting much thought or effort into it. This inconsistency can be seen in the following two quotes.

*You don’t have to push it down people’s throats, you have to kind of encourage them, so what I tend to do sometimes is when I am with a mother I kind of ask them has anybody been talking to you about breastfeeding and what have you been told and it’s good that you build up on that* (Paediatrician 1)

*Actually we are a little bit behind, we should have an effort and putting input to that, we should encourage ourselves to go to mom and talk to her especially the females who have babies, they will know how to tackle mum from which area and when I think about myself I should encourage them* (Paediatrician 5)

Obstetricians generally saw their role in the promotion of breastfeeding and in encouraging women.

*I see my role in promotion, because usually I don’t physically get to help, because the midwife does that* (Obstetrician 6)
[I see my role in] encouraging people for breastfeeding, to tell them what’s the benefit for that and that’s really it and if they have any problem any trouble (Obstetrician 5)

Some obstetricians commented on the difficulty of encouraging breastfeeding in the current bottle feeding culture.

I’d be a strong advocate of breastfeeding hmm from an obstetric point of view I would encourage mothers to do it but in the climate it can be quite difficult to convince them to do so (Obstetrician 3)

For GPs, encouraging and supporting breastfeeding mainly involved explaining the benefits of breastfeeding and encouraging the mother to breastfeed for these reasons.

I try to encourage breastfeeding, I know it’s the best for all sorts of reasons including the bonding but also for you cannot conceivably surpass breastfeeding, it has to be the most natural thing and then anything else is artificial, so that’s the premise I go by (GP 3)

Some, however, did not feel that they are the best placed to promote and support breastfeeding as they felt that their knowledge was not sufficient.

Maybe if they decide that they want to come to the GP it would be nice if you could give some solid advice you know, cause they probably do trust us but I don’t think we have any more knowledge in general than most people (GP4)

One GP commented on how they sometimes need to be reminded to encourage women to breastfeed and this was seen in the comment of another GP who described not thinking about breastfeeding as an issue for discussion.

So it’s not something that I, I’ve never brought it up actually as an antenatal thing. Unless the patient brings it up herself, otherwise no I wouldn’t really. There’s no reason, I just never think about it (GP8)
Practice nurses described in broad terms the importance of promoting and supporting breastfeeding.

Well I would encourage anyone to breastfeed. Now I don’t have a huge input into antenatal, it would be mostly postnatal and feel that yes they should be breastfeeding and give them as much encouragement as possible (Practice nurse 3)

Only one of the practice nurses had a midwifery qualification and she described trying to give women confidence to breastfeed in public.

Often a mother would come here after and I’d give the baby vaccines and they’ll say is there a room that I can breastfeed? And I’d say do it downstairs, hump the begrudgers and that would be my attitude but like I had someone in yesterday and I said that to her and I said are you happy with that cause I can put you up in our kitchen but I don’t think that’s the right thing because otherwise every time you go somewhere you’re wondering where. I said you should be able to breastfeed anywhere (Practice nurse 3)

4.9.4.2 Breastfeeding perceived as difficult

Many interviewees perceived breastfeeding as being difficult and they felt that women were not adequately prepared for it being harder than they expected.

My experience would be that a lot of people give it up fairly quickly cause they think oh my God this is far too hard. And it genuinely is difficult but I think a lot people don’t realise that it takes six weeks for it to settle down (Practice nurse 1)

I think a lot of women, especially with their first baby don’t realise what they’re in for, generally I don’t think it’s talked about so I’d imagine that’s
a very difficult aspect to deal with for them you know the time pressures and the fatigue and the exhaustion (Obstetrician 3)

One midwife described how the promotion of breastfeeding does not depict a realistic image and that this in turn had an effect on women’s expectations in the postnatal period.

I sometimes feel that we as a group aren’t totally honest with the women, you know we paint this picture of it’s absolutely gorgeous and it’s fantastic and it’s the most natural thing in the world and it’s the best thing for you and it’s the best thing for the baby but we don’t say you know, it is hard work and in the first two to three weeks the baby just feeds at night all the time (Midwife 8)

4.9.4.3 Supporting breastfeeding and bottle feeding

Health professionals discussed the importance of respecting a woman’s choice of whether to breastfeed or bottle feed and that it was important to remain balanced about both forms of feeding.

As far as breastfeeding I’d be supporting that really and then encouraging it as much as possible and then supporting parents with whatever choice they make after that really (Practice nurse 2)

My main views would be to promote breastfeeding but at the same time respecting a mother’s choice in what kind of feeding that she wishes to choose and then supporting her in that (PHN10)

Some interviewees also mentioned the importance of not making the woman feel guilty about her choice of feeding.

Well ideally if the woman can, I prefer her to breastfeed, but I won’t put any pressure on her either if she has made up her mind I don’t feel it is my
place to actually make her feel any different (Midwife 17)

The importance of women having enough information to be able to make an informed choice was discussed by some health professionals.

Breast is best, for definite. I think mums should have informed choice and their choice shouldn’t be influenced by us unless it’s informed or with antenatal education (Midwife 3)

4.9.4.4 Breastfeeding support groups

Breastfeeding support groups were discussed by PHNs as many of them held such groups in their clinics or in local community centres. Most were very positive and enthusiastic about the groups.

It [breastfeeding support group] has been hugely successful and we’ve got wonderful feedback from mothers and you know, women who have continued to breastfeed and they wouldn’t have and they said it was only for the support in the group, that they’d felt like giving up but they knew that the support was there (PHN 1)

Some of the groups were held in community halls and this was considered preferable to them being held in the health centre as it meant there was less of a clinical emphasis put on breastfeeding and the environment was more natural and informal.

It was away from the health centre and it gave a nicer feeling you know the mothers didn’t feel that it was so clinical and what we like to promote is breastfeeding being a natural thing and that you don’t have to come to the health centre (PHN 14)

In addition, the issue of weighing babies at support groups was discussed by many PHNs and many felt that weighing babies took away from the support group as the emphasis was placed more on weights than support. Those that held the support groups in the
health centres found it difficult to refuse mothers when they wanted to weigh their baby. It was felt that the emphasis on weighing babies is somewhat a further endorsement of the ‘medicalisation’ of breastfeeding and takes from the support aspect of support groups.

‘It’s held in one of the clinical rooms. So as a result of that, from listening to other people who have other breastfeeding support groups, it tends to be more, it can be more clinical than just support. A lot of people would say to you oh I come here to get the baby weighed to avoid the queues in the other clinic (PHN 15)

The facilities that were available for some support groups were an issue, especially where the group met in a room in the health centre and a lot of mothers attended the meeting.

‘It’s quite crushed in there you know. Sometimes if they have toddlers with them, you know, a second time mum maybe coming down, they bring their toddler with them and sure the toddler just creates mayhem and then the mum feels oh I can’t come back again. So maybe more time and a health promotion room would be a great asset to it, you know’ (PHN 14)

One GP commented on how beneficial breastfeeding support groups are and she described encouraging her patients to attend for both the support and social aspect.

So the breastfeeding support group isn’t just for helping women with breastfeeding it’s also sometimes just to get a little network going when you’re on maternity leave and you’re on your own for a lot of the day, you meet a few women in similar situations (GP 4)
4.9.5 Training

4.9.5.1 Attitude towards training

The attitudes towards training differed amongst health professional groups. Some professions, especially doctors, could not recall any training which they had received on breastfeeding and as described previously they felt that having personal experience of breastfeeding replaced the need for training. For some, having personal experience of breastfeeding replaced the need for training. Also, some GPs did not see their role in promoting and supporting breastfeeding and consequently questioned whether they needed training. They also discussed having to weigh up the time involved in attending training on breastfeeding with the need for training in more pressing areas.

_The issue about training for us is always the time involved in doing any sort of postgraduate training and we have to do a certain amount of hours per year and really there’s a lot of sort of, what I suppose feels like more pressing stuff, you know like, keeping up to date on disease management and that, that if it were offered I quite likely wouldn’t actually take it up because of time constraints in going out to a meeting elsewhere because we do attend a fair number of meetings as it is already_ (GP2)

While others, especially one GP who demonstrated a ‘belief’\(^6\) in breastfeeding during the interview, felt that training would be beneficial.

_I would be very interested in knowing more about it, because what I go by is, yes I’ve read things in the past but I’ve had no training, no proper training and it’s all personal really, probably, a lot of it is personal_ (GP 3)

In contrast to the lack of interest shown by most of the GPs towards training, other

\(^6\) She described breastfeeding as follows “There’s lots of convenience with it in addition to it being so good for the baby and the bonding is really important, very important. You can see a bouncy baby coming in who is being breastfed, well I think you can, they are so bubbly and so confident”
health professionals such as PHNs and midwives commented on the importance of doctors having knowledge about breastfeeding.

*I think doctors aren’t and even GPs they definitely don’t. They feel maybe that it’s not in their remit that they should be trained but I think there’s a big area there with the GPs as well* (Midwife 4)

Obstetricians could not recall receiving any formal training in breastfeeding and if anything training just involved what one obstetrician referred to as a “comprehensive overview”. While obstetricians were in favour of training, they generally preferred this to be quick and in the form of a talk.

*I suppose maybe at our induction at the beginning of the year maybe a 15 minute talk on breastfeeding wouldn’t go astray. Yeah that would be worthwhile* (Obstetrician 3)

*I would like training but not very intensively, but yes it would help to give basic answers to their questions and things like that* (Obstetrician 5)

Paediatricians had received more training than obstetricians and two of the paediatricians had attended the 18 hour breastfeeding management course, outside of Ireland. Junior doctors received short training as part of their induction and during the course of the research, plans were being put in place for paediatricians to attend one day of the 20 hour breastfeeding management course. One junior paediatrician did, however, explain that the short talk at the induction was not much use as it was very quick but she showed interest in being able to attend a course on breastfeeding.

*We had a twenty minute talk about a week ago and amm which didn’t really go into any detail because she didn’t have time but she’s going to organise a training session for us and there is a course that she said we might be able to go on as well* (Paediatrician 3)
One of the midwives commented on the issue of doctors in the hospital not willing to spend much time on breastfeeding training and this illustrates what some of the obstetricians said regarding wanting very brief training.

\[ \text{However, they [doctors] don't see it [training on breastfeeding] as their thing and to give three days, it's a three day programme and to attend for three days, it's too much of their time to be putting into it} \ (\text{Midwife 10}) \]

Similar to GPs, some of the practice nurses had to prioritise what they needed training in and they had to balance training with what they had dealt with most in their work and often breastfeeding was not commonly dealt with.

\[ \text{I think it's not a priority for me because I'm not as I say dealing with antenatal people. So there's so many other things. I haven't prioritised it and I know it is important and everything but for the amount of interaction I would have about it I suppose it hasn't been a priority for me} \ (\text{Practice nurse 1}) \]

Some practice nurses were interested in getting training in breastfeeding as they were eager to become involved in caring for women and their babies and they felt that attendance at a breastfeeding management course would improve their chances of this. Another practice nurse who was a midwife explained that she would like an update on practice just to ensure that she was giving correct information on certain clinical issues.

\[ \text{I suppose an update on what you're doing for people with problems with engorgement or you know afterwards for a breast abscess. Probably updates on that wouldn't be a bad idea} \ (\text{Practice nurse 3}) \]

Most of the midwives and PHNs recognised a very clear need for training and felt that it was very important to their practice. The importance of keeping up-to-date with the
latest evidence was discussed, in addition to checking the internet for what women may
be reading about breastfeeding.

    You have to keep up-to-date because you have to read, you have to go on
    the internet and look to see what the other women are looking at. You
    know, because they can have misconceived ideas about what’s printed on
    all those websites. So you have to have a look at those as well (Midwife 4)

The majority of midwives and public health nurses had attended training and this was in
the form of a 20 hour breastfeeding management course and also a one day refresher
course. All of those who had attended the course spoke highly about it and found it very
beneficial.

    It was absolutely brilliant. It takes you from the very basics right through
    supporting women who have problems like flat nipples, inverted nipples,
    you know, to the way of preventing engorgement or mastitis, it is really a
    very nice course (Midwife 11)

Community and hospital nurses had attended the course together and this was
considered to be a benefit as they could share experience.

    Also attending there was a few practice nurses as well. A few outsiders the
day I was in and I think it might have been the first time they had included
them. So it’s good to meet other people that would be involved with
children and breastfeeding and that as well, you know (PHN 14)

One midwife acknowledged the fact that the 20-hour breastfeeding management course
is not standardised in Ireland and that different geographical areas do similar but
different courses. Therefore staff from different hospitals may have different training.

    I think on a national scale here in Ireland the big thing is there is no
    uniformity within that training. We would do a training programme here
and somebody else in Limerick will do a different programme, Galway, you know, there’s no uniformity (Midwife 10)

In addition, despite wanting training, some PHNs discussed the difficulty in getting off work to attend and so this proved to be a barrier.

You’d like to be able to do that up-to-date course but that doesn’t always happen for the fact that there isn’t enough staff here, you can’t get away, so that can be an issue (PHN 3)

4.9.5.2 Training in the future

Health professionals discussed the kind of training they would like on breastfeeding and made suggestions about how this could be delivered. Interest in training differed within and between professional disciplines. As discussed previously, most of the GPs were not interested in attending training on breastfeeding and instead favoured having a quick reference guide which they could check when needed.

I was just actually looking at all the courses I want to do, that would probably go down a little bit on priority but yeah I think certainly something that a quick reference guide, I mean I know things, I couldn’t probably tell you off the top of my head, what the latest evidence is in terms of what breastfeeding, you know, the things that it helps, like eczema and all of those things (GP5)

Obstetricians were mainly interested in gaining skills in the best way to talk to a mother about breastfeeding in the antenatal stage. Some also mentioned the importance of being able to advise about latching on and positioning as mothers sometimes asked them to help with this after the birth of their baby. Obstetricians were generally willing to spend no more than one hour on training.
It [being able to show correct positioning and attachment] could be important because ladies are asking us after delivery and not always midwives are around and they just ask to show and they are breastfeeding after delivery and I can just help them to change position if the baby does not like this position (Obstetrician 6)

This was also of importance to paediatricians with some admitting that they don’t feel confident advising on this and yet it can be something they are asked to help with. Paediatricians were generally enthusiastic about receiving training and some already had plans to attend one day of the 20 hour breastfeeding management course, in the near future.

Practice nurses mentioned very specific areas in which they would like training. These related to issues that may occur in the postnatal period. Some practice nurses were interested in receiving training on positioning and latching on, what to do when the baby is not gaining weight and dealing with a breast abscess. They mentioned the IPNA’s local branch meetings as a good venue in which to have talks on breastfeeding and some were interested in attending such talks.

Within the hospital the lactation consultants have the responsibility of organising training on breastfeeding and they run the 20 hour breastfeeding management course three times yearly. This is a very popular course and it was mentioned that sometimes there is a waiting list. One midwife mentioned the difficulty with getting time off for training and thought it would be very helpful to have short training sessions in the nursery or on the wards just to review practice. Some other midwives spoke along similar lines and commented how beneficial it would be if they could speak and learn
from the lactation consultants as issues arose in practice during the week. This would involve short learning sessions in the clinical areas.

*I think probably if they did more amm, in the clinical area if they did more sessions during the week, like what I found of more benefit was probably like that, more practice issues that you had and you had maybe 10 minutes to talk to the lactation consultant*’ (Midwife 12)

For PHNs and midwives the importance of having a practical aspect to training was highlighted.

*So I think if that [being able to watch a mother breastfeeding] had been part of the course or if you had have been maybe able to go out and get a bit of practical experience it would have been helpful* (PHN 6)
4.10 Discussion

This study considered the issues for six different groups of health professionals in providing support for breastfeeding. While the scope of the study was quite wide, it did prove interesting to consider the different professions collectively because it provided the opportunity to gain an insight into the different ways they provide support for breastfeeding, the contrasting training needs and the ways in which they consider their role in the promotion and support of breastfeeding. The data were collected from a small number of health professionals in North Dublin and so are not generalisable to a broader population of healthcare workers. The primary aim of qualitative research is not, however, to produce findings which can be generalised (Coffey & Atkinson, 1996), but to produce rich data. In addition, this study relied on participant’s self-reported behaviour and so the findings are based on the assumption that they reported their thoughts and experiences honestly. Despite these limitations, the study highlights some of the issues and difficulties for health professionals in supporting breastfeeding. In addition, this research is the first qualitative study conducted in Ireland which explored the issues for different health professional groups in providing support for breastfeeding.

Healthcare workers discussed the barriers which made their job in supporting breastfeeding more difficult. Midwives in particular mentioned time as being a huge issue in the quality of care they could give a breastfeeding woman. The issue of insufficient time is not unique to Ireland and other studies have found this to be a problem (Coreil et al., 1995; West & Topping, 2000; Graffy & Taylor, 2005; Nelson, 2007). Lyons et al., (2008) looked at cultural diversity in Dublin maternity services and found health professionals discussed difficulties such as frustration, being tired and
pressures of workload and time consuming activities. Nearly all health professionals in this study described how a lack of time and understaffing lead to women not receiving the care they needed. Lyons *et al.*, (2008) also found this, with nearly all participants in the study mentioning the need for extra staff to improve the quality and continuity of care for all women attending the maternity services. A recent report by KPMG (2008) of maternity and gynaecology services in the three maternity hospitals in Dublin city centre criticised the inadequacy of the staffing levels and internal infrastructure. This is unfortunate as mothers who have a positive experience of breastfeeding in the ward, have been found to cope better with it (Tarkka *et al.*, 1998). A study of health system factors that contribute to breastfeeding success found that support of breastfeeding women during their hospital stay was an important factor in the woman breastfeeding successfully (Kuan *et al.*, 1999). One midwife referred to the first few days postnatally as being “*make or break*” with regards to establishing breastfeeding successfully. Midwives found it frustrating not being able to sit down and spend time with women. The findings from this study would indicate that women are not being given enough help in hospital with breastfeeding. This may be the reason why in a recent national infant feeding survey, 55% of women initiated breastfeeding but by 48 hours only 42% were exclusively breastfeeding (Begley *et al.*, 2009). The issue of time was also discussed by PHNs, however, this was more so in the context of needing to spend a lot of time with breastfeeding women and they found this to be very time consuming especially with heavy caseloads. This has also been commented on by Nic Philibin *et al.*, (2010) and Lane & Hegarty (2002).
This study also highlights discrepancies between health professionals and their support of breastfeeding. Healthcare workers appeared ‘at odds’ in their support of breastfeeding. This was in relation to differing views between doctors and nurses/midwives on whether a breastfed baby should be supplemented with formula and it also related to different levels of ‘ownership’ by professionals towards breastfeeding. The issue of conflicting advice between doctors and nurses regarding supplementing babies has been attributed to ‘conflicting occupational philosophies based on differing professional knowledge foundations’ (Furber & Thomson, 2007). There was a sense from midwives and PHNs that doctors “medicalised” breastfeeding and so readily recommended formula if a baby was losing weight. The medicalisation of breastfeeding has been discussed in the literature in terms of breastfeeding having entered the medical domain. Dykes (1997) attributes this phenomenon to the early twentieth century when doctors and scientists began to recommend “scientific, mechanistic practices for breastfeeding”. Schmied et al., (2001) have drawn an analogy between the “medicalisation” of childbirth and the subsequent “professionalisation” of breastfeeding, whereby traditional sources of support are devalued and the role of health professionals is emphasised. Dykes (2005b) and Righard (2001) have questioned the constraints that this puts on women in them having confidence in their ability to breastfeed. While midwives in this study approached breastfeeding from a more holistic perspective, they too were limited in the care that they could give because of the medical world in which they were practising.

Supplementing breastfed babies can have a negative effect on breastfeeding duration (Blomquist et al., 1994; Hill et al., 1997). Hill et al., (1997) described how it can
undermine the mother’s confidence in feeding her baby herself and also due to the process of supply and demand, if the baby feeds less frequently at the breast then the mother will not produce as much milk. Paediatricians were aware of their role and responsibility in ensuring that the baby gained sufficient weight and some admitted that recommending formula was sometimes due to a fear of the baby losing too much weight. Midwives and PHNs, however, trusted more in the process of breastfeeding. Interestingly, Hillenbrand & Larsen (2002) conducted a study involving an educational intervention with paediatric residents and found that while the intervention resulted in overall improved knowledge and confidence amongst the residents, many both before and after the intervention disagreed that early supplementation is a cause of breastfeeding failure. Training that deals with such issues is important to ensure that all health professionals are working to evidence based practice guidelines. The issue of health professionals being at odds could be improved by multi-disciplinary training as it could help bridge the different ‘occupational philosophies’. One PHN mentioned how she had attended training with community and hospital nurses and it was beneficial to her practice as they could share experience and expertise. Multi-disciplinary training could also help in ensuring that women receive consistent messages from all health professionals. Inconsistency in information about breastfeeding was found to be an issue in this study and it is often referred to in the literature as being a problem for both women (Rajan, 1993; Dykes et al., 2003) and health professionals (Simmons, 2002; Tennant et al., 2006; Nelson, 2007).

Health professionals were also ‘at odds’ in the level of ‘ownership’ and responsibility they felt towards breastfeeding. McCarter-Spaulding (2008) has acknowledged that ‘at
the same time medicine promotes and takes authority over breastfeeding it often does not provide appropriate education and support in practice’ and so while breastfeeding has been allowed to become ‘medicalised’, some health professionals are unwilling to take it on as an issue of concern. In this research it is interesting that some GPs did not consider breastfeeding an issue which they needed to address because they did not think it was a medical issue, however, in doing this they were abdicating responsibility for something that has been let to enter the medical domain and has in many respects become a ‘medical issue’. This could cause problems for women who seek breastfeeding support from GPs but find that their needs are not being met. Swanson & Power (2005) and Blyth et al., (2004) emphasise the crucial role that health professionals play in communicating positive views about breastfeeding. However, health professionals sometimes play down the importance of their role in promoting and supporting breastfeeding (Dillaway & Douma, 2004; Taveras et al., 2004a) and this contrasts with the support that their clients expect from them.

Training health professionals about breastfeeding increases knowledge and confidence in providing support (Taddei et al., 2000; Kramer et al., 2001; Ingram, 2006; Kronborg et al., 2008) and has a direct positive effect on increasing breastfeeding rates (Martens, 2000). Bernaix (2000) found that nurses’ knowledge about breastfeeding and their attitudes were the most influential in predicting their actual supportive behaviour. Some health professionals in this study had received little or no training in breastfeeding and they relied on their own personal breastfeeding experience or on other health professionals for knowledge. This is similar to the findings of a study in Australia where doctors reported personal experience of breastfeeding as being their most useful source
of breastfeeding knowledge (Brodribb et al., 2009). Jamieson (1997) has, however, commented that while it may be reasonable for a health professional who has had a positive experience of breastfeeding to reflect on this it may not be positive if they had a negative experience. Most of the midwives and PHNs had attended a 20 hour breastfeeding management course and refresher course, based on the WHO/UNICEF model of training. While these two courses were received favourably by those that had attended, it was felt that a practical element to the course would be beneficial to practice. This was also found in a study of the participants’ views of an 18 hour breastfeeding management course in the former Midland Health Board region (Lane & Hegarty, 2002) and in the views of trainers of the course (Healy, 2004). In addition, there was some criticism that the course is not standardised and so there were recommendations that it should become so. This was also highlighted by Healy (2004). The EU Project on Promotion of Breastfeeding in Europe (2008) described the WHO/UNICEF model as meeting the best evidence based standards for breastfeeding training. A study evaluating the effect of a 20 hour breastfeeding management course based on the UNICEF/WHO model found a significant change in knowledge following the course (Wissett et al., 2000).

While training was generally favoured by midwives, PHNs, paediatricians and obstetricians, this study highlighted the need for training to be developed according to the needs of the different professional groups and in a suitable format. Obstetricians mentioned their interest in having counselling skills as they felt that their main role in breastfeeding support is in the antenatal stage. Rea et al., (1999) assessed the effectiveness of a WHO/UNICEF breastfeeding counselling course on health
professionals and found that it increased health workers’ counselling skills. Usually courses focus on developing knowledge around the clinical and theoretical aspects of breastfeeding, however, for some health professionals the counselling aspect was important. Other techniques such as motivational interviewing, which are used in health promotion, could also be considered for training obstetricians (Emmons & Rollnick, 2001; Resnicow et al., 2002). Paediatricians favoured training in clinical skills and it was mentioned that training could be better if carried out by a paediatrician and a lactation consultant. The importance of obstetricians and paediatricians in the protection, promotion and support of breastfeeding is recognised. The AAP and American College of Obstetricians and Gynecologists (ACOG) recommend that doctors counsel mothers in breastfeeding as well as ensuring they themselves become knowledgeable and skilled in the clinical management of breastfeeding (Gartner et al., 2005). Doctors are sometimes a forgotten group when it comes to training in breastfeeding and yet this study highlights the need for further attention in this area.

GPs, however, did not show much interest in attending training and this may be for two reasons. As discussed previously, GPs had little sense of ‘ownership’ towards breastfeeding and consequently could not see why they needed training in it. In addition there was a sense from both GPs and practice nurses that they were a ‘Jack of all trades’, a concept which has been coined before for community health professionals (Winters et al., 2007; Abdul-Ghani, 2010; Nic Philibin et al., 2010). While such a description may seem to have a negative connotation, it also refers to the “holistic clinical care” given by community based health professionals (Nic Philibin et al., 2010). The difficulty in being a ‘Jack of all trades’ is when it leads to an overload of work which consequently leads to
having to prioritise workload (Nic Philibin et al., 2010). In this research it seems that within such prioritisation, breastfeeding is put low on the list. One of the objectives of the strategic action plan for breastfeeding in Ireland (Department of Health and Children, 2005) is that “health workers have the knowledge and skills necessary to protect, promote and support breastfeeding”. The findings from this study indicate that before training is put in place for some professions, they first need to be made aware of the need for breastfeeding support skills because without this realisation they are unlikely to attend training. Dillaway & Douma (2004) found that while doctors felt their support roles should be minimal, mothers reported their support did have a significant and lasting impact. A study by Leahy-Warren (2007) of first time mothers in Ireland found that two thirds of first time mothers relied on professionals for information, however, nearly half would have liked more information from professionals. Doctors therefore may think that they do not play much of a role in supporting and encouraging breastfeeding, however research has shown that they do.

The EU Project on Promotion of Breastfeeding in Europe (2004) advocates that professional associations should issue recommendations and practice guidelines based on national breastfeeding policy. This study indicates the need for some health professional groups to take ‘ownership’ of breastfeeding and this could be achieved through health professional organisations such as the ICGP, The Institute of Obstetricians and Gynaecologists, The Faculty of Paediatrics and the IPNA, defining and endorsing the role of their members in protecting, promoting and supporting breastfeeding. A study which looked at the major psychosocial determinants of the intention of health professionals to recommend breastfeeding, within the context of
Ajzen’s theory of planned behaviour, found that in order for the healthcare workers to recommend breastfeeding it was important to address their perceived professional role and their perception of control over perceived barriers (Daneault et al., 2004). This study highlights the need for both of these aspects to be addressed. In particular, in the case of healthcare workers, who are not allied to midwifery or public health nursing, there is a need for their professional responsibility towards breastfeeding to be clarified and reinforced. In addition, in relation to all healthcare workers, their perceived barriers in providing support for breastfeeding, such as a lack of time, being too busy and not being confident to provide support for breastfeeding need to be addressed.

These recommendations continue to place breastfeeding support within the medical world, and this is in contrast to one of the findings whereby the medicalisation of breastfeeding was found to be a barrier to professional support for breastfeeding. As long as childbirth remains medicalised, breastfeeding is also bound to be placed within the same context. Hunter (2004) described an unlikelihood in there being a shift away from medicalised childbirth with the current trends in reproductive medicine such as assisted medicine, genetic screening etc. Equally women have been found to value medical expertise in hospital, in the postnatal period (McLachlan et al., 2009) and so for the immediate future breastfeeding is bound to remain within the medical domain. It is therefore important that all healthcare workers feel a responsibility towards breastfeeding and have the skills to protect, promote and support it.

Finally, one alternative means of support to alleviate the issue of healthcare workers being too busy and not having enough time to support breastfeeding in hospital could be to give a greater role to voluntary breastfeeding peer supporters by enabling them to
provide support in hospital in the post-partum period. This has been suggested by Dykes (2006a) as an interim solution to the issue of women not being sufficiently supported with breastfeeding in the early postpartum period. It has proven to be a successful source of support for women in the US (Merewood & Philipp, 2003). Community based peer support has been found to help health professionals by ‘spreading the load’ of breastfeeding support (Curtis et al., 2007). However, such initiatives can lead to tensions at the peer-professional interface with healthcare workers feeling that peer supporters are infringing upon their area of expertise (Curtis et al., 2007; Kirkham, 2008). Despite this, there is potential for using peer supporters in the postnatal period and further research is needed to evaluate the effectiveness of such an initiative.

4.11 Conclusions

The results of this study reveal fragmented support for breastfeeding from health professionals. Some healthcare providers had a strong sense of their role in promoting and supporting breastfeeding, while for others there was little sense of ‘ownership’. The results highlight differences between the approach of midwives and PHNs to breastfeeding with that of doctors and practice nurses. This therefore gives a sense of disjointed care with mothers having to perhaps navigate their way through a range of opinions and information from health professionals about breastfeeding.

The study also reveals limiting external factors which influenced the level of support which health professionals could give despite their eagerness to help women with breastfeeding. These included a lack of time, being too busy, working in an environment in which breastfeeding was medicalised and also health professionals lacking confidence
in providing breastfeeding support. In addition, issues around training were highlighted with there being a lack of interest in training by some professions because of breastfeeding not being a priority for them.

The results point to a need for discussion about the role of the different professional groups in supporting breastfeeding and these roles need to be clarified and reinforced by professional organisations. The role of each profession needs to be considered within the current constraints of the professionals, such as those identified in this study of having a lack of time, being too busy, etc. Finally, consideration needs to be given to alternative support, if some health professionals are unwilling and unable to adequately promote and support breastfeeding. These alternatives could include giving a greater role to voluntary peer supporters by enabling them to provide support in hospital in the post-partum period.
CHAPTER 5

5 Women’s experience of professional support for breastfeeding in the first year postnatally

This chapter describes a qualitative study, the aim of which was to explore women’s experience of professional support for breastfeeding in the first year postnatally.

5.1 Introduction

The postnatal period can be a time when women are faced with practical, social, emotional, and cultural challenges and constraints (Marshall et al., 2007) and issues around breastfeeding can be of great importance to women at this time (Schmied et al., 2001). Research has shown that women face different issues when breastfeeding, such as having to contend with not being adequately prepared for breastfeeding (Mozingo et al., 2000; Bailey et al., 2004; Sheehan et al., 2009), not feeling confident about their ability to breastfeed (Blyth et al., 2002; Marshall et al., 2007; Avery et al., 2009), perceiving that they have insufficient milk (Kirkland & Fein, 2003; Lewallen et al., 2006), receiving conflicting advice which can consequently undermine their confidence (Hoddinott & Pill, 2000; Graffy & Taylor, 2005; Moore & Coty, 2006) and feeling embarrassed about breastfeeding in public (Stewart-Knox et al., 2003; Tarrant, 2008; Begley et al., 2009b). A lack of support in hospital and the community can also be an issue. This was highlighted in a recent national infant feeding survey (Begley et al., 2009b) whereby 19% of women indicated that they had not been shown how to put their
baby to the breast in the first few days postpartum. In addition, 45% of women would have liked to breastfeed for longer than they did. The issue of breastfeeding support has also been discussed in a review of support services provided by PHNs in Ireland, whereby many women did not feel that they were adequately supported in hospital and in the community (Leahy-Warren et al., 2009).

Breastfeeding is a learned skill and so in countries such as Ireland, where there is a lack of a breastfeeding culture and women are often unable to get breastfeeding skills from female friends or relatives, success may depend on the skilled support of health professionals in the early postnatal period (Berridge et al., 2005). However, as has been described in chapters three and four, health professionals are sometimes not the best placed to provide this support, given that they themselves may lack knowledge and a positive attitude towards breastfeeding. Women have sophisticated needs in relation to breastfeeding and health professionals are sometimes unaware of these and unable or unwilling to meet these needs. While the exclusive goal for health professionals is sometimes for women to initiate breastfeeding, women instead seek maternal, baby and family wellbeing (Hoddinott & Pill, 2000; Murphy, 2003). Women seek consistent advice and support (Ingram et al., 2002) that is practical and individualised to their needs (Hoddinott & Pill, 2000; Murphy, 2003; Graffy & Taylor, 2005). Support, however, can be uncaring, routine, distant, standardised or rushed (Nelson, 2006).

Research into women’s experiences of breastfeeding in Ireland has been mainly in the form of quantitative surveys (Tarrant, 2008; Begley et al., 2009b), with only a small qualitative aspect (Begley et al., 2009b). Qualitative research provides the opportunity to gain greater insight into issues at work around breastfeeding (Bailey et al., 2004) and it
can uncover issues which are perhaps missed by quantitative research (Mahon-Daly & Andrews, 2002). Sheehan et al., (2009) described there being a paucity of qualitative research specifically reporting women’s experiences and expectations of professional support for breastfeeding. A deeper understanding of such issues would enable the development of strategies to improve practice (Spencer, 2008). While studies have been conducted in Ireland looking at women’s experience of postnatal care (Murray et al., 2000; Cronin & McCarthy, 2003), there have been no qualitative studies exploring women’s experience of breastfeeding support. For this reason a qualitative study was conducted to examine women’s experience of breastfeeding support in the first year postnatally.

5.2 Aims and Objectives

The aim of this study was to examine women’s experience of professional support for breastfeeding in the first year postnatally. Breastfeeding has been described as an “engrossing, personal journey” (Nelson, 2006). Thus, it was felt that in interviews women would not be able to only reflect on their experience of professional support because their whole experience of breastfeeding was likely to have affected and have been affected by professional support. For this reason the objectives of the study were broader than the initial aim. The specific objectives were to look at women’s experience of breastfeeding, their expectations and perceptions of professional and non-professional support for infant feeding and how communication about breastfeeding was perceived by mothers. It was anticipated that this broader perspective would aid in providing a deeper understanding of women’s experience of professional support for infant feeding.
5.3 Methods

As described in chapter two, this study is a qualitative descriptive study with grounded theory “overtones”. The specific aspects of the methods that were used in the study were described in detail in chapter four and so a more concise description of the methods for this chapter will be given below.

5.3.1 Research setting

As with both the quantitative and qualitative studies described in chapters three and four, this study was also conducted in North Dublin.

5.3.2 Sampling Strategy

As was previously described in chapter four, theory based sampling was used, where possible. Where this was not possible, sampling was done on the basis of convenience.

5.3.2.1 Recruiting participants

Women were recruited through PHNs in North Dublin. Initially, permission was sought from the DPHNs, to use the list of PHNs which had been provided for the studies described in chapters three and four. Two of the DPHN granted permission to use the lists and one of the DPHN provided the names of seven PHNs in her area that would be willing to be help with the study. PHNs were then contacted from each of the three LHOs in North Dublin. They were asked to give information sheets about the study (Appendix XIV) to women who had any experience of breastfeeding in the previous year. The woman could then either contact the researcher (Barbara Whelan) directly or
give the PHN permission to pass on her contact details to the researcher.

The selection criteria for participants were as follows:

- The woman was aged 18 years or over
- She had a healthy, term ($\geq$ 37 weeks gestational age), singleton baby, weighing $\geq$ 2.5kg (5.5lbs) at birth, in the past year
- She initiated breastfeeding and had either continued to exclusively breastfeed, mix feed (both formula and breast milk) or give formula

Where possible, the participant characteristics and type of infant feeding experience which were needed based on theory based sampling were explained to the PHNs and they helped to identify potential participants. There was some evidence of gatekeeper bias whereby PHNs facilitated access to women who they felt were ‘good breastfeeding’. Once I became aware of this an effort was made to reduce the bias by explaining to the PHNs that women who had any experience of breastfeeding were eligible to participate in the study and that as much as possible, I wanted to record a range of experiences. In addition, one PHN suggested that I attend two breastfeeding support groups to meet mothers who may be interested in participating in the study and women were also recruited in this way.

5.3.3 Data collection

Data were collected from face-to-face, individual interviews. An interview guide (Appendix XV) was used in order to provide a framework around which the interview could be conducted. Questions were based on the aims and objectives of the study and also on the literature. In addition, the key findings from the qualitative and quantitative
studies with health professionals were further explored. These included the ambivalence of some healthcare workers towards breastfeeding and the lack of time that health professionals had to support women. The questions were broadly divided into women’s experience of breastfeeding in the antenatal, hospital and postnatal stage and addressed women’s experience in relation to their personal experience, health professionals and society and the promotion and support available for breastfeeding. The questions were piloted in an interview with a breastfeeding mother. She made some suggestions regarding the order in which the questions could be asked.

5.3.3.1 Interview process

In total, twenty-two interviews were conducted. Interviews took place over a six month period, between July 2009 and December 2009. All interviews, except for two were conducted in the women’s homes. Two interviews were conducted in a play-group where there was a mother and parent toddler group meeting. All of the interviews were recorded, with permission, using an Olympus VN-2100 Digital Recorder. The interviews lasted an average of forty minutes.

The interviews followed guidelines described by Kvale (1996), as described in chapter four (section 4.3.3.2). The questioning technique used in the interviews was such that the participants were encouraged to speak as freely as possible. The first question for each interview was “could you tell me about your experience of infant feeding?” and this yielded spontaneous, rich description. As described in chapter two, probing questions were used to encourage participants to expand on what they said. All interviewees were
asked to sign a consent form and to fill out a brief demographic questionnaire. These are both provided in Appendix XVI.

5.3.3.2  Transcription of interviews

All of the interviews were transcribed by the researcher (Barbara Whelan), using the same technique as that described in chapter four (section 4.3.3.3).

5.3.4  Data analysis

The computer software NVivo 8 was used to store the data and to help with data analysis. The procedures used in analysing and coding the data were the same as those described in chapter four, section 4.4 and 4.5. In keeping with grounded theory methods, the process of initial coding, focused coding, writing in the research journal, memo writing and modelling were conducted in a cyclical manner and not sequentially. An example of the kinds of initial codes that were generated is shown in Appendix XVII. Some of the initial codes with their corresponding text from the transcripts are shown in Table 5.1. Through the process of initial coding, writing memos and modelling, coding became less disjointed and more focused leading to the development of concepts and categories. Data collection and analysis continued until no new concepts or categories appeared in the interviews and all categories were developed with some depth and variation.
**Table 5.1   Examples of initial codes**

<table>
<thead>
<tr>
<th>Original text from transcript</th>
<th>Initial code</th>
</tr>
</thead>
<tbody>
<tr>
<td>when I went back to the group in the Rotunda and there the lactation nurse seemed to know a lot like she was there if you get this we know how to do different things and she seemed to have very specialised knowledge about it so I think that was really important.</td>
<td>Health professionals having expertise</td>
</tr>
<tr>
<td>I think a big part of it is I had decided I was going to breastfeed and that’s it, like I think if I hadn’t made that strong a decision to be honest you do really have to fight and even if you get a lot of help I do think you have to have made that decision yourself.</td>
<td>Being determined</td>
</tr>
<tr>
<td>I always had the idea of give it a go and if it didn’t work out it didn’t work out and not to be beating myself up about it. you can you know talk to other mothers who have experienced different things like you know if you want to know about kind of like expressing or you know like sometimes she’s unsettled in the evenings you know do they have that or what do they do</td>
<td>If it works it works, if it doesn’t it doesn’t Sometimes other mothers are the best people to speak to</td>
</tr>
</tbody>
</table>

**5.3.5   Quality in qualitative research**

Respondent validation or member checking, as it is sometimes called, was employed in this study to see if participants felt that the account produced by the researcher of
women’s experience of professional support for breastfeeding, summed up their general experience. A summary of the results was sent to all of the interviewees. Seven of the participants responded with positive comments and they felt that the results were a good representation of women’s experience of professional support for breastfeeding. In addition, in keeping with recommendations by Fade (2003) to maintain authenticity and integrity, consideration was given to a range of views and raw narrative is presented in the results to support the findings.

5.4 Results

Twenty-two women were interviewed. Eleven women were exclusively breastfeeding (infant receives only breast milk) at the time of the interview. Four women were complementary feeding (breast milk and any other food or liquid including formula given at six months of age or beyond). The remaining seven women had breastfed (breast milk and any food or formula) for 3-7.5 months and had stopped by the time of the interview. The demographic details of the participants are provided in Table 5.2. As can be seen in Table 5.2 the majority of interviewees were Irish and had third level education.
<table>
<thead>
<tr>
<th>Socio-demographics</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nationality</strong></td>
<td></td>
</tr>
<tr>
<td>Irish</td>
<td>20</td>
</tr>
<tr>
<td>European</td>
<td>2</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
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<tr>
<td>25-29</td>
<td>3</td>
</tr>
<tr>
<td>30-34</td>
<td>13</td>
</tr>
<tr>
<td>35 years or more</td>
<td>6</td>
</tr>
<tr>
<td><strong>Partner status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>20</td>
</tr>
<tr>
<td>In a relationship</td>
<td>2</td>
</tr>
<tr>
<td><strong>Level of education</strong></td>
<td></td>
</tr>
<tr>
<td>Second level</td>
<td>2</td>
</tr>
<tr>
<td>Third level</td>
<td>20</td>
</tr>
<tr>
<td><strong>Parity</strong></td>
<td></td>
</tr>
<tr>
<td>Primiparous</td>
<td>13</td>
</tr>
<tr>
<td>Multiparous</td>
<td>9</td>
</tr>
<tr>
<td><strong>Maternity care</strong></td>
<td></td>
</tr>
<tr>
<td>Public (with combined antenatal care)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Semi-private (with combined antenatal care)</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Private (with combined antenatal care)</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Home birth with an independent midwife</td>
<td>1</td>
</tr>
<tr>
<td>Domino scheme</td>
<td>1</td>
</tr>
<tr>
<td><strong>Age of baby at time of interview (months)</strong></td>
<td></td>
</tr>
<tr>
<td>Birth - &lt;2</td>
<td>2</td>
</tr>
<tr>
<td>2 - &lt;4</td>
<td>6</td>
</tr>
<tr>
<td>4 - &lt;6</td>
<td>4</td>
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<td>6 – &lt;8</td>
<td>6</td>
</tr>
<tr>
<td>8 - &lt;11</td>
<td>4</td>
</tr>
</tbody>
</table>
5.4.1 Conceptual framework

The findings of this qualitative study are presented within a conceptual framework called ‘the world of breastfeeding’ (Figure 5.1) which is made up of three separate concepts: ‘the woman’s own world’, ‘the medical world’ and ‘the world of support’. Each of these is in turn affected by the culture of breastfeeding in Ireland, which is placed at the centre of the model. A ‘world’ may be defined as all that belongs to a particular sphere of activity and so in this case it is used to summarise the factors which are associated with women’s experience of professional support for infant feeding support. The concept was referred to by one of the women in the study who said that “especially the first time breastfeeding mother, you wouldn’t be aware of the world” and consequently it emerged from the interviews to encapsulate women’s experience of support: women had to navigate through the ‘world of breastfeeding’ which was defined by their own world, the medical world, the world of support and the culture of breastfeeding in Ireland. Each of the concepts is described in further detail below.

Code numbers have been used to present the participants comments and to maintain confidentiality.
Figure 5.1. A conceptual framework of ‘The World of Breastfeeding’

The woman’s own world
- Deciding to breastfeed
- Giving breastfeeding a go
- Being determined
- Experience not meeting expectations

Culture of breastfeeding in Ireland

The World of Support
- Support from family and friends
- Breastfeeding support group
- Having the right people at the right time
- Support that women want

The Medical World
- Being facilitated
- Being disappointed
- Being discerning
- Conflicting information
- Seeking expert help
5.4.2 The woman’s own world

The concept ‘the woman’s own world’ is made up of four categories which describe women’s personal characteristics, their approach to breastfeeding and experience of it.

5.4.2.1 Deciding to breastfeed

All of the women in this study had initiated breastfeeding and could identify reasons for doing so. For some women their decision was based on their own mothers and or sisters having breastfed and so it was a natural progression for them to do it too.

I really wanted to breastfeed because both my sisters had and my mam had and it was just something I wanted to do (10)

For others breastfeeding was the obvious choice with it being best for their baby and for themselves. They considered it to be natural and what nature had intended them to do.

I had read quite a bit on breastfeeding and the advantages of it and it's like it's nature's way. We're built that way so why wouldn't you (3)

Women discussed the benefits of breastfeeding with many mentioning the convenience, especially at night time when they did not have to prepare a bottle.

You don’t have to come down and walk on cold tile floors and start counting, when you’re half asleep and you can’t remember how many scoops you’ve put into the bottle or whatever (6)

In addition, women marvelled at the fact that they could leave the house with their baby and all they needed was a nappy in their pocket. Both the health benefits of breastfeeding and the bond that it created between the mother and baby were also discussed.
5.4.2.2 Giving breastfeeding a go

Some women described wanting to give breastfeeding a go. They did not define from the beginning how long they would breastfeed for but simply decided to try and to see how things went.

*I just thought you know why not give it a try. I read up about all the benefits, I mean the list is endless and I just thought I’ll just give it a try. I wasn’t saying oh I’m going to breastfeed my baby for a year, I didn’t and I’m still not saying that, it’s one week at a time, it really is, but I just wanted to give it a try* (11)

Women had a sense that breastfeeding sometimes did not work out and so their attitude of giving it a go was in response to this sense of breastfeeding being difficult.

*I mean a lot of women that are dead set on breastfeeding and they have the baby and they find that it’s just not working out for them whereas I think if you go in with a more open mind of ok I’ll give it a go and if it doesn’t work out, cause it’s so emotional anyway, you don’t really need to be beating yourself up about not breastfeeding as well* (17)

It seemed that women’s attitudes towards giving breastfeeding a go was more of a way of protecting themselves from disappointment if breastfeeding didn’t work out. This was seen in the following two comments from women who described giving breastfeeding a go but actually caring if it didn’t work.

*I had kind of gone into it with the attitude that I would take it and see how I got on. I wasn’t going to get very hung up on oh I have to breastfeed, I have to breastfeed and if it didn’t work, I wouldn’t do it, I’d kind of give up. I went in with quite an open attitude hopefully but I had kind of really wanted to do* (15)

*I had said in my head I will breastfeed if I can and if I can’t it won’t be a
big deal and then realised that when I had him if I couldn’t it would have
been a big deal (13)

5.4.2.3 Being determined

In contrast to the attitude of ‘giving it a go’ and in some cases in spite of this, women
also discussed their determination to breastfeed despite breastfeeding being very
difficult in the beginning. Some women suffered from soreness, blisters, cracked
nipples, mastitis and thrush but continued to breastfeed because of their “stubbornness”
and “sheer bull-headedness”. Being determined to breastfeed was an important trait that
women seemed to need in order to continue breastfeeding through difficult times.

I think a big part of it is I had decided I was going to breastfeed and that’s it, like I think if I hadn’t made that strong a decision to be honest you do
really have to fight and even if you get a lot of help I do think you have to
have made that decision yourself because it’s still quite difficult even if you
have help you know it’s not an easy thing to kind of get through the
beginning (13)

Some women described their determination to breastfeed as being the factor in them not
accepting professional advice to give formula.

If you were a soft touch you might just say ok but I had heard that before
like people had told me that babies can go for hours without feeding and
you have to be just strong and say you know that they will feed when they
want to feed. You just have to be sure of yourself and confident enough to
say no I want to breastfeed and that’s it (20)

Only that we were so stubborn that we didn’t, that we said right we’re not
giving her formula we’re not going down that road that we said we’ll seek
every avenue and pay to see a lactation consultant (2)

Sometimes determination bordered on perseverance, with women describing persisting
with breastfeeding in spite of it being really hard. One woman described it as “torture”, as can be seen in the following quote.

I used to break out in a sweat every time I had to feed him. I was like roaring crying. He fed every two hours and I have to say, I don't really remember the first few months, well the first few weeks. I have to say he was a joy as a baby and maybe all mothers are the same but it was kind of like torture at the start. It was only the perseverance that I knew it was the right thing to do (1)

Another woman spoke about having a “strong conviction” to breastfeed, in spite of it being painful.

5.4.2.4 Experience not meeting expectations

For many women their experience of breastfeeding did not meet their expectations of what it would be like. Some women had thought that breastfeeding would be much easier and more natural than what it actually was and they wondered why they had not been told that this could be the case.

I think you think you're prepared for it and I thought it was going to be easy and you just do it and like they say you just put the baby on in the first hour and they just feed away and it is all so wonderful and that didn’t happen at all. Yes the baby was put on and no he couldn’t feed and it was painful (10)

I’d always intended to do it and I always thought it was going to be such a total natural thing that I was just going to pick up straight away and you know it was going to work miraculously well for me from day one but it just wasn’t that at all and I suppose it felt really sort of well why didn’t someone tell me that it was going to be like this (22)

This woman also described how practicing with dolls in the breastfeeding class and
actually feeding her baby were two very different things. Despite feeling prepared for breastfeeding, the reality of a “wriggling hungry baby” was different to a doll and all that she had learned “went out the window”. Many women reiterated the fact the breastfeeding was more difficult than they had thought it would be and that while breastfeeding is natural it is still a learned skill. This can be seen in the following quote.

I think a difficult time to learn something new but I definitely had no idea how difficult it was going to be or how hard it was going to be. It was quite a shock to me. Definitely it doesn’t come naturally, or it doesn’t come naturally to everyone. It’s natural, but it doesn’t come natural (13)

One woman who had attended an antenatal class whereby the reality of breastfeeding was described, felt that she was more prepared for what to expect. She learned that breastfeeding may involve an effort in the beginning but that it would be worth it in the end

We did the course and that helped a lot you know she kind of, you know reality sort of checks like instead of saying, it’s not all mother earth sitting there feeding your child, like there is it’s difficult to get the whole thing moving and get it going but it’s worth it when you get it established properly (17)

Women described the promotion of breastfeeding as extolling the benefits but not actually preparing them for it. While they recognised the importance of breastfeeding being promoted, they also described the importance of actual support for breastfeeding being given.

I think it's more the technique that people need help with rather than the background information. That's the only way people are going to be able to do it (1)
5.4.3 The Medical World

This concept is made up of five categories and describes women’s experience of breastfeeding in relation to their direct encounters with health professionals.

5.4.3.1 Being facilitated to breastfeed

Some women were happy with the help and support that they got with breastfeeding, in hospital.

*Very good, they were very good. They asked me before if I was going to and they really tried to, I had decided anyway that I was going to breastfeed but they were all very helpful from the beginning* (18)

Women appreciated midwives who actively helped them get skin to skin contact and helped with latching on when the baby was born.

*The midwives in the delivery suite were great, they put her on straight away and they were really good about getting skin to skin contact and all those things that kind of are supposed to be really important* (14)

They also liked when midwives could sit with them and help them with breastfeeding.

*They do try hard to help you and if you have a problem they do sit with you and you know you do get very emotional and you don’t know what you’re doing and then the baby cries, of course the baby’s hungry but they do give great support, just keep trying, trying and do your best* (12)

This scenario was not, however, so common as women recognised that midwives were under huge time constraints.

*Genuinely I needed help but I don’t think it was necessarily the nurses’ fault it was just there is so much to do in there like they are constantly on the go but I think you need a little more support* (4)

Some women mentioned how their paediatrician was very supportive of breastfeeding.
In the hospital the paediatrician was really nice and she was really encouraging with breastfeeding and actually she gave me some tips about positioning and feeding and stuff so that was good (19)

A few women found their GP to be supportive of breastfeeding and in most cases this GP was a woman who was also a mother herself. Women appreciated getting encouragement and recognition for breastfeeding.

My GP was great when I got pregnant and all the way through. She’s three kids herself and I’d maybe recommend that to any body expecting because I felt more that I was dealing with somebody that had been there done that (17)

Most of the women interviewed were happy with the support which they got from their PHN(s). They appreciated PHNs being accessible and the fact that the PHN could visit them in the comfort of their own house.

Any time I went up there was always someone there, I didn’t feel I was a being a burden to them at all (4)

It’s such a good resource to have that someone comes into your home and helps you and comes as often as you need it (21)

Many PHNs provided support and encouragement and in some cases gave their phone numbers to women so that they could call/text them whenever they needed.

She was kind of saying oh you’re doing the right thing, the baby’s gaining weight, the baby’s healthy. She said if I needed anything to call her, she would come to you, she gave me her phone number. She was great (12)

Women liked their PHN being “down to earth” and being able to meet them where they were at with breastfeeding, not imposing their own views on women. Women wanted health professionals to give advice that was suited to their particular situation and that
was not prescriptive. They appreciated getting practical help and PHNs taking the time to watch them breastfeeding to assess whether the baby was latched on alright or not.

She wanted to kind of see you latching on to see to make sure you were fine, rather than just going yeah yeah things are fine they were like no show me how you’re getting on (15)

Some women felt that health professionals could facilitate them better if they had personal experience of breastfeeding.

The PHN is up there, has kids, has breastfed herself so she has the experience so I think that’s probably something that makes the difference, you know. You know when you’re going to someone and asking questions, the fact that they’re just giving you text book answers that you can kind of find yourself by looking up the internet doesn’t really help that much (13)

Other women, however, felt that having personal experience of breastfeeding was not important and that because everyone can have a different breastfeeding experience a health professional reflecting on their own experience may not be appropriate.

I’ve breastfed my baby but I could meet another mum that has had a very different experience and a different baby so I think it’s more, yeah the health professional is more, was able to, was positive about breastfeeding and could trouble shoot (19)

5.4.3.2 Being disappointed

While some women had a positive experience in hospital and were happy with the level of support which they got, many described the hospital environment as being very busy and hectic and were disappointed with their experience. They commented on there being a lack of continuity of care.

There was always a different midwife on, like I was there for three days
and that’s just the shift changes and some of them were very experienced and probably you know older women would have breastfed themselves and some of them were like you know great and so nice and everything but no experience of breastfeeding (22)

Women who had more than one baby compared their experiences and felt that the maternity hospitals had gotten busier and the midwives had less time to help. Many described the midwives as being very nice and helping as much as they could but because they were so busy, they could not give any dedicated time to women and so as soon as they helped latch a baby on they were gone, leaving the mother to her own devices.

While they would help you, while they were very nice, they were extremely busy and you know as soon as you were latched on they were running out the door to attend to another mother who you know had some other query or concern or whatever (6)

Women felt that it was time consuming for midwives to support breastfeeding mothers and so they sometimes remained impartial in their support of breastfeeding.

I genuinely don’t think they have the time to do more, I think they’re completely overstretched and that’s why you don’t get the support, it’s literally the question when the baby’s born, you know are you bottle or breast and you know if you say bottle they’ll get you the bottle, if you say breast they’ll say do you need a hand to latch on but I think if you say unsure, I don’t know that they’ll have the time to physically give you the support (16)

Some women were surprised at how the promotion of breastfeeding did not mirror the actual support given when they had their baby and they were disappointed and somewhat disillusioned with this inconsistency. In particular women were surprised that
what was ‘being preached was not being practiced’.

I had been to the breastfeeding classes in the hospital and they really did push breastfeeding and they pushed it the same way on both pregnancies. They were very pro-breastfeeding on both pregnancies in the clinics. But the first time they didn’t, it didn’t show up in the ward the support that you were supposed to get. As in you are supposed to breastfeed within 30 minutes of your baby being born but two hours later, myself and my husband were like, what are we supposed to do, are we supposed to pick the baby up and breastfeed ourselves (2)

Other women also commented on how they were not helped to initiate breastfeeding after the birth despite being told that it was very important and they felt let down by this lack of support.

There was kind of no help or encouragement after the birth when you’re supposed to do it straight away so I was kind of a bit annoyed about that (20)

There were certain practices that women did not like and these included when midwives invaded their personal space.

One of the times a particular midwife came in and she practically grabbed me and put the baby on to me and it was like oh, uhh God, like cringe worthy, like that’s my personal space (16)

They also disliked being encouraged to give formula when it directly went against their wishes to breastfeed.

Another midwife that I met in Holles Street when I had Paul said ah sure listen just give one bottle at night time and get some formula on your way out (2)

They found it frustrating when they were not given any practical help when they found it
really painful to breastfeed.

at one stage I was actually crying with the pain and the midwife gave out to me and said like you know you’ll upset the baby and you know the baby’s going to know that you’re upset and that’s going to affect her feeding (22)

I had blisters all over me, my nipple was bleeding and they were all saying you know, ohh leave him there, leave him there, leave him there. You get to a point where you can’t really leave him there anymore (1)

Two women, whose babies had tongue-tie commented on their paediatricians not appreciating the difficulty that this caused for breastfeeding. One paediatrician refused to accept that tongue-tie caused any breastfeeding difficulties and so the mother had to seek help from another paediatrician in another hospital, who was able to resolve the issue.

So she [lactation consultant] sent me to [a paediatrician], he’s a paediatric surgeon, he basically didn’t even entertain us for two seconds. He told us that tongue-tie doesn’t cause breastfeeding problems (2)

Some women were disappointed that their GP did not mention nor encourage breastfeeding and they felt that they should have taken the opportunity to discuss it. Others felt that the GP should have been able to tell them about local breastfeeding support groups.

But GP wise no, she didn’t really push it or she didn’t, I can’t even remember having a conversation with her to be honest (11)

Like my GP is a male so he could just say you know there is support if you need it or if you find it difficult you know that kind of way. You know he just says oh is she feeding, like you know, literally one question like, you know, I just think they should say there is support out there (20)
Obstetricians were described as playing a similar role to GPs. While some obstetricians asked if the mother was going to breastfeed, it was more so as a passing comment rather than an opportunity to discuss the subject. Many obstetricians did not engage and nor did mothers expect them to engage in conversation about breastfeeding, but some felt that it would have been a good opportunity to show that they lent their support to it.

_I would have seen the consultant prior and she just basically mentioned it, are you planning on breastfeeding? Oh that’s great and that was the end of it, you know it was a passing comment_ (15)

Women found that sometimes they were getting text book answers to their questions and instead preferred more personalised care.

_You know when you’re going to someone and asking questions, the fact that they’re just giving you text book answers that you can kind of find yourself by looking up the internet doesn’t really help that much_ (13)

Finally, while some women described their PHN as being lovely and friendly, they were disappointed because ultimately they were not able to give the support which the mother needed.

_She’s lovely but didn’t really mention breastfeeding, well she did mention it and said oh you’re great, you’re brilliant and keep it up and she weighed her and she said obviously everything’s going well and that was kind of it then, you know encouraging but nothing more than that really_ (21)

_The public health nurse that I got she was absolutely lovely but I knew as much about breastfeeding as I felt she did. I felt that, lovely woman but I knew as much as she did about it_ (4)

### 5.4.3.3 Being discerning

Many women had decided whether their GP was “pro-breastfeeding” or not and based
on this decision they decided whether to go to their GP for advice or support.

*My GP is not very pro-breastfeeding, give the bottle, give the bottle. So I didn’t have a lot of contact with him at all (5)*

Women seemed to pick up subtle messages from their GP which helped them decide whether they supported breastfeeding. These messages were for example the GP telling the mother that she would have to give up breastfeeding at some stage and so it may as well be sooner than later, that breastfeeding for two months was sufficient, not being able to advise on issues such as cracked nipples, pain etc. when breastfeeding, and the GP not encouraging breastfeeding either in the antenatal or postnatal period.

*I never got the vibe from my GP, just with other things going down to her that she was amm, I remember once she said to me oh yeah well you’re going to have to get him on the bottle eventually so in that sense, I just don’t think, not that she’s not supportive of either way I just think that she would be quite indifferent of whichever way as long as he’s feeding and putting on weight and whatever he’s eating she doesn’t mind (18)*

Women who had decided that their GP was not so supportive of breastfeeding sought support elsewhere, such as from their PHN, a breastfeeding support group or a private lactation consultant. In addition, some women changed GPs in order to get a better service. Women differentiated between family GPs and GP clinics. They felt that the latter were not so interested in things such as breastfeeding and that the former were better for families with young children.

*Every GP surgery is different. My GP is more about making money as opposed to health promotion and stuff. It just, I imagine there are other GP surgeries that are better at it (16)*

Unfortunately, a few women found that their PHN was not so knowledgeable about
breastfeeding and could not answer queries which the mother had. In addition, some PHNs were known in their area for not being so supportive of breastfeeding.

I would have dropped in a few times but to be honest any of the questions I had for them I never got answers to, I always got a “yeah, I’m not really sure” or “yeah I don’t really know” or “yeah, I’m sure that’s fine” kind of thing, so it was quite wishy washy (13)

In these situations, like with GPs, most women actively sought help from other sources and they did not depend on information or advice from healthcare workers that could not provide it. Experience of breastfeeding also made women more self confident in their own ability to decide what was best for their baby and this was illustrated in the following comment.

Whereas in the beginning we were getting advice, especially she was getting a bit colicy, from everybody and doing everything whether it conflicted or not. We just did everything everyone told us and now I think we’d just be a bit more discerning like I think now we’d know to rely on our own opinion as well (21)

Finally women demonstrated discernment by describing their time in hospital as their opportunity to get help with breastfeeding, before being discharged into the community where there may not be as much support available.

I just kept asking and asking you know to make sure I was doing things right because you know the way, once you come home you’re kind of on your own (14)

5.4.3.4 Conflicting information

Many women discussed their frustration of getting inconsistent and conflicting advice about breastfeeding from health professionals. In the hospital, midwives gave
inconsistent advice about how often to feed the baby, three hourly, four hourly or on demand and whether to feed from one breast or both.

_The only thing I would say about the support in the hospital was it was very inconsistent so you’d have a different person coming to you each time with a different technique_ (6)

Women also found that different midwives had different techniques for holding and feeding their baby. One woman saw this as an opportunity to pick the one that suited her best.

_different nurses saying different things, giving you different advice, now I was willing to take on board anything so if one thing you felt wasn't working I thought at the time maybe this other information will work_ (3)

Conflicting information was also given in relation to using nipple shields. One woman described how a midwife told her to buy them but later the lactation consultant disagreed.

_She [lactation consultant] wasn’t too impressed with that at all cause she said they should only be, she should really be saying, like prescribe them like, use these if things are serious, you know you can’t be giving them out willy nilly because they do have an effect on how things work_ (12)

Another woman, whose PHN recommended she use nipple shields, said that she “never looked back” after using them as they helped her to continue breastfeeding. There was evidence of other advice which healthcare workers gave women and which went against evidence based practice and these related to using soothers, expressing breast milk and mix formula and breast feeding. In many cases they were aware that the advice went against best practice but felt that it was the best solution to the particular situation. This can be seen in the following quote.
She [the PHN] was the first to say look nurses would never recommend a soother but at the same time, when you’re being used for a soother and soothers are actually made now that they’re good for their teeth or whatever, if that would help, so I tried that and that worked as well (10)

Women also found, however, that because some advice was not best practice, health professionals avoided discussing certain solutions. In one situation a woman wanted to use nipple shields but the midwives ignored the issue and would not discuss it with her. In the end she did what she felt was best for her.

I kept saying it to the nurses like it’s sore should I use like a breast shield and they just blanked the information. I knew they didn’t necessarily like using them but they just ignored you, they didn’t want to talk about it so by the time I got home I thought this is ridiculous it’s way too sore so I got some breast shields and that actually got me past the hump (15)

Interestingly, women who were aware that they may get conflicting advice in the hospital were better prepared for this and had the attitude that they would choose the advice that worked for them and would not take it all on board.

People before hand that I’d spoken to and they said that part of the problem is the nurses keep giving you different information and they got so confused by it all they just gave up, whereas I kind of went, I kind of knew that going in, so you had to kind of pick and choose what worked for you basically, not what you wanted to hear but what worked for you (15)

Conflicting advice was not unique to the hospital and women also described it in relation to the community. One woman’s GP told her not to breastfeed while on antibiotics for mastitis. Her pharmacist and PHN told her otherwise.

The doctor said you will have to stop breastfeeding, you could give your baby mastitis and you can’t take, the antibiotics are going to go into the
baby and I said, you know but I’ve heard of mums having mastitis and feeding through it, are you sure. I was devastated. He said well now you'll have to pump for ten days and then start breastfeeding. [My husband] went into the pharmacy and told her what happened and the pharmacist said look don't be ridiculous, she can feed, it's perfectly fine (2)

Another woman’s PHN told her to give her baby a bottle of formula in addition to breastfeeding but later another PHN told her that she would not have recommended this.

That particular PHN would have advised me eventually to give [my baby] the formula whereas the other one would have been definitely more for trying to stick with the breastfeeding and gave loads of positive advice and support and you know (3)

Some women also described their feeling of vulnerability after having their baby and so were not as well able to deal with conflicting advice.

you’re too kind of vulnerable to think that those first couple of weeks you really don’t know what’s what, you know, you’re tired and you’re emotional and you just need someone to tell you this is the right thing to do so to be told five or six different things, it just makes things that bit harder (22)

5.4.3.5 Seeking expert help
Many women were aware of health professionals having expertise in breastfeeding through having a lactation consultant’s qualification. They appreciated this additional expertise and felt that it added to the help and support which they got for breastfeeding.

I think I do appreciate that extra qualification or that specialised knowledge of how to kind of treat things if problems come up. I think in that way the lactation consultant qualification gives you more information about things (19)
Some women clearly differentiated between midwives and lactation consultants with the lactation consultant’s help considered better than a midwife’s.

It would have been nice to see the lactation consultant when I was in the hospital. Because although the midwives, of course they’re very experienced, lets say the lactation consultant, that’s all she does, it’s just breastfeeding and she is so positive and she is so good you just need someone like that (22)

Women sought the help of a lactation consultant either through their maternity hospital, before and after discharge or privately. In most cases they were seeking expert advice or a second opinion or reassurance that breastfeeding was going alright.

5.4.4 The World of Support

The concept ‘the world of support’ describes four different categories in relation to women’s experience of breastfeeding support.

5.4.4.1 Support from family and friends

Women discussed the importance of their partners, friends and family being supportive of breastfeeding.

I know when things were tough I was just, I was finding it really difficult and if I didn’t have like my mum and my sisters, like you know, a couple of friends to talk to, I definitely would have been throwing my hat in it completely (22)

Some women got support from friends who had themselves breastfed. They provided a good source of advice and encouragement, when it was needed.

I called them in tears and I said you know, how am I going to carry on and
half of me wanted them to say, you know, look, just leave it, you’ve been through enough, just don’t worry, give the baby a bottle and it’ll be fine you know, don’t worry so much about the breastfeeding but neither of them did. They just kept saying you know, just keep trying and you know calm down a little bit and you know keep trying and every feed is a bonus (6)

Other women got support from family members.

I suppose my father would be quite pro-breastfeeding as well. I suppose he was the one who actually like, yeah I know it's very hard, he was the one who kind of gave me, yeah this is normal, this is hard, it's ok, cause I just kept thinking I was doing something wrong (1)

In contrast, women also discussed their family, in-laws and friends being unsupportive. In some cases this was due to them not trusting that breast milk was sufficient for a baby.

In terms of family support it was almost a case of from both mother and mother-in-law it was a case of like when are you going to finish that, when are you going to give him proper food. They were the messages. You don’t know how much he’s getting, you know. That’s very discouraging (7)

It was also due to them not having experience of breastfeeding and not being able to understand how a breastfeeding mother felt. One woman described having to confront her mother after she told her she could feed in another room.

I have had a negative experience like with me family. In my own mother’s house, she didn’t realise and she said I have a room where you can sit down and feed the baby so I was pushed out of the conversation and sent to another room and at that stage, that was on my first and I cried and she said are you tired feeding (said in a pitying voice), no I said, I’m crying because I feel like I’m doing something wrong and I’m being punished and being put into a room. You are all sitting in there, I’m not offending
anybody, you see nothing, you see more with a low cut top. Now she thought she was doing me a favour but actually it really upset me. It was like what I was doing was wrong (8)

Negative comments from friends and family made women question whether their baby was getting enough milk.

It knocks your confidence when it is your first time as well. Particularly in those early days when you’re vulnerable and you’re thinking oh God maybe you’re right, maybe the baby isn’t going to get enough milk or maybe, you know but you look back on it then and you think you know, the baby was bursting out of his clothes you know every week (6)

5.4.4.2 Breastfeeding support groups

The importance of attending a breastfeeding support group was highlighted by nearly all of the women. Most women spoke highly of their breastfeeding support group and for many women it was an outing and a social occasion which got them out of the house and interacting with people.

It was a great incentive to get up and get out in the very early stages, you know, I went up to that group every Thursday religiously, hail rain and literally snow. Yes I went out in the snow because I felt it was very important to get out (2)

Women described the informal, social aspect of the support group and in many cases the women did not go to the group to get help with a particular issue but instead just for a chat with other mothers.

It was very very sociable first of all, so you’d have a cup of tea and you mightn’t necessarily, you know, it mightn’t be the first thing you would talk about and in fact an awful lot of times I was going up there without needing help to a specific problem (6)
They found that speaking to other women who were experiencing breastfeeding and motherhood was really beneficial.

That breastfeeding group has been gold for me, with anything, not always the nurses but just with the other mothers they might have had something or we had had a similar issue and they might have solved it, you know, I don’t know I’m the first one of my group of friends with a child as well so I couldn’t go to them. It has just been so good to meet other people in the same situation (18)

In addition, women could get advice and information on a range of things, not only breastfeeding.

even if you were moaning about the sleeping patterns of the baby you know she and maybe others within the group would say well why don’t you try this, so it’s not just about breastfeeding but it’s just you know the support is there and the support is brilliant (6)

Also some women commented on their breastfeeding support group being quite relaxed and so while breastfeeding would be promoted as the best thing it was not the only option and women who were mix feeding with both breast milk and formula, or had stopped breastfeeding could also attend. This worked to the advantage of one woman whose public health nurse encouraged her to attend the breastfeeding support group despite changing from breast milk to formula in the first two weeks of her baby being born. Through continuing to attend the group it gave her the knowledge and confidence to breastfeed her next baby.

I still used to go down even though I only fed her for two weeks, the public health nurse said come down and mingle with the mothers and learn and I did and I think that probably helped and kept me kind of going you know that I’m definitely doing it next time (9)

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Another woman did, however, discuss how a lot of women in her breastfeeding support group were weaning by three or four months and so she, as a mother who was breastfeeding exclusively for longer than that, started to feel a little isolated.

_The breastfeeding group, by three or four months a lot of people are weaning, even like at six weeks people are topping up with bottles, so if you are exclusively breastfeeding you sort of feel a little bit out of the loop even in a breastfeeding group (2)_

One advantage of the breastfeeding support group, which many women commented on, was that they could weigh their babies at the group and so this meant that they did not need to go to the health clinic at another time. In one group, however, a lot of mothers were attending the group just to get their babies weighed and so the support group was less about actual support and more about weighing the baby.

_All the babies are getting weighed and people are going down to get their babies weighed and the focus is now off having a chat with other mums, it's getting their babies weighed and they are going to get their babies weighed and are running out ten minutes later (2)_

Women enjoyed the camaraderie in the breastfeeding support group and of being able to see other babies who were a little older than their own and so they knew what to expect in the next stage of their baby’s development. In addition, many women were not from Dublin and so the group provided an additional support when they did not have family and friends around who could help. Women discussed how some breastfeeding support groups were better than others and they felt that this was partly down to luck that the people in the group got on well and also down to how the public health nurses facilitated the group, making everyone feel welcome. In addition, many women commented on the venue for the breastfeeding support group and they preferred when this was not the local
health centre but instead a more neutral venue such as a local hall.

*It seems to be a particularly good group and you know well run and well organised and a good bunch of people* (13)

Despite there being breastfeeding support groups in North Dublin a few women were not able to access information about the groups and were disappointed that they could not attend. In addition, some women did not have a breastfeeding support group in their area or if they did it was often not well attended and so did not work well.

While the majority of women attended support groups that were run by their local public health nurses, a few women attended classes and groups organised by two voluntary breastfeeding organisations: Cuidiú and La Leche League. One woman described her experience of the two groups, with Cuidiú being more “*middle of the road*” and La Leche League being “*too pro-breastfeeding*”. Another woman described attending a La Leche League meeting and while she found them really helpful she also described them as being ‘cult like’ in their support of breastfeeding.

*I went to a La Leche meeting once, they are brilliant. They are fabulous, they should be paid for what they do. They’re pro breastfeeding to the point of cult, you breastfeed, you breastfeed regardless, formula tchhhh* (5)

Other women despite not having any direct experience of La Leche League also had the impression that they were extreme in their support of breastfeeding and this put them off attending, for fear of being the only one having difficulties.

*I had heard a lot of stuff that they are very strict and that it was total breastfeeding or nothing else and that you wouldn’t want to show up with a bottle in sight kind of thing, terrible, like totally, they might be absolutely the opposite but I had it in my head and because then I was having such problems I was like oh God I don’t want to go and be the only one who*
can’t do it and that kind of thing (10)

5.4.4.3 Having the right people at the right time

Many women described instances of having the right person at the right time to help them through a difficulty they had with breastfeeding. This person was usually a health professional, and it was almost a matter of luck that they came into the woman’s life when she was struggling with breastfeeding.

*When I hear people saying it didn't work out for me that's where I feel, I feel like alarm bells in my head saying that is because there wasn’t the right help given, it wasn’t in place for her. I was so lucky to have had the right people at the right time who could advise me from the start.* (3)

Women singled out these people as providing consistent help and support, giving the mother the skills and confidence to breastfeed.

*There was one particular nurse in the hospital that night. I can’t think of her name, and if she hadn’t been there I would have given up, she was fantastic, she sat with me the whole night really, really made me feel like this is ok, like it’s ok that she’s not latching on, we’ll just keep trying so the second night in the hospital I didn’t even need her support.* (11)

In addition, these people sometimes needed to take control of a situation and women appreciated this.

*An absolutely fantastic midwife, who wasn't Irish, she was an Indian girl, she was fantastic, she came in and I was in a dreadful way and she said you have been feeding and I said I have been feeding all night [said in a crying voice] and she said who told you to keep feeding and I said she told me to keep feeding the baby and she said, oh my God she said and she was just fantastic. She took over, she showed me how to position the baby, she came back to me every two hours, all through the day, she made me rest,*
she just, she was amazing (2)

Sometimes women were on the verge of discontinuing breastfeeding, but because they encountered someone who could support them, they ended up continuing.

[The PHN] mentioned that there was a breastfeeding nurse in the area and I rang her and she came that afternoon and from then on my experience completely changed. I mean I had been thinking about giving up because I was so, I felt so bad at it and I didn’t know how much milk he was getting and at the same time I was racked with guilt, thinking why can’t I do it (10)

5.4.4.4 Support that women want

Some women wished that health professionals would show more of an interest by not just asking if they were going to breastfeed or give formula but also promoting and supporting breastfeeding. The following quotes show that women do not just want support from midwives and PHNs but instead from all professional groups.

Definitely think they could do more to encourage breastfeeding because they do just ask breast or bottle which some people might think is fair enough and they’re not kind of forcing the issue either way but it’s not about forcing the issue, you could gently coax someone into giving something a go and if it doesn’t work out it doesn’t work out (17)

It would be good if the GP, cause you go there every so often when you’re pregnant, if they would, they should promote it I think or at least talk to you about the options you have (18)

I think the staff from the hospital I’d say and the consultants, is important in the way to know what to expect and to kind of tell people it is really important to breastfeed because the breast milk is best as they say (12)

Women wanted practical help, especially in the first few days with latching the baby on
and they wanted to be sure that they were doing this correctly.

*I think from the start, they were all very good with the advice but they never actually watched the latch and I think he got the latch wrong which is why I ended up with two blisters around my nipples. So it was great with advice but because he had a bad latch, which, it's the mechanics of it that I think people need more help with* (1)

They also wanted to be told about support that was available in the community when they were being discharged from hospital. They appreciated having the phone number of someone that could support them in the community. In the following quote a woman discusses the importance of having someone who can give dedicated breastfeeding support.

*I think it would be better if before you leave the hospital if you're breastfeeding to say you have somebody in your area that will be able to call, at least if you felt you could ring her and she said look I'll come around to you tomorrow, or Wednesday do you know what I mean, I'll be there for you, but in the meantime do this, do that, don't panic, you've plenty of time* (6)

Some women were not happy with the support which they got and they emphasised the need for good support, especially in the first few days. One woman described it in terms of a “battle”.

*The level of support I would say is probably not what I would have liked it to have been, you know, so very often you're fighting a battle there to persevere in the early days* (6)

There was a sense from some women that they already knew the theory and they just needed the practical support.

*Stop giving us all the things, we have the information, we just need help* (1)
Finally, women commented on wanting more contact with PHNs: that they could visit their home more often than just once and also that they could work at weekends and so if a mother was discharged at the weekend she would have the support of a PHN.

    It would be nice if the public health nurse could come to your house a bit more often, especially in the first three months but she only comes once or twice (18)

    I think again there should be more funding to allow public health nurses work through the weekend. I am sure they’d probably shoot me for saying that. You know everybody likes their weekend off but I think it’s very important for new mothers coming out of hospital to have someone there because it’s very scary. You’re so vulnerable (3)

5.4.5 Culture of breastfeeding in Ireland

Each of the three concepts are influenced by the culture of breastfeeding in Ireland. Ultimately, women were breastfeeding in a culture in which it was not so common. Some women commented on how none of their family or friends had breastfed. This had an influence on their attitude towards breastfeeding and also it meant that they relied on other sources of support, such as from health professionals.

    I don’t have anybody in my family to teach me that and I know historically I know that would have been the case. It would have been passed down from generation to generation but I know most people now who do breastfeed, we don’t have that anymore, we don’t have anyone to teach us so (1)

    None of my friends did it, none of my family did it so all I heard was a lot of stories about people that couldn’t do it, so friends of mine that were like oh I tried but I couldn’t do it, I was too sore, or I didn’t have any milk or blah blah blah (11)
Quite a few women commented on a feature, a few weeks previous to the interviews, on a national radio chat show, where a woman had phoned the show and described how she had been breastfeeding in a pub while having lunch and had been asked by the manager to move into a private room to continue feeding her baby. A debate about breastfeeding in public had followed this call and many callers opposed women doing this. This feature reminded women that breastfeeding is not always supported and made them conscious that it can be an issue for some people.

Many of the women felt that if there was more of a breastfeeding culture in Ireland then this would have a knock-on effect on people’s attitudes, health professionals’ knowledge and the support that was available for breastfeeding and their subsequent breastfeeding experience.

*It is probably partly because so few people breastfeed in Ireland that we don’t have that experience coming down to the next people or whatever. If everyone breastfed then it’s more likely that you’re going to get a health nurse or doctor who breastfed or who knows someone who’s breastfeeding or whose parents breastfed so I think it is partly the fact that so few people do do it, they don’t have the experience to share* (13)

*If we got better at it in Ireland, it would become, there would be more people, everyone would know someone if we were better doing it in the first place* (14)
5.5 Discussion

This study considered the experience of twenty-two women in relation to professional support for infant feeding. Study participants were primarily older and were educated women, characteristics that are associated with breastfeeding initiation (Begley et al., 2009b; Tarrant et al., 2010). In addition, most of the women breastfed for longer than three months and so when one considers the low rates of breastfeeding in Ireland, the women in this study are perhaps not ‘typical’. However, it was important to get women’s perspectives of professional support in order to better understand issues around professional support for breastfeeding. Mahon-Daly & Andrews (2002) have suggested that the experience of middle class women is sometimes overlooked in favour of lower socio-economic groups. The results of this study cannot be generalised to represent the experience of all breastfeeding women in Ireland, however, they do give an insight into an area of which little research has been conducted in Ireland.

One of the reasons that some women initiated breastfeeding was because their mothers and or sisters had breastfed and so it was a natural progression for them to do so too. Marshall et al., (2007) found a similar reason amongst the women they interviewed. As was found in the national infant feeding survey (Begley et al., 2009b), and in other studies (Dykes, 2005a; Marshall et al., 2007) a women’s main reason for breastfeeding was because of the benefits to the baby’s health. They also discussed breastfeeding in terms of it being natural and what nature intended. However, some women discussed the importance of recognising that while breastfeeding is natural, it is also a learned behaviour. Interestingly, Avery et al., (2009) identified that women who considered
breastfeeding a learned process are possibly more likely to breastfeed than those who consider it ‘natural’ and easy’.

Many of the women expressed their determination to breastfeed and this was what kept them going, through difficult times. This has been described by Sheehan et al., (2003) who found that women committed themselves to breastfeeding in an effort to respond to the fear of breastfeeding difficulties. In addition, it was sometimes this determination that prevented women from, for example accepting professional advice to top up with formula or to stop breastfeeding in the case of mastitis. Women also described ‘persevering’ with breastfeeding despite it causing a lot of pain and distress for the mother. The concept of persistence has been discussed in the literature and Botoroff (1990) described ‘persistence’ as being an important trait mentioned by women who were breastfeeding. Persistence can also result in women continuing to breastfeed despite not getting much enjoyment or benefit from it. Indeed, Schmied et al., (2001) have described concern for the level of distress experienced by some women with breastfeeding and they feel that health professionals are somewhat implicated in this as they encourage women to persevere in order to be a ‘good mother’. Some of the women in my study were pushed by healthcare workers to continue breastfeeding despite it being extremely painful. Women found it particularly frustrating when they were told to persevere but were not given any practical help to alleviate the pain or support with latching the baby on to the breast. This was also a source of frustration for women in the UK (Hoddinott & Pill, 2000).

While many women were determined to breastfeed some (also) described ‘giving breastfeeding a go’ and so they approached it as something that might or might not work
out. Bailey et al. (2004) have described this phenomenon and feel that it is the “self-preserving compensatory” response of mothers to hearing on the one hand that breast is best and on the other hand that difficulties will occur with breastfeeding. Interestingly, however, although women described being somewhat indifferent as to whether breastfeeding worked out or not, many showed persistence and absolute determination to breastfeed and so while they said that they would “give it a go”, their actions said otherwise. McBride-Henry (2010) found a similar dichotomy in women, whereby women described how they would like to be able to tell another woman that it was ok to give up breastfeeding if it was not working, however, they acknowledged that they wouldn’t be able to do it themselves owing to a sense of failure.

As in other studies (Coreil et al., 1995; Bailey et al., 2004; Graffy & Taylor, 2005; Sheehan et al., 2009), women frequently discussed being unprepared for the reality of breastfeeding and this resulted in them being disappointed and doubting their ability to feed their baby. Mozingo et al., (2000) described this being due to women having an “idealised expectation” of breastfeeding which “clashed with reality”. Spear (2004) illustrated how having too much information about problems that may occur when breastfeeding could cause stress and anxiety for women, equally not having enough information could ‘foster psychological and emotional discomfort’. There has been criticism of the pro-breastfeeding health discourse for not describing the possible unpleasant aspects of breastfeeding for fear of women being discouraged (Knaak, 2006). Increasingly, there is a call in the literature for women to be prepared for breastfeeding as they are prepared for birth – ‘knowing that it is not always a connected harmonious, intimate and emotionally fulfilling experience’ (Schmied et al., 2001). The results of this
study would indicate that women need more realistic information in the antenatal period so that they are adequately prepared for breastfeeding.

Studies have shown that women are often dissatisfied with the care given in hospital in the postnatal period (Yelland et al., 1998; Rice et al., 1999). In this study some women discussed being eager to initiate breastfeeding soon after their baby was born but not being encouraged or helped to do so. Women found this distressing as they had been told that it was important to latch the baby on as soon as possible after the birth and so advice in the antenatal period was not met with actual practice postpartum. According to Svedulf et al. (1998) a woman’s first experience of breastfeeding is the most important factor in determining whether she breastfeeds or not and a positive experience is determined by receiving encouragement, help and support while breastfeeding for the first time. Having skin to skin contact in the first half hour of birth is one of the Ten Steps to Successful Breastfeeding (WHO & UNICEF, 1989) and it is associated with a greater rate of exclusive breastfeeding (Asole et al., 2009). Many women also described not being adequately supported to breastfeed in hospital. As was described by Sheehan et al., (2009), while women had informed themselves about breastfeeding in the antenatal period, when it actually came to breastfeeding they still needed practical support and guidance.

The women in this study described the hospital environment as being very busy. Kirkham et al., (2002) found that women seemed to understand the dilemma for midwives, in that they were under pressures of work and time. However, they were disappointed that the midwives tended to focus on clinical tasks, rather than supporting them emotionally and psychologically. Dykes (2006a) also found that women were
aware of how busy midwives were and while they were not satisfied with their care, they did not blame the midwives for this but the system which made midwives busy and stressed. This was also the case in my study, whereby women described the hospital environment as being quite hectic and frequently mentioned that midwives were under a lot of pressure. They were disappointed when midwives were unable to sit with them and support them. In my study, as in other research (Mozingo et al., 2000; Marshall et al., 2007) some women described being uncomfortable with midwives ‘grabbing’ on to their breast. Whelan & Lupton (1998) found that women did not like midwives ‘doing’ rather than ‘teaching’ how to position the baby at the breast. The benefit of a specific “hands-off” technique taught to mothers in the early postnatal period has been shown to improve women’s chances of breastfeeding successfully and reduced the incidence of problems (Ingram et al., 2002).

While there is some evidence in the literature, of women considering health professionals the “repositories of the wisdom and knowledge necessary to breastfeed” (Schmied et al., 2001), this study showed that women were quite discerning in their approach to health professionals. While on the one hand they placed their trust in some healthcare providers, such as midwives and public health nurses, on the other hand they were wary of advice and information from other professions, such as GPs. They did not always follow their advice blindly but instead questioned it and sought a second opinion. O’Keeffe (2006) has commented that while the medical profession will probably continue to build upon its current power, the rise in a consumerist attitude among patients may act as a counterbalance to this which could shift the balance of power. She associates this potential shift to the proliferation of websites and parenting forums with
information about breastfeeding. While it is a positive step that women are more informed about breastfeeding and question medical advice, this is particularly beneficial when advice is incorrect. However, when the advice is based on medical evidence, then women may be doing a disservice to themselves in not choosing the best thing for them. It is also important to remember that many of the women in my study were motivated and determined to breastfeed and demonstrated discernment in accepting or rejecting professional advice. This would not always be the case and so women who were less confident and determined may unwittingly accept incorrect professional advice or be discouraged from breastfeeding. Marshall et al., (2007) have also found that the more confidence a mother has with breastfeeding, the more likely she is to come up with solutions herself and to discount health professional’s solutions if they do not “fit”. With experience, women are able to evaluate a range of information from different sources and can decide for themselves that which is best for them (Murphy, 2003). This was the case for some of the mothers in my study.

Women expected professional support for breastfeeding in the hospital and the community and were surprised when this was not available. In addition, many women were aware of there being lactation consultants and they also wanted this level of expert help. A recent study by Leahy-Warren et al., (2009) in Ireland emphasised this dependence of women on specialist support with nearly half of the women in the study indicating that help from a breastfeeding specialist at home or in hospital would have helped them to decide to breastfeed or to continue to breastfeed. Barona-Vilar et al., (2009) described a similar phenomenon in Spain, with women from higher socio-economic groups regarding health professionals as holders of more reliable scientific
knowledge. They found that the value given to women’s own mothers advice decreased as socio-economic status increased. This is probably as a consequence of the medicalisation of childbirth and breastfeeding whereby women feel that they need support from health professionals in the transition to motherhood (Forster et al., 2008). Dykes (2006a) has also shed light on this phenomenon and she relates it to women not having any vicarious experience of breastfeeding, whereby they watch other women breastfeeding. She describes this lack of culturally acquired knowledge as creating an opening for authoritative biomedical knowledge to predominate and a consequent lack of confidence in breastfeeding amongst women, leading to them depending on healthcare workers for assistance, information and encouragement. Dykes (2006a) also found that women focused on the ‘correct’ technique of feeding the baby. I also found this in my study, with women wanting to be given a set of rules with regards to how often they should feed their baby, how long they should feed on each breast and whether they should feed from one breast or both at any particular feed. Interestingly, while on the one hand women wanted clear guidelines about breastfeeding, they also wanted advice which was not prescriptive.

As in many other studies (McFadden & Toole, 2006; Moore & Coty, 2006; Manhire et al., 2007; Montalto et al., 2010) women reported frustration with receiving conflicting advice from different healthcare workers. In a study conducted in Malta, half of the mothers in the sample (n=405) who initiated breastfeeding stopped after receiving incorrect advice from health professionals (Montalto et al., 2010). They suggest that poor advice is being consistently given to women at all time intervals after the birth, indicating that no one profession is responsible. Women described conflicting advice in
relation to being told how often they should feed their baby, with advice varying between on demand, every three hours and every four hours. Simonds (2002) discussed the different approaches within the medical discourse on breastfeeding with different advice regarding how long and how often a baby should be fed. She offered an extract from a book on obstetrics whereby breastfeeding frequency was advised prescriptively: every 3-4 hours for 4-5 minutes or 15-20 minutes, depending on the baby. She contrasted this with a less ‘medical’ book which recommended women ‘discard the clock altogether and instead feed when the baby wants to’. There is a conflict, and it was seen in this study, that on the one hand women are being told to feed on demand and allow the feeding to be baby-led but then on the other hand they are being given a strict routine for feeding. In some cases this went against women’s instincts of wanting to let their baby wake in their own time and to feed them when they were ready. Dykes (2006a) related this conflict to the orientation of midwives to the clock and a preoccupation with schedules, times and routines. She found that while midwives paid lip-service to the notion of demand feeding, in their language they gave mixed messages by requesting detailed information about how frequently the baby fed. This fits in with a medical approach to breastfeeding and a concomitant lack of trust in breastfeeding. It is frustrating that in one respect there is an appreciation for breastfeeding and all that it can offer, but on the other hand there is a suspicion of it not actually living up to expectations.

Many of the women in this study attended a breastfeeding support group and most commented on the benefit of being able to check their baby’s weight at the group. Mahon-Daly & Andrews (2002) described a similar phenomenon with the primary
reason for women attending a clinic being to weigh their babies and this was found to be as important as the peer support and pastoral care role of the clinic. Berridge et al., (2005) also found this, with women attending an infant feeding clinic being concerned about whether their infant was gaining weight and the main priority was to weigh their baby. They felt that this was because of women not being able to see how much milk their baby was getting and because they did not trust their own instincts about whether their baby was content and developing well. Women described negative comments from family members about their baby not getting enough milk and so in weighing their baby it provided proof that they were gaining weight which in turn would hopefully stop any further negative comments. This is similar to a strategy employed by some of the women in another study (Marshall et al., 2007) whereby women who received negative messages about breastfeeding from family members and friends, actively sought out allies to help increase confidence. The breastfeeding support group also provided the opportunity for women to talk to other mothers and to compare notes about breastfeeding and motherhood in general. Women were empowered and reassured from knowing that they were not the only ones going through a particular phase and they also liked being able to see the stage of development of other children a few months older than their baby. Berridge et al., (2005) found similar findings from their study of attendees at an infant feeding clinic.

The support needs of the women in this study were similar to those identified by Gill (2001). She found that women wanted three different types of support: informational, encouragement and interpersonal support. Women wanted to be shown how to position the baby at the breast and to receive practical information, in addition to information
about support in the community. Women also wanted health professionals to encourage them both to breastfeed and to continue breastfeeding. As in this study, Gill (2001) found that mothers wanted their wishes to breastfeed to be respected and did not want health professionals encouraging the use of formula. Moore & Coty (2006) described mothers liking when health professionals could spend time with them, giving them positive support and encouragement. In my study, it was found that time was often a limited resource, especially in the hospital. However, sometimes, particularly at night, midwives had more time to spend with women and in some cases they provided consistent regular support over a night which women really benefited from and appreciated. Continuity of midwifery-care is associated with more positive experiences of postnatal care even when other organisational and social factors are taken into account (Brown et al., 2005).

Bartlett (2005) described it as “naïve” to suppose that breastfeeding is something that one could choose and perform without reference to social and cultural factors and how they impact on a mother and her baby. Dykes (2005a) has explained how healthcare workers are likely to have been socialised through the same culture as the women they support and so their attitudes towards breastfeeding may not be any different to the general population. This was also suggested by some of the women in this study and they felt that if there was more of a breastfeeding culture this would have a consequent effect on health professionals’ knowledge and attitudes. As has been found in other studies, the lack of a breastfeeding culture also meant that women did not have family or friends that could help them with breastfeeding and so they had to depend more on health professionals for skilled support (Berridge et al., 2005).
5.6 Conclusions

The results of this qualitative study demonstrate that breastfeeding is not something that a woman simply decides to do or not but that instead she needs to navigate through ‘the world of breastfeeding’ and to do this she needs a certain level of confidence, persistence, support and luck. As Dykes (2006a) identified, women’s experience of breastfeeding can be complex and the results of my study shed some light on this complexity.

The study points to some failings in the current model of professional support that is offered to women both in the antenatal and postnatal periods. Many women described being inadequately prepared for breastfeeding and this may indicate that the current promotion of breastfeeding paints an idealistic view and/or that antenatal education is not preparing women for the experience of breastfeeding. The study highlights deficiencies in relation to professional support for breastfeeding, with many women commenting on receiving conflicting advice and not being supported with breastfeeding. Women described specific needs in relation to breastfeeding support and these included wanting practical help and information and also encouragement.

Battersby (2006) explained how women’s attitudes towards infant feeding are not developed in isolation and that they are developed in response to cultural norms, experiences and beliefs. This study suggests that women’s experience of professional support for breastfeeding is interconnected with the individual woman’s personal characteristics and experience, the culture within which she is living and within which support for breastfeeding is given and the medical world that she is exposed to. Any endeavour to improve women’s experience of professional support is therefore likely to
need recognition for each of these factors.
CHAPTER 6

6 Using Forum Theatre to Promote Breastfeeding: A Preliminary Study

This chapter describes the evaluation of a forum theatre production to promote breastfeeding.

6.1 Introduction

The most recent government policy document on breastfeeding in Ireland (Department of Health and Children, 2005) outlines two important goals: that all families have the knowledge, skills and support to make and carry out informed infant feeding decisions, particularly those least likely to breastfeed and that Irish society recognises and facilitates breastfeeding as the optimal method of feeding infants and young children. Ireland has a predominantly formula feeding culture (Tarrant & Kearney, 2008). The promotion of breastfeeding in Ireland typically involves the benefits of breastfeeding being described. This approach has been criticised because it does not acknowledge the society and culture within which a woman breastfeeds. There is a disparity between the formal health promotion approach of ‘breast is best’ and the informal social network and culture in which breastfeeding is carried out (Bailey & Pain, 2001). Breastfeeding does not ‘take place in a social vacuum’ (Bailey & Pain, 2001) and so it needs to be promoted with recognition of the society and culture within which it is occurs. It is also a social
behaviour and Battersby (2006) has described that in order for women to have a positive breastfeeding experience, there needs to be a conducive and supportive environment for breastfeeding. Tarrant & Kearney (2008) described the need for ‘more creative national breastfeeding campaigns’ that address the negative cultural perception of breastfeeding in Ireland.

The importance of the arts in healthcare has been recognised (Smith, 2002). In particular, the arts have been used in the promotion of health (Starkey & Orme, 2001; Peerbhoy & Bourke, 2007; Neumark-Sztainer et al., 2009). Forum theatre is a form of interactive theatre which has been used, among other things, in nutrition and health promotion (Seguin & Rancourt, 1996; Parker, 1997). It originated with Augusto Boal in the late 1970s and his aim was to help people address and find solutions to issues of oppression. Boal aimed to transform theatre from a ‘monologue’ as seen in a traditional theatrical performance into a ‘dialogue’ between the audience and the stage. Boal coined the word ‘spectactor’ to describe the audience members such that they would become empowered and would play a part in the drama in a ‘real and meaningful way’ (McClimens & Scott, 2007). The scenes played out in forum theatre are expected to resonate strongly with the usual experience of the audience such that they are transformed from passive spectators to engaged spectactors (Sullivan et al., 2008). In a forum theatre production a play is played in full and the audience are then asked to decide which scene/scenes they would like to replay and change. The scene is replayed and a member of the audience shouts ‘stop’ at the part they want changed. They then take the place of the actor and change the particular scene to the way they would like to see it. The play and audience interaction are presided over by the ‘joker’ (facilitator)
whose job it is to engage the audience and encourage participation ensuring the audience understands their role. In a single forum many different solutions can be enacted and this results in what Boal has described as a “rehearsal for reality” (Boal, 2002). Forum theatre has been identified as a ‘powerful agent for positive change’ in both industrialised and developing countries (Seguin & Rancourt, 1996).

In an effort to raise awareness of breastfeeding and to address the need for more ‘creative’ breastfeeding promotion, the HSE Dublin Mid-Leinster along with the area Breastfeeding Steering Committee commissioned a drama facilitator to develop and facilitate a forum theatre production called “Milk It! Much Ado about Nothing?”. This chapter describes the detailed evaluation of this production.

6.2 Aims and objectives

The aim of this evaluation was to examine the role of forum theatre in creating an increased awareness of breastfeeding. The specific objectives were to assess the outcome of using drama to engage people in discussion and debate about breastfeeding, to promote breastfeeding as the norm rather than the exception and to allow participants develop solutions to identified barriers to breastfeeding.

6.3 Evolution of the play - Milk It! Much ado about nothing?

In line with a forum theatre production, “Milk it! Much ado about nothing?” was developed from women’s true stories of their experiences around infant feeding. These stories were collected from interviews with women who had either breastfed or formula-fed their babies. Once the stories were collected, workshops were held weekly for ten
weeks and the process of developing the stories into a play began. The stories which had been collected originally were further developed by the actors and drama facilitator, into short sketches. This resulted in the development of the script by the seventh week. In order that the play remained loyal to the stories that had been collected, three protagonists were written into the play as opposed to just one, which is the norm for forum theatre. This, along with the fact that two professional actors performed in the play with four ‘non-actors’, were the only exceptions made to Boal’s model of Forum Theatre.

The three protagonists were:

- Lizzie, a young woman of 18-20 years who was pregnant. She hadn’t planned the pregnancy and did not know what to expect. She had not put any thought into how she would feed her baby.

- Heather, a woman in her early thirties who was very excited about being pregnant and was really looking forward to the experience of breastfeeding. She planned to breastfeed for six months.

- A midwife who worked in a busy maternity hospital and who was frustrated that she did not have enough time to help and support women.

The issues which were dealt with in the play included: breastfeeding not being a social norm; lack of information on breastfeeding and bottle feeding antenatally; positive and negative attitudes to breastfeeding; lack of support for breastfeeding women from health professionals and family members; and midwives having insufficient time to support women. A synopsis of the play is provided in Appendix XVIII.
6.4 Methods

This was a cross sectional mixed methods study which was conducted from September to October 2008. The use of questionnaires in evaluating community arts based interventions often do not yield much information and other studies have found that a more qualitative approach to data collection may be preferable (Peerbhoy & Bourke, 2007). As has been recommended for the evaluation of community-based health promotion programmes, there was an emphasis on both process and outcome evaluation (Judd et al., 2001). This meant that each performance was observed and notes were taken (process evaluation) while also the effect of the play on people’s awareness of and opinion towards breastfeeding were recorded (outcome evaluation). While this study used a mixed methods approach with both quantitative and qualitative methods, the main part of the evaluation was qualitative, involving interviews with members of the audience and observation of each of the performances of the play. The quantitative methods comprised a postcard survey which was used to determine the opinions of those who saw the play. The study took part in three main stages and the research protocol is shown in Figure 6.1.

6.4.1 Research setting

The play was performed in four different venues and so these provided the research setting. The venues were situated in South Dublin and Co. Wicklow. They included a Youthreach group (a training programme for unemployed early school leavers), a Traveller Training Centre, A College of Further Education (for school-leavers and adults returning to education) and a Maternity Hospital.
<table>
<thead>
<tr>
<th>Stage 1: To explore people’s experience of and attitude towards breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior to seeing the play</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Stage 2: To observe the reaction and interaction of the audience to and with the play. Also to gather information regarding people’s opinion of the play, the main message, and the role of drama in discussing breastfeeding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During the play and immediately afterwards</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 3: To determine people’s opinion of the play and to see if their attitudes and awareness of breastfeeding had changed after seeing the play</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>After seeing the play</strong></td>
</tr>
</tbody>
</table>

Figure 6.1. Research protocol for evaluation of the forum theatre
6.4.2 Quantitative methods and sampling

The quantitative part of the evaluation involved using a postcard survey (Appendix XIX) which was distributed to viewers of the play after seeing it. This survey was similar to that used by Orme et al. (2006). The survey aimed to gather information regarding people’s opinion towards the play, the main message of the play and the role of drama in discussing breastfeeding. The postcard was piloted amongst a group of women (n=20) who watched a rehearsal of the play and their feedback was sought on the content of the postcard. Overall feedback was positive and so no changes were made to the postcard.

The sampling strategy used was convenience sampling based on recruiting all of those that had seen the play.

6.4.2.1 Quantitative data analysis

Data were analysed with SPSS version 15.0 (SPSS, Chicago, IL, USA) using descriptive statistics. Categorical data were described using frequencies and percentages. Qualitative data from the open-ended questions were transcribed and analysed thematically.

6.4.3 Qualitative methods

Qualitative data were collected from individual and focus group interviews. Some viewers of the play were interviewed before watching the play and again afterwards. This was to ascertain if their attitudes and awareness towards breastfeeding had changed. The views of additional audience members were also sought after seeing the play and this was to ensure that a wide range of views had been obtained. Each performance of the play was observed and details were recorded under the following headings:
organisation, venue, description of the audience, reception and engagement of the audience, a description of the audiences’ interventions (Appendix XX).

6.4.3.1 Sampling strategy

A purposive and convenience sample was used for the individual and focus group interviews conducted both before and after watching the play.

6.4.3.2 Interviews

Individual and focus group interviews were conducted. Focus groups are a form of group interviews which are useful for exploring people’s knowledge and experiences (Kitzinger, 1995). Focus groups can also combine with other methods of data collection such as individual interviews (Kitzinger, 1995). They can include 2-15 participants, however, as Peek & Fothergill (2009) have highlighted smaller group sizes run more smoothly and enable better interaction than larger groups. This was the case for the focus groups which were conducted in this research. In total, eleven focus groups were conducted comprising 2-15 individuals each. At the beginning of each focus group, the facilitator (Barbara Whelan) explained the aim of the discussion and encouraged people to talk freely (Kitzinger, 1995). Each focus group was recorded using an Olympus VN-2100 digital voice recorder. The facilitator had a topic guide which was developed from the aims of the research and from reading the literature. Focus groups lasted an average of 40 minutes.

Individual face-to-face interviews were also conducted when this was a more convenient option for participants. These were semi-structured interviews and as with the focus
groups, the interviewer followed the same topic guide. In total, eight individual
interviews were conducted. All interviews were recorded except for one, where the
person did not want to be recorded. In this case notes were made during the interview
and were written up afterwards. Interviews lasted an average of 30 minutes.

6.4.3.3 Transcription of interviews
All of the interviews were transcribed by the interviewer as recommended by Easton et
al., (2000). In order to ensure that the form and style of participant’s expression was
captured, incomplete sentences, repetitions and poor grammar were included in the
transcripts (Bazeley, 2007). Following transcription of each interview and prior to
analysis, the script was checked for accuracy by listening to the recording again and
comparing it with the scripts. All interviews were transcribed in Microsoft Word.

6.4.3.4 Qualitative data analysis
Data were analysed thematically using the technique outlined by Burnard (1991). This
technique is a method of thematic content analysis, based on aspects of grounded theory
and other methods of content analysis (Burnard, 1991). The data were organised into
categories and sub-categories and emerging themes were recorded and described. NVivo
8 was used to aid in analysing the data.

6.4.4 Ethical considerations
Ethics approval for this study was granted by Dublin Institute of Technology Research
Ethics Committee (reference 37/08). The evaluation was explained to all participants
and they were given information about the study and a consent form (Appendix XXI).
For those with reading difficulties the information was read aloud. All participants were assured that they were under no obligation to take part in the study and that they could withdraw from the study at any time. Written and verbal assurances of confidentiality were given and all of the names of those that participated in the study were changed so that qualitative data could not be identified to a particular person.

6.4 Results

The play was performed in four different venues. As described earlier, these venues included a maternity hospital, a college of further education, a youth training centre and a traveller training centre. The audiences ranged from teenagers to those in their fifties and included both students and professionals.

6.5.1 Qualitative data: Observation of the plays

Each performance of the play was observed and details were recorded about the venue, audience members and their level of engagement with the play and the interventions that were put in place as part of forum theatre. These observations are included in Appendix XX. Audience size differed depending on the group with a range of 21-65 audience members. Overall the play was well received and the audience engaged well with the concept of forum theatre.

6.5.2 Quantitative data: The postcard survey

6.5.2.1 Response rate and characteristics of respondents

In total approximately 160 people watched a performance of the play. One hundred and
ten people responded to the postcard survey giving a response rate of 69%. The vast majority of participants were under thirty years of age. The demographic details of the respondents are described in Table 6.1.

### Table 6.1. Demographic information by venue of those that participated in the postcard survey

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Youthreach (n=21)</th>
<th>College of Further Education (n=33)</th>
<th>Traveller training centre (n=16)</th>
<th>Maternity hospital (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤20</td>
<td>16</td>
<td>16</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21-30</td>
<td>3</td>
<td>10</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>31-40</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>41-50</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>51-60</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Youthreach</th>
<th>College of Further Education</th>
<th>Traveller training centre</th>
<th>Maternity hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Female</td>
<td>16</td>
<td>29</td>
<td>16</td>
<td>36</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Profession</th>
<th>Youthreach</th>
<th>College of Further Education</th>
<th>Traveller training centre</th>
<th>Maternity hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>18</td>
<td>28</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Health professional</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Administration</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Engineer</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>10</td>
</tr>
</tbody>
</table>

#### 6.5.2.2 Participants’ views of the play

Nearly all of those who saw the play thought that it was enjoyable. In addition, the majority thought that it was interesting, informative and professional. Seventy eight percent (n=86) of those who filled out the postcard survey thought that the issues raised in the play were relevant to them (Table 6.2).
Table 6.2. Participants’ views of the performance (n=110)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes %</th>
<th>No %</th>
<th>No response %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you enjoy the play?</td>
<td>98</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Did you think the play was Interesting</td>
<td>95</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Did you think the play was Informative</td>
<td>91</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Did you think the play was Professional</td>
<td>85</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Did you think the things discussed in the play are relevant to you?</td>
<td>78</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Did you think the play was a good way of discussing breastfeeding?</td>
<td>95</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

6.5.2.3 The main message of the play

Four different themes were identified as to what viewers felt was the main message of the play: the need for information and support, the importance of breastfeeding and the need to encourage it, challenging attitudes to breastfeeding and highlighting the obstacles that exist around breastfeeding.

6.5.2.3.1 The need for information and support

Some people felt that the main message of the play centred on there being a need for information and support for women before and after pregnancy.
Need extra staff, more support for women, more time spent educating, listening and supporting women (Midwife, Maternity hospital)

Others felt that the play highlighted the lack of information and support available to women.

It shows the lack of support for breastfeeding in the community and that midwives are sometimes too busy to help expectant mothers (Student nurse, Maternity hospital)

Two students in the College of Further Education mentioned the importance of women informing themselves about breastfeeding so that they would be prepared and also having a support system ready. They acknowledged the fact that the information is there if people looked for it.

Self education and informing yourself is very important. It’s not all going to be there on a plate (Student, College of Further Education)

6.5.2.3.2 The importance of breastfeeding and the need to encourage it

Some people felt that the main message of the play was to highlight the importance of breastfeeding and the need to encourage it.

The message was to tell you that breastfeeding is the best start to your baby’s life and there is lots of good advantages (Student, Youthreach)

Others felt that the main message was that breast is best but that in order for this message to be appreciated, attitudes need to change amongst the public.

Breast is best but changes need to be made by all members of the community. Social change is the key to promoting breastfeeding (Student, Maternity hospital)
7.5.2.3.3  Challenging attitudes to breastfeeding

It was felt by some that the play challenged attitudes to breastfeeding and cultural norms.

*That breastfeeding should be treated like a normal everyday thing in Irish society and not frowned upon* (Student, College of Further Education)

*How society is ignorant when it comes to the most natural and healthy way to feed your child. And also how there is a lack of information given to women about feeding* (Student, Youthreach)

6.5.2.3.4  Highlighting the obstacles that exist around breastfeeding

A few people mentioned that the play highlighted the obstacles that can exist around breastfeeding and the importance of being prepared for these.

*Highlighted many issues relating to breastfeeding and mothers i.e. being unaware of its benefits for both mum and baby, wanting to do it and not succeeding – the trials and tribulations associated with it - also it showed how midwives may not necessarily have the time to discuss the different methods of feeding and its benefits* (Student nurse, Maternity hospital)

*The main message is to promote breastfeeding as a positive thing to do. Also to realise that there will be obstacles along the way but to get advice, information and ask questions* (Administration staff, Maternity hospital)

6.5.2.4  The play as a forum for discussing breastfeeding

Ninety-five percent of viewers thought that the play was a good way of discussing breastfeeding (Table 7.2). Their reasons were broken down into six themes and these were as follows (an example of a quote for each theme is included).
6.5.2.4.1  The play being different to other ways of promoting health

Respondents mentioned the difference between the play and other ways of promoting health such as receiving lectures and leaflets. It was felt that the play was a more effective medium through which the message could be transmitted and it was more engaging for the audience.

*It brings a reality to it that reading a leaflet never would. It was a very good portrayal of the benefits and problems with it* (Student nurse, Maternity hospital)

6.5.2.4.2  Informal and fun way of highlighting issues around breastfeeding

The fact that the play was fun and informal was mentioned by a few people and they felt that this aided in their enjoyment of the play and in being attentive to what was happening in the play.

*A great way to be able to discuss breastfeeding. An interesting and friendly way to discuss. You have put on a very good play* (Student, Traveller Training Centre)

6.5.2.4.3  It was real and shed light on the reality

Many respondents appreciated that the play depicted real situations. Some mentioned that by being ‘real’ the audience could understand breastfeeding and different situations related to it better than just reading about them and that they could relate better to a breastfeeding woman after watching the play.

*Because it showed real life situations as they would happen; situations that might be hard to put into words in a verbal description of situations that could arise* (Student, College of Further Education)
6.5.2.4.4  Thought provoking

Some respondents felt that the play was thought provoking and in the case of some health professionals, it encouraged self reflection with regards to their own work practice. For others the play provided the opportunity to have an ‘insider’ look into situations that can arise around breastfeeding

*It highlights different issues e.g. social perception of breastfeeding, family support that all affect breastfeeding* (Student, College of Further Education)

6.5.2.4.5  Provided opportunity to give own opinion

Some of the students from the College of Further Education, Youthreach and the Traveller Training Centre commented on the fact that the play provided the opportunity for people to give their own opinion about breastfeeding and to be involved in the different scenes of the play. They appreciated this aspect of the play.

*I thought it was very good because you could discuss your opinions and also alter the play itself. Thank you!* (Student, Youthreach)

6.5.2.4.6  Informative

Some of the students in Youthreach commented on the fact that the play gave information about breastfeeding and they learned things from it.

*It is because it explains a lot on breastfeeding and a lot of things I didn’t know and it’s a fun way of explaining it* (Student, Youthreach)
6.5.3 Qualitative data: Interviews

In total 11 focus group discussions (n=80) and 8 individual interviews were held with some members of the audience, in each of the four venues, prior to and after seeing the play. The majority of participants were female (n=75), while 5 participants were male. In the case of the Youthreach group and the College of Further Education, the majority of participants were students, under 21 years of age. In the traveller training centre and the maternity hospital, participants ranged from 18-55 years of age.

6.5.3.1 Prior to seeing the play

The aim of the interviews prior to seeing the play was to determine people’s experience of and attitude towards breastfeeding. In most cases the interviews were held the week prior to seeing the play, while for some the interview was held on the day of the performance. Four themes were identified from the focus group discussions and individual interviews. These were embarrassment about breastfeeding, opinions about breastfeeding, attitude to people breastfeeding in public and the media and breastfeeding.

6.5.3.1.1 Embarrassment about breastfeeding

Embarrassment about breastfeeding was a theme that came up especially among those with very little exposure to breastfeeding, such as in Youthreach and the Traveller Training Centre. Some women felt that it would be embarrassing to breastfeed and they wondered about what their partners along with other people would think if they did it.

*A lot of people think what will the people think like* (Mary, student, Traveller Training Centre)
But I think like if you had your partner with you or if you had a partner, they’d just get embarrassed like and probably tell you to cop on. They would like, they’d probably say what are you doing like making a show of me (Sharon, student, Youreachreac)

6.5.3.1.2 Opinions about breastfeeding

When asked what people’s views were about breastfeeding, responses were mixed with some being very positive and supportive of breastfeeding.

I have read the benefits of it on lets say the information that the hospital gives out and it makes sense to me really to breastfeed or for women to breastfeed you know (Paul, engineer, Maternity hospital)

Others felt that breastfeeding was something they felt they would like to try if they had a baby however they would be open to how long they would continue doing it.

I probably would try it I’d say. I wouldn’t mind like anyone looking at me or whatever, it wouldn’t bother me. But I’d say I probably would try just to see and then I wouldn’t do it for the long term (Susan, student, College of Further Education)

The importance of being shown how to breastfeed when a woman is pregnant was highlighted by one respondent as she felt that many women do not understand what it means to breastfeed and so can’t make an educated decision about whether to do it or not.

I think that you should be shown when you’re pregnant how to breastfeed, if you want that like. Like they just say do you want breastfeeding and you say no and it’s like how do you know what you want when you’re not shown (Mary, student, Traveller Training Centre)

One woman reflected on the fact that although breastfeeding would be better for her
child, it never came into her mind to breastfeed her baby, it was something that she simply had not considered.

_It never came into me mind to breastfeed. I just didn’t see meself breastfeeding. If I had to just like you know use the pump like but I wouldn’t actually breastfeed. I don’t know I just wouldn’t. It’d be better for the child alright but I just I don’t know, it never came into me mind like to breastfeed. I went straight to formula_ (Sharon, student, Youthreach)

It was obvious from the group discussions that some groups had much more exposure to breastfeeding than others. Of course those in the Maternity hospital had plenty of exposure, however, those in the College of Further Education could also elaborate on their own personal experience of breastfeeding or that of someone close to them. This was not the case with those in the Youthreach group or the Traveller training centre. Discussion around breastfeeding was more limited in the Youthreach group because of the lack of exposure to breastfeeding. Interestingly some of the stories that people told during the interviews prior to seeing the play were reflected in a number of scenes in the play.

6.5.3.1.3 _Attitude to people breastfeeding in public_

Generally amongst those in Youthreach there was a feeling that it was unacceptable to breastfeed in public although some people did say that if the mother covered up then it was alright. One woman described seeing a woman in a café breastfeeding a few weeks earlier and was unsure about whether she felt it was ok to do that.

_It’s just like all of a sudden I looked and there she was breastfeeding like. It didn’t bother me as such but I’m sure like it probably bothered a few other_
people. I don’t know. The child’s hungry she has to be fed but I don’t know, I don’t know (Sharon, student, Youthreach)

It was suggested that a woman could express the milk and then give the baby a bottle in public. One young woman showed disgust at the idea of breastfeeding in public and someone in the group asked her ‘What if your child was hungry and you were breastfeeding?’ and she replied ‘Put it in a pump and bring it in a bottle’ (Louise, student, Youthreach)

None of the participants in the college of further education or the maternity hospital had an issue with women breastfeeding in public.

It wouldn’t bother me to see someone breastfeed their baby, I think it would be ok (Elizabeth, student, College of Further Education)

I think it’s kind of an encouraging thing because if more and more women are willing to breastfeed in public other women would see them doing it and if you see someone doing something you kind of think ah sure there’s nothing wrong with that. It might encourage them to do it themselves, you know (Paul, engineer, Maternity hospital)

6.5.3.1.4 The media and breastfeeding

Students in Youthreach, the Traveller Training Centre and the College of Further Education all related stories about breastfeeding which they had picked up in the media through television programmes and new stories. This showed the influence of the media on their perceptions of breastfeeding. Some of the stories were the same across all three groups and related to women breastfeeding different babies and not just their own.

And is it dangerous for them to be breastfed by some other woman. Did you ever see the way they’re doing that nowadays. They had a programme
about that on the telly. It was weird. I think that’s disgusting, I really do. There’d be a sitting room and all these mothers and they’d just swap the child (Sarah, student, Youthreach)

The stories also related to women expressing breastmilk and selling it.

It was mostly based in the States wasn’t it and where women who had had children expressed their milk if they had too much and you could buy it from them and give it to your own (Elaine, student, College of Further Education)

Someone also discussed that formula had been taken off the shelves in England a few months earlier because of a scare.

In England there a while back there was scares with the formula, in May I think it was, it was taken off the shelves. At least with breastfeeding you know what’s going in (Anne, student, Traveller Training Centre)

6.5.3.2 Conclusions

The groups in which the discussions took place were very diverse and discussions were equally diverse. Common themes were, however, found between some or all of the groups. Participants in different groups were of different ages and backgrounds, however, all could give their opinion about breastfeeding and could relate either personal stories or those from family, friends and the media.

6.5.4 After seeing the play

The aim of these interviews was to determine people’s opinion of the play and to see if people’s attitudes and awareness of breastfeeding had changed after the seeing the play. These group discussions and individual interviews were conducted from a few days after
seeing the play and up to five weeks after. Two main themes were identified and these were participants’ views of the play and change in perspective after seeing the play.

6.5.4.1  Participants’ views of the play

People generally had a positive response to the play and their views differed as to their impression of the play and what they liked/disliked about it. Table 6.3 includes descriptions of participants’ views of the play.

Table 6.3.  Participants’ views of the play

<table>
<thead>
<tr>
<th>Realistic</th>
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<tbody>
<tr>
<td>Participants commented on the play being very realistic and this surprised some of them as they had expected it to be more idealistic and less typical of what actually happens in real life. Other people commented that the play brought the reality to life more than a leaflet would and this made it more enjoyable to watch.</td>
</tr>
<tr>
<td>When you’re watching a play it’s like real life because amm it’s just like watching a film there (Mary, student, Traveller training centre)</td>
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<table>
<thead>
<tr>
<th>Literacy friendly</th>
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<tr>
<td>Some participants that have worked with disadvantaged groups commented on the fact that the play was literacy friendly.</td>
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<tr>
<td>I thought it was a great way of educating people or young mothers, particularly those who would be coming from disadvantaged areas who mightn’t have literacy skills and I think it’s a great method because basically many of these people aren’t able to read leaflets or interpret them (Jenny, dietitian, Maternity hospital)</td>
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<table>
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<th>Promotes awareness about breastfeeding</th>
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<tr>
<td>In general, participants felt that the play would not change people’s minds as to whether they would breastfeed, but that it would create an awareness around breastfeeding which was very positive for the promotion of breastfeeding. This awareness was demonstrated by the fact that one of the traveller women described how she had gone home and told</td>
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</table>
I was just explaining to my daughters and all that. They probably wouldn’t still breastfeed but I was just explaining about how good the play was and everything (Mary, student, Traveller Training Centre)

**Audience participation**

Many people commented on how they enjoyed the aspect of the audience participation. One student nurse explained how she felt that the interaction with the audience, whereby they had to change scenes and make them as they would like to see them, was empowering and enabled self reflection as to how she herself could improve things.

Because we were made to intervene and interact and change things, oh here’s the bigger picture, I can actually do something, I can help and it certainly made me look at who I can possibly influence in the picture and who I can help from my own knowledge (Shauna, student nurse, Maternity hospital)

**Criticisms**

Most of the respondents felt that the play was balanced with regards to its portrayal of bottle and breast feeding. However, there was criticism from one respondent, who felt that breastfeeding was pushed too much in the play.

I personally felt that breastfeeding was being pushed down her throat. I think that, I felt that it wasn’t being very objective, to me I felt it was very much, it’s breastfeeding and nothing else (Jenny, dietitian, Maternity hospital)

**Different from usual health promotion**

Those interviewed enjoyed the fact that the play differed from normal health promotion in that it was visual and interactive and kept their attention. Many commented on the fact that it was better to watch the play than read a leaflet. Two students from Youthreach said that

I think it’s nicer to have it more as a sketch than having a leaflet. I think it grabs your attention more.
Yeah, you took more note of it. Whereas if it was on a piece of paper we probably wouldn’t even bother looking at it
6.5.4.2 Change in perspective after seeing the play

Having watched the play some participants were much more communicative in the focus group discussions. This was particularly obvious in the Youthreach group where participants had been initially hesitant to talk but after seeing the play they spoke more openly and freely. This change was commented on by one of the tutors in the group and was in reference to a story that one of the students told about being in a maternity hospital a few days before and a woman in the unit wanting the father of another baby to wait outside while she breastfed her baby. The student had told the story in detail and had said that all the woman had to do was cover herself as nothing would be seen. Respondents in other groups discussed how they had talked to friends and family about the play, encouraging discussion about breastfeeding.

One of the young women who spoke in the first interview and had been unsure as to whether she thought it was ok for a woman to breastfeed in public, had less of an issue with it having seen the play. In response to whether she would care if a woman was feeding in public she said “It wouldn’t bother me but I just wouldn’t do it meself like”. This would indicate a change in attitude but also shows that breastfeeding in public was not something that she would consider herself. This was the case with a lot of respondents. While the play certainly raised awareness and more tolerance towards breastfeeding it didn’t change people’s minds as to whether they would breastfeed themselves. Having seen the play, however, this woman did acknowledge that if she had wanted to breastfeed she could have gotten the support. She had not mentioned this in the first interview and it would indicate that the play had created an awareness that support is available and that it is only a matter of seeking it out.
Some of us have kids and we had the option but we just didn’t want to do it like. But we could have done it like and we could have got support but we just didn’t want to (Sharon, student, Youthreach)

It was felt by one respondent that the play made midwives more aware of how women are sometimes treated in hospital and how a little support can really help them.

They [midwives] were discussing it and they could see as well, they felt they were portrayed very badly and stuff like, so that definitely did register with them, maybe God if I do have an extra two seconds just to help this woman or look for the dad or the partner just to inform them (Paula, student nurse, Maternity hospital)

A lot of people felt that the play had raised awareness about breastfeeding and this was in regards to helping people be more accepting of it, being more prepared in the future if they ever had a baby themselves, knowing that the law protects a woman from discrimination if she is breastfeeding in public and also giving an awareness of various issues that breastfeeding women can come up against.

You might be more prepared for the situation, like you know you mightn’t realise. I suppose when you’re going into hospital to have a baby you’re just thinking about the baby and you’re not really thinking about afterwards but like if you saw that before hand you know you might be thinking in your head oh maybe I will have to push for information or push for help (Kathy, student, College of Further Education)
6.6 Discussion

The aim of this evaluation was to examine the role of forum theatre in creating an increased awareness of breastfeeding. The evaluation was based on a cross-sectional study which employed both qualitative and quantitative methods and was based on both process and impact levels of evaluation (Judd et al., 2001). The response rate to the survey was relatively high, however, still 30% of people did not respond and so there may be a response bias in the quantitative results, with those more enthusiastic for the study having made more of an effort to answer the survey. In addition, some of the focus groups which were conducted had quite large group numbers and as Peek & Fothergill (2009) described, in larger groups some views and opinions can be stifled. While every effort was made to ensure that everyone got a chance to speak, the opinion of some people may have been missed. Despite these limitations, this study is a preliminary study to examine the role of forum theatre in promoting breastfeeding and in so far as achieving the aims of the evaluation the methods used did help to achieve this.

This project was quite novel in so far as it aimed to get people discussing and debating breastfeeding through the use of drama. It also presented breastfeeding in many different guises and so did not only present the benefits of breastfeeding, but also presented the stories of real women who had experienced both breastfeeding and bottle feeding, hence drawing a more realistic picture that the audience could connect with and believe in. Because the play was presented in the form of forum theatre the audience had the opportunity to change scenes in the play and to discuss and debate the different issues that arose. This resulted in what has been described as the transformation of the audience from passive spectators to engaged spectactors (Sullivan et al., 2008). This
transformation is empowering because the audience takes control of what happens in the play and this in turn creates an awareness of issues and can also provide the opportunity for a ‘rehearsal for reality’ as described by Boal (2002).

This play was performed in front of four diverse groups, and although each group was different from the other, each audience engaged well with the play and the concept of forum theatre. The response to the play was positive with nearly all of those that responded to the postcard survey saying that they enjoyed the play and agreeing that the play was a good way of discussing breastfeeding. The comments regarding what respondents felt was the main message of the play were all related to social and cultural aspects of breastfeeding, such as challenging attitudes to breastfeeding and cultural norms and highlighting the obstacles that exist around breastfeeding. It is important that breastfeeding is promoted with recognition of these aspects because the process of breastfeeding is ‘greater than the biology’ and individual, cultural and social dimensions influence each mother’s breastfeeding experience (Manhire et al., 2007). Greene et al., (2003) acknowledge how ‘breastfeeding is a social decision and not just a nutritional one’. Societal embarrassment and perceived social isolation have been identified as barriers to breastfeeding (Stewart-Knox et al., 2003). Mothers can be undermined by the lack of knowledge about breastfeeding or negative attitudes in their social network (Smith & Tully, 2001). A play such as “Milk it! Much ado about nothing?” can help bring these social aspects to the fore making people more aware of the issues, helping them see some practical ways in which mothers can be helped.

Wall (2001) has described how the promotion of breastfeeding usually implies that “breastfeeding is natural for women and that women, as a universal category, have the
inherent capacity to breastfeed”. She feels that this trivialises the differences between women and the difficulties that individual women can face when breastfeeding. Sheehan et al., (2003) have also commented on the need for acknowledging a range of experiences and expectations of women around breastfeeding. Many people in the evaluation commented on how realistically breastfeeding was portrayed. In addition, the play presented two very different women’s realities: one being very eager to breastfeed and the other not sure what way to feed her baby. Each woman faced different obstacles and the play therefore provided the opportunity for the audience to see these different realities, reminding them that everyone’s experience of breastfeeding can be very different. In addition, in providing a more realistic portrayal of breastfeeding the play could potentially be used to help women in the antenatal stage to be more prepared for breastfeeding. Findings in the literature indicate that women often do not feel adequately prepared for breastfeeding and this can have negative consequences on their experience (Coreil et al., 1995; Bailey & Pain, 2001; Bailey et al., 2004; Graffy & Taylor, 2005; Sheehan et al., 2009).

Studies have described the use of forum theatre being used in the promotion of nutrition related topics. One such study by Neumark-Sztainer et al., (2009) looked at the effect of a theatre-based after-school programme with obesity prevention messages and found that the intervention did help increase awareness of the need for behavioural change but did not result in actual behaviour change. This shows, as did the present study, that there is a potential for forum theatre in making people aware of a particular health promoting activity but ultimately more is needed to make people actually change their behaviour. Ajzen’s Theory of Planned Behavior (Ajzen, 1991), states that a person’s behaviour is
determined by their intention which in turn is determined by their attitude toward the specific behaviour, their subjective norms and their perceived behavioural control. Ajzen (1991) defines subjective norms as perceived social pressure to perform or not to perform a behaviour. The forum theatre “Milk It! Much Ado about Nothing?” encouraged discussion about breastfeeding amongst people, potentially improving subjective norms, whereby breastfeeding would become more socially acceptable and the norm. The use of forum theatre in health promotion could therefore result in actual behavioural change, if it was used in conjunction with other interventions to improve for example, perceived behavioural control.

Finally, one of the performances of the play was in a maternity hospital. The findings from the evaluation there indicate that through watching the play it encouraged health professionals to reflect on their practice in relation to supporting breastfeeding. Schmied et al., (2001) have drawn attention to the importance of health professionals understanding how some women may be experiencing breastfeeding and they feel that this requires the ability of healthcare workers to be reflexive about their own position. Health professionals are typically educated within a model of health promotion which fails to acknowledge the social and emotional nature of breastfeeding (Schmied et al., 2001). The forum theatre production “Milk it. Much ado about nothing?” recognises these aspects of breastfeeding and so there is certainly potential for its use in training health professionals.
6.7 Conclusions

The play achieved its aim of raising awareness of breastfeeding amongst people through discussion and debate and this was the case for all groups. Using forum theatre to promote breastfeeding is quite novel and as already mentioned, different to usual health promotion. People in this study appreciated the novelty of breastfeeding being promoted through drama. This evaluation describes a preliminary study and provides evidence for the potential of using forum theatre to change attitudes to breastfeeding and also for its use in training health professionals. Further research and evaluation is needed to determine the extent to which “Milk It! Much ado about nothing?” could be used to achieve these objectives.

6.8 Afterword

The results of this evaluation have been written up and published in Nutrition and Food Science. The paper is available in Appendix XXII. “Milk It! Much ado about nothing?” also won the award for Best Health Promotion Project at the Crystal Clear MSD Health Literacy Awards 2010. The play has been made into a DVD which is currently being evaluated for use as a tool in training health professionals.
CHAPTER 7

7 Discussion, Conclusions and Recommendations

This chapter provides a discussion of the mixed methods study, outlines the overall conclusions reached from this research and makes recommendations regarding how to improve professional support for breastfeeding. In addition, some suggestions are made for further research.

7.1 Introduction

The rates of breastfeeding in Ireland are one of the lowest in Europe with exclusive breastfeeding at discharge from hospital being 45% (Health Research and Information Division, 2009). Breastfeeding is a learned skill and so in a country such as Ireland, where there is a lack of a breastfeeding culture (Tarrant & Kearney, 2008) and women are often unable to get breastfeeding skills from female friends and relatives, they may depend on the skilled support of health professionals in the early postnatal period (Berridge et al., 2005). Increasing emphasis is being placed on the role of health professionals in promoting and supporting breastfeeding (Sikorski et al., 2003). Little, however, is known about professional support for breastfeeding in Ireland and this study, therefore, was undertaken to explore this subject. The research considered issues for health professionals in promoting and supporting breastfeeding and also women’s experience of professional support for breastfeeding. In addition, a forum theatre
production was evaluated which aimed to raise awareness of breastfeeding amongst health professionals and the general public.

7.2 The Mixed Methods Study

The initial part of this research comprised of three separate studies, one of which was a quantitative study and the other two, qualitative studies. In conducting a mixed methods study it provided the opportunity for gaining greater knowledge around the issues of health professional support for breastfeeding because the qualitative data added depth of understanding to the quantitative data. In addition, through gaining women’s perspectives of professional support for breastfeeding it added another important dimension to understanding this area of support. The findings from each of these studies were presented in their respective chapters (three, four and five). There were similarities and inconsistencies between the results of each study and these will be discussed below.

7.2.1 Discrepancies between health professionals in their approach to breastfeeding

While the three studies in the mixed methods research focused on different aspects of professional support for breastfeeding, the findings of the three collectively helped to create a more comprehensive picture of the issues involved. This has also been the outcome of other studies that considered both women’s and health professional’s views of professional support for breastfeeding (Dillaway & Douma, 2004; Taveras et al., 2004a; Smale et al., 2006). The quantitative study identified discrepancies in the knowledge and attitudes of professionals towards breastfeeding and also pointed towards
different degrees of enthusiasm for training. GPs were the least likely to want to attend training in breastfeeding in the next year, despite having knowledge deficits and lacking confidence in dealing with some key areas of breastfeeding management. The qualitative study of health professionals enabled further investigation of this and found that there were low levels of ‘ownership’ amongst GPs towards breastfeeding. Many did not feel that it fell within their professional remit. They did not think that breastfeeding was a medical issue and therefore it was not something that they needed training on. Miller et al., (2007) have described the reluctance of physicians in America to take responsibility for educating women about breastfeeding. They put this reluctance down to training inadequacies around breastfeeding and proposed that if these were improved, health professionals would consequently feel more prepared to support breastfeeding and thereby increase their ownership towards it.

The issue of health professionals having a lack of knowledge and low self-efficacy in dealing with breastfeeding issues is usually dealt with by providing training, as healthcare workers having knowledge about breastfeeding is associated with more supportive behaviour (Bernaix, 2000; Kronborg et al., 2008). However, while this mixed methods study found a need for all professional disciplines to receive training around breastfeeding, it also showed that before training is provided, some health professionals need to be made aware of their role in supporting breastfeeding because they are unlikely to seek training without this. This has been alluded to by Ekstrom et al., (2005a), who identified that an interest in breastfeeding needed to be developed among health professionals involved in breastfeeding counselling in order to provide good counselling and thorough knowledge of breastfeeding management.
The ambivalence which was demonstrated, in particular by GPs, in both the quantitative and qualitative studies, was picked up on by mothers in the final qualitative study of ‘women’s views of professional support for breastfeeding’. Many women wanted their GP and obstetrician to do more than simply ask them if they were going to breast feed or give formula and instead wanted them to encourage and promote breastfeeding. In addition, women were aware of health professionals paying lip-service to breastfeeding but not actually being able to help with issues that arose. In this case many women showed discernment in seeking help elsewhere. While this strategy usually worked, it must be remembered, however, that the women in the qualitative study were not so ‘typical’ of other Irish women as indicated by their duration of breastfeeding and their determination to breastfeed. Other women, without these characteristics could easily be discouraged when faced with health professional ambivalence or lack of knowledge.

The mixed methods study therefore points to a need for discussion around the role of each professional group in the protection, promotion and support of breastfeeding. Currently the role of each discipline is not well defined and as described earlier there are different levels of ‘ownership’ towards breastfeeding. The AAP and the ACOG have drawn up guidelines for ensuring doctors counsel mothers in breastfeeding as well as ensuring they themselves become knowledgeable and skilled in the clinical management of breastfeeding (Gartner et al., 2005). There are no such guidelines amongst health professional organisations in Ireland. Research on professional healthcare knowledge has found that practitioners gain an understanding of the perceived relevance of their work practices and will adopt the attitudes and behaviours of work that they see valued by their peers (Dahlgren et al., 2004). This would indicate, therefore, that if
breastfeeding is not considered a worthwhile topic to study, for example amongst doctors, then it is unlikely that the majority will seek to become knowledgeable about it.

7.2.2 Breastfeeding support

While on the one hand the findings from the mixed methods study indicated a need for outlining the role of professional groups in the protection, promotion and support of breastfeeding, on the other hand they also pointed towards a need for discussion around the medicalisation of breastfeeding. Currently breastfeeding is placed within the ‘medical world’ and so consequently health professionals are an important aspect of support. This study found that women have also placed breastfeeding in this ‘world’ with a lot of mothers discussing the need for more lactation consultants and the importance of having access to such specialist care. While this is a worldwide phenomenon and is somewhat inevitable due to the medicalisation of childbirth (Schmied et al., 2001), this study found failings in placing breastfeeding within a medical model. In both qualitative studies, the hospital environment was described as being busy and hectic. Mothers and midwives described the lack of time available for breastfeeding support. Midwives were sometimes taken up with clinical tasks and could not dedicate time to sitting with a woman while she breastfed. Mothers described disappointment with not being helped with the first breastfeed and were surprised when they were left alone, especially when they had been told in the antenatal period about the importance of initiating breastfeeding within the first half hour. Some paediatricians and obstetricians described how women asked for their help in latching their baby on, immediately postpartum if there were no midwives available. Many were not, however, confident in their skills to do this and were unable to help.
In addition, issues around conflicting information were described by both health professionals and mothers. Findings from the quantitative and qualitative study indicated that this is inevitable with so many different professional groups assisting the mother-infant dyad and with there being discrepancies in the knowledge and attitudes of the different healthcare workers. Krogstad et al., (2002) identified hospitals as ‘being divided by the tendency of every profession or group to develop its own objectives, procedures and routines’ and so while doctors and nurses work side by side they can have parallel agendas and separate aims for their patient. This reflection on hospitals is insightful to the way in which support around breastfeeding is currently delivered and it points to the fragmented sense of care which was described in both qualitative studies.

Given the constraints of the current medical model of breastfeeding, alternative forms of support for women need to be considered. This has already been suggested by Dykes (2006a) who has challenged the suitability of the hospital as a place in which women begin breastfeeding. A recent review of maternity services in the Dublin area (KPMG, 2008) called for midwifery-led, community models of care being made available to women. Such a recommendation is supported by findings from a Cochrane Review which advocated that most women should be offered midwife-led models of care (Hatem et al., 2008). This review also found that women who give birth in midwife-led care are more likely to initiate breastfeeding. In Ireland there are currently only two midwife-led units and an evaluation of these has led to recommendations that more midwifery-led units be established across Ireland (Begley et al., 2009a). Other alternative forms of support could include breastfeeding peer supporters being employed to help women in maternity wards. This approach has been found to be successful on
postnatal wards in Boston, whereby peer counsellors could manage time consuming cases such as social support, while lactation consultants could deal with more high-risk, medically complicated cases (Merewood & Philipp, 2003). Such an approach of employing breastfeeding peer supporters on maternity wards in Ireland could also be successful and could limit the issue of women getting conflicting advice and not getting sufficient support in hospital.

One form of support which was commented on by both mothers and health professionals as being beneficial was attendance at a breastfeeding support group. PHNs and breastfeeding women both recognised the importance of having a social support network. PHNs recognised the need to let women support each other while also being there if help was needed and women acknowledged this as being really beneficial to their breastfeeding experience. Both the PHNs and mothers that were interviewed also described the need for an adequate venue for the group, preferably not in the health centre. In addition, they mentioned how babies were often weighed at the group and while most mothers felt that this was an important support, some PHNs and women felt that this took from the support aspect of the group and kept breastfeeding within a medical domain.

### 7.3 Conclusions

The overall results of this research convey a sense of disjointed support for breastfeeding amongst health professionals. Some ambivalence was apparent in relation to professional responsibility for promoting breastfeeding and also in knowledge and attitudes towards breastfeeding, indicating that perhaps health professionals are not
immune to the culture of formula feeding in Ireland. A lack of consistency in health care workers’ perceived knowledge and self-efficacy in dealing with breastfeeding issues were identified, reflecting the fragmented support for breastfeeding which was experienced in the qualitative study with mothers. Mothers described inconsistencies in the support which they received from health professionals and this caused frustration and difficulty in the postpartum period. The findings from the evaluation of the forum theatre production, which was developed to generate debate on breastfeeding, provided evidence for its use as a tool to train health professionals. In particular, it could be used to highlight the role that health care workers can play in supporting breastfeeding and also encourage reflection amongst those that see the play regarding their knowledge and practices in promoting and supporting breastfeeding.

Many health professionals appeared to depend on their personal experience of breastfeeding, indicating a lack of formal breastfeeding training. This study suggests that health professionals have different requirements for knowledge and skills in supporting breastfeeding. Despite this, each profession does play a role and this research identified the importance of each professional group being aware of their role and of having the knowledge and skills necessary to support breastfeeding. The research identified a clear need for training around breastfeeding for all health care workers, specific to their professional requirements for knowledge and skills in supporting breastfeeding.

This research also identified barriers for health professionals in supporting breastfeeding. These were in relation to health care workers having a lack of time and being too busy to adequately support breastfeeding. Women described not being helped with breastfeeding in hospital in the postnatal period and this had a negative
consequence on their experience of breastfeeding. Alternative support therefore needs to be considered, especially on the postnatal wards and in the community, on discharge from hospital. Breastfeeding peer supporters should be allowed onto postnatal wards to provide support and encouragement for breastfeeding women. This would take away the emphasis on breastfeeding being a ‘medical issue’ and also would enable midwives and lactation consultants to focus on more complicated cases.

The promotion of breastfeeding needs to be met with a concomitant assurance by health professionals that they have the knowledge and skills to encourage and support breastfeeding. In addition, health professionals should not be the only purveyors of breastfeeding support as they are limited in the extent that they can support breastfeeding by external barriers. It is important, therefore, that alternative support is also provided. The more women that receive adequate support with breastfeeding, the more women will enjoy their breastfeeding experience and become advocates of it which in turn will change the tide of existing low breastfeeding rates in Ireland.

7.4 Recommendations

Based on the findings from this research a number of recommendations have been made.

- The role of each health professional discipline in protecting, promoting and supporting breastfeeding needs to be defined and endorsed by health professional organisations.
- Only those health professionals that have undergone training on breastfeeding should be involved in the support of breastfeeding mothers.
• Training should address negative or neutral attitudes to breastfeeding and should include the opportunity to reflect on personal experience of breastfeeding.

• Health professionals should be made aware of women’s support needs and this could be accomplished by providing practical workshop based training with breastfeeding women.

• Training should be multi-disciplinary so that different health professional groups can gain an understanding of the role and experience of other disciplines in supporting breastfeeding.

• The area of peer support should be developed and made available to women in hospital.

• Time should be allocated for health professionals to provide support to breastfeeding mothers.

• Efforts should be made to make breastfeeding more simplified and less ‘medicalised’.

• Health professionals and mothers should have exposure to positive breastfeeding models.

• The use of forum theatre to promote awareness amongst health professionals of issues around breastfeeding support should be further evaluated to determine its effectiveness in training health professionals.

7.5 Further Research

This research was an exploratory study into health professional support for breastfeeding. Further research should be carried out to expand on knowledge in this
area. A national survey should be conducted to verify and expand on the results and to provide a more complete assessment of health professional support for breastfeeding. In addition, training should be developed specific to the needs of different health professional disciplines and such training should be evaluated.
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## Appendix I

### Major Components of human milk and their function

<table>
<thead>
<tr>
<th>Factor</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oligosaccharides</td>
<td>Function as ligands – binding to bacteria, toxins and viruses, inhibiting adhesion to the infant’s epithelial cells</td>
</tr>
<tr>
<td>Immunoglobulins</td>
<td>Predominately sIgA, IgM and IgG – function by direct binding to microbial antigens, enhancing phagocytosis, modulating local immune function and contributing to the infant’s immune system development</td>
</tr>
<tr>
<td>Lactoferrin</td>
<td>Functions via iron chelation, blocks adsorption/penetration of viruses and adhesion of bacteria. Helps reduce intestinal infection</td>
</tr>
<tr>
<td>Fatty acids</td>
<td>Lyse various viruses, have an antiprotozoan effect, especially against Giardia</td>
</tr>
<tr>
<td>Lysozyme</td>
<td>Lyse bacterial cell walls, increase IgA production and contributes to macrophage activation</td>
</tr>
<tr>
<td>Bifidus factor</td>
<td>Stimulates lactic acid bacteria</td>
</tr>
<tr>
<td>Complement</td>
<td>Plays a role in chemotaxis and phagocytosis</td>
</tr>
<tr>
<td>Cytokines</td>
<td>Modulate epithelial barrier integrity, play a role in chemotaxis and phagocytosis</td>
</tr>
<tr>
<td>Growth factors</td>
<td>Influence the growth and development of the gastrointestinal tract, improving its function as a barrier</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lactoferrin</td>
<td>Non-inflammatory antimicrobial, disrupting the bacterial outer membrane</td>
</tr>
<tr>
<td>Hormones</td>
<td>May act on mucosal development</td>
</tr>
<tr>
<td>Macrophages</td>
<td>Demonstrate phagocytic activity and secrete immunoregulatory factors, contain sIgA and can release on encounter with bacteria</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>T cells and B cells; essential for cell-mediated immunity; antiviral activity; memory T cells give long term protection</td>
</tr>
<tr>
<td>Nucleotides</td>
<td>Contribute to the growth of <em>Lactobacillus</em> and <em>Bifidobacteria</em> in the infant’s gut and the growth, development and repair of the gastrointestinal mucosa</td>
</tr>
</tbody>
</table>

Adapted from Wambach *et al.*, (2005) and Lawrence & Pane (2007)
# Appendix II

Health benefits of breastfeeding for children in developed countries based on reviews by Ip et al., (2007)* and Horta et al., (2007)§

<table>
<thead>
<tr>
<th>Illness</th>
<th>Effect of breastfeeding</th>
<th>Studies included</th>
<th>Additional comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute otitis media</strong></td>
<td>Reduced risk comparing children who were ever breastfed with those exclusively bottle-fed (OR 0.77, 95% CI 0.64-0.91) and comparing exclusive breastfeeding for &gt;3 or 6 months with never breastfed (OR 0.50, 95% CI 0.36-0.70)*</td>
<td>5 cohort studies and one case-control study</td>
<td>Four of the cohort studies were of fair/moderate methodological quality while the other and the case-control study were rated poor</td>
</tr>
<tr>
<td><strong>Atopic dermatitis</strong></td>
<td>Reduced risk in those with a family history of atopy and exclusively breastfed for &gt;3 months compared with those not (OR 0.58, 95% CI 0.41-0.92) and reduced risk amongst those without a family history but exclusively breastfed for &gt;3 months versus those not (OR 0.84, 95% CI 0.59-1.19)*</td>
<td>One meta-analysis of 18 prospective studies</td>
<td>Study of good methodological quality</td>
</tr>
<tr>
<td><strong>Gastrointestinal infection</strong></td>
<td>Reduced risk of diarrhoea in those breastfed compared with those not (OR 0.36, 95% CI 0.18-0.74)*</td>
<td>A systematic review of 12 prospective cohort studies, 2 retrospective cohort studies and 2 case control studies. Also one case control study</td>
<td>Systematic review of fair/moderate methodological quality. Result based on one case control study</td>
</tr>
<tr>
<td><strong>Lower respiratory tract infection</strong></td>
<td>72% reduction in risk of hospitalisation in those exclusively breastfed for ≥4 months compared with those formula fed (RR 0.28, 95% CI 0.14-0.54)*</td>
<td>Meta-analysis of 7 cohort studies</td>
<td>Methodological quality of the meta-analysis rated good</td>
</tr>
<tr>
<td>Illness</td>
<td>Effect of breastfeeding</td>
<td>Studies included</td>
<td>Additional comments</td>
</tr>
<tr>
<td>-------------------------</td>
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<tr>
<td>Cognitive development</td>
<td>Evidence is not conclusive, with some methodologically sound studies demonstrating little or no evidence for an association between breastfeeding and cognitive development*. Amongst those who had been breastfed performance in intelligence tests was higher amongst those breastfed with mean difference of 4.9 (95% CI, 2.97-6.92)§.</td>
<td>3 meta-analysis, secondary analysis of a prospectively collected data set and 7 prospective cohort studies*. A meta-analysis of 7 cohort studies and 1 randomised controlled trial§.</td>
<td>Maternal intelligence was not controlled for in some studies, which would likely be a confounder.</td>
</tr>
<tr>
<td>Overweight and obesity</td>
<td>Pooled adjusted odds ratio of overweight/obesity comparing ever breastfeeders to never breastfeeders was 0.76 (95% CI, 0.67-0.86) and 0.93 (95% CI, 0.88-0.99) in two analyses. One meta-analysis found each month of breastfeeding was associated with a 4% decrease in the risk of overweight per month of breastfeeding exposure*. There was a reduction in overweight/obesity amongst breastfed individuals (OR 0.78, 95% CI 0.72-0.84)§.</td>
<td>2 meta-analyses and 1 systematic review*. 4 systematic reviews on the relationship between breastfeeding and overweight§.</td>
<td>Studies were rated good or of moderate methodological quality. Potential confounders could not be accounted for in all studies. The exclusivity of breastfeeding was not defined in the majority of studies.* Possible publication bias. Studies that controlled for socio-economic status and parental anthropometry reported breastfeeding associated with a lower prevalence of obesity§.</td>
</tr>
<tr>
<td>Type 1 diabetes</td>
<td>Any breastfeeding for &gt;3 months compared with breastfeeding for &lt;3 months is associated with a reduced incidence of type 1 diabetes (OR 0.81, 95% CI 0.74-0.89 and OR 0.88, 95% CI 0.81-0.96)</td>
<td>A meta-analysis and systematic review of 17 and 18 case-control studies respectively.</td>
<td>The evidence must be interpreted with caution because of possibility of recall bias.</td>
</tr>
<tr>
<td>Illness</td>
<td>Effect of breastfeeding</td>
<td>Studies included</td>
<td>Additional comments</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Type 2 diabetes</strong></td>
<td>Reduced risk of type 2 diabetes with any breastfeeding compared with exclusive formula feeding (OR 0.61, 95%CI, 0.44-0.85* and OR 0.63, 95%CI, 0.45-0.89§)</td>
<td>Systematic review and meta-analyses of 7 cohort, cross-sectional and case-control studies*. Meta-analysis of 5 cohort studies§.</td>
<td>Cannot be completely sure that all primary studies adjusted for confounding by birth weight and maternal factors.</td>
</tr>
<tr>
<td><strong>High blood pressure</strong></td>
<td>Amongst two meta-analyses, reduction in mean diastolic and systolic blood pressure of 0.5/0.36mmHg and 1.4/1.1mmHg respectively in adulthood amongst subjects who were breastfed in infancy compared with those who were formula fed*. Reduction in systolic blood pressure 1.21mmHg (95%CI, -1.72 to -0.70) and 0.49mmHg in diastolic blood pressure (95% CI, -0.87 to -0.11)§.</td>
<td>Two meta-analyses – 26 studies (13 were common to both meta-analyses)*. Two meta-analyses of 40 mainly cross sectional and cohort studies and four recently published studies§.</td>
<td>Methodological quality was rated moderate*. Possible issue of publication bias§.</td>
</tr>
<tr>
<td><strong>Cholesterol</strong></td>
<td>Mean reduction in total and LDL cholesterol was 0.18mmol/l and 0.2mmol/l respectively in adults who had been breastfed in infancy compared with those who were formula fed*. Adults (&gt;19 years) who were breastfed compared with those formula fed had lower mean total cholesterol of 0.18mmol/l (95% CI, 0.06-0.30mmol/l)§.</td>
<td>One meta-analysis of 37 cohort and cross sectional studies*. One meta-analysis of 23 mainly cohort and cross sectional studies§.</td>
<td>Higher serum lipid levels were observed in infancy – significance is unclear. Methodological quality rated poor and so authors conclude relationship between breastfeeding and effect on cholesterol cannot be correctly characterised*.</td>
</tr>
<tr>
<td><strong>Sudden Infant Death Syndrome (SIDS)</strong></td>
<td>Ever breastfeeding associated with a reduced risk of SIDS (OR 0.64, 95%CI 0.51-0.81)</td>
<td>One meta-analysis of 6 case-control studies</td>
<td>Studies provided objective definition of SIDS, clear reporting of breastfeeding data and outcomes adjusted for important confounders/risk factors.</td>
</tr>
</tbody>
</table>
### Illness | Effect of breastfeeding | Studies included | Additional comments
---|---|---|---
**Childhood Leukaemia** (*Acute lymphocytic leukaemia* (ALL), *Acute myelogenous leukaemia* (AML)) | Breastfeeding (≥6 months) significantly reduced risk of ALL (OR 0.80, 95%CI 0.71-0.91) and AML (OR 0.85, 95%CI 0.73-0.98) | One systematic review of 10 case control studies and one meta-analysis of 14 case control studies. | Studies were of good methodological quality. Further evaluation necessary with more large-scale case control studies.

**Necrotising enterocolitis (NEC)** | Reduced risk of NEC when comparing the effects of breast milk feeding on pre-term babies with formula milk feeding (OR 0.42, 95% CI 0.18-0.96) | One meta-analysis of 4 randomised controlled trials | There were differences between the trials in relation to time periods when studies were conducted, wide range of gestational ages, birth weights and different degrees of illness.

**Asthma** | Reduced risk of developing asthma with ≥3 months exclusive breastfeeding compared with not (OR 0.72, 95% CI 0.35-0.79). Greater protective effect in children with family history of atopy or asthma (OR 0.52, 95% CI 0.35-0.79)* | Meta-analysis of 12 prospective observational studies | Quality of meta-analysis rated good.

(OR indicates odds ratio and CI confidence interval)
Appendix III

Ten Steps to Successful Breastfeeding

Protecting, Promoting and Supporting Breastfeeding: The Special Role of Maternity Services (WHO & UNICEF, 1989)

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 no food or drink other than breast milk, unless medically indicated.
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.
Appendix IV

The Seven Point Plan for Sustaining Breastfeeding in the Community

(UNICEF, 2008)

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Support mothers to initiate and maintain breastfeeding
5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods
6. Provide a welcoming atmosphere for breastfeeding families
7. Promote co-operation between healthcare staff, breastfeeding support groups and local community
Appendix V

Breastfeeding in Ireland: A five-year strategic action plan

(Department of Health and Children, 2005)

Summary of the goals and objectives of the action plan

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>All families have the knowledge, skills and support to make and carry out informed infant feeding decisions, particularly those least likely to breastfeed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>• The individual and family needs for breastfeeding information, support and protection are identified and addressed</td>
</tr>
<tr>
<td></td>
<td>• The needs of partners, grandparents and the extended families of expectant and newly breastfeeding mothers are identified and addressed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>The health sector takes responsibility for developing and implementing evidence based breastfeeding policies and best practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>• Evidence based policies and best practice related to breastfeeding are identified and disseminated throughout the health care system</td>
</tr>
<tr>
<td></td>
<td>• Health workers have the knowledge and skills necessary to protect, promote and support breastfeeding</td>
</tr>
<tr>
<td></td>
<td>• Relevant health care facilities and organisations support and implement the WHO/UNICEF Baby Friendly Initiative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Communities support and promote breastfeeding in order to make it the normal and preferred choice for families in Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>• Support for breastfeeding is fostered in family, friendship and community networks</td>
</tr>
<tr>
<td></td>
<td>• The specific needs of communities or groups with lower than average breastfeeding rates are assessed and addressed</td>
</tr>
<tr>
<td>Goal 4</td>
<td>Objectives</td>
</tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 5</th>
<th>Objectives</th>
<th>Irish society recognises and facilitates breastfeeding as the optimal method of feeding infants and young children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Employers support and protect breastfeeding among their employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Positive images of breastfeeding are universally promoted, especially in mass media portrayals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Breastfeeding information and promotion is incorporated into the education system</td>
</tr>
</tbody>
</table>
Appendix VI

Types of maternity care available to women

Public care: All women are entitled to free maternity care. Public care includes antenatal and postnatal care and care during labour and childbirth. In this care the woman is not guaranteed to see the same midwife or doctor at each visit. Some hospitals have a midwives’ clinic which enables public patients, who are considered to have an uncomplicated pregnancy, to have continuity of care where possible from a hospital midwife. Midwives are in charge of the woman’s care and a doctor usually only becomes involved if an assisted delivery or caesarean section is needed.

Semi-private care: This can mean that a woman attends the same consultant privately when pregnant but the birth of the baby will be attended by the doctor on duty that day/night. In some hospitals it means that a woman attends a semi-private clinic which is run by a consultant and senior members of his/her team. The woman does not see the same doctor at each visit but one of the members of the team is usually available for the birth of the baby. After the birth, the woman stays on a semi-private ward where there are usually up to five beds.

Private care: The woman sees her consultant at each antenatal visit and he/she is usually available for the birth of the baby. After the birth, the woman usually has her own individual room.

Combined care: The woman’s GP provides about half of the antenatal care and the rest is provided by the maternity hospital/unit. Care from the GP is free and depending on
whether the woman goes public, private or semi-private, care in the hospital may also be free.

**Midwifery-led units:** This type of care is provided by a team of midwives to women who are considered to have a low-risk pregnancy. Women have the opportunity to get to know the midwives in the antenatal period and so usually have continuity of care. The units provide the opportunity for women to give birth in a homely environment and they can usually avail of early discharge with daily visits at home, if necessary, from a midwife.

**Community and Domino midwives scheme:** These schemes are for women who are classified as being low-risk. They allow for women to see a team of midwives for their ante-natal care. With the community midwives scheme, a woman has the choice of giving birth either at home or in the hospital. With the Domino scheme, the woman gives birth in hospital but has early discharge home with home visits from a midwife.

**Early-transfer home scheme:** This scheme allows for women who have had a normal birth and who feel well to leave hospital early and then receive daily visits from a midwife for up to five days.

**Home birth with an independent midwife:** Women can contact an independent midwife directly and receive antenatal, postnatal care and give birth in their home. In some geographical areas a grant is available from the local health office and in addition private health insurance covers some of the cost of a home birth.

(Adapted from Cuidiú-Irish Childbirth Trust’s Consumer Guide to Maternity Services in Ireland)
Appendix VII

Questionnaires which were used in the quantitative study with health professionals

General practitioners: pp. 334-340

Public health nurses: pp. 341-347

Practice nurses: pp. 348-354
Study title: Knowledge, attitudes and training needs of health professionals towards breastfeeding

**All the information in this questionnaire is strictly confidential**

A

<table>
<thead>
<tr>
<th>What is your profession? (please tick)</th>
<th>GP □ Public Health Nurse □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Midwife □ Practice nurse □</td>
</tr>
<tr>
<td></td>
<td>Paediatrician □ Obstetrician □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt;30 □ 30-40 □ 41-50 □ &gt;50 □</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male □ Female □</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you have children?</th>
<th>Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, were any of your children breastfed? Yes □ No □</td>
<td></td>
</tr>
<tr>
<td>If yes, what was the longest time one of your children was breastfed?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How many times in the past year in the course of your work, have you dealt with issues related to breastfeeding?</th>
<th>0 □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 10 □</td>
</tr>
<tr>
<td></td>
<td>11 - 49 □</td>
</tr>
<tr>
<td></td>
<td>50 or more □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Of the following health professionals, which do you believe most influence a woman’s decision to breastfeed?</th>
<th>GP □ Practice nurse □ midwife □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Antenatal class midwife □ Obstetrician □</td>
</tr>
<tr>
<td></td>
<td>PHN □ Other □ _____________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do you discuss feeding plans at antenatal visits?</th>
<th>Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>If no why not?</td>
<td></td>
</tr>
</tbody>
</table>

334
If yes, do you promote breastfeeding Yes □ No □
In what form do you give information about breastfeeding:
written □
verbal □
other □ (please state)
_______________________________

<table>
<thead>
<tr>
<th>Do you have any formal breastfeeding qualification?</th>
<th>Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes which one?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which of the following has been the greatest source of your breastfeeding knowledge? (please tick 1)</th>
<th>Personal experience □</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Undergraduate training □</td>
</tr>
<tr>
<td></td>
<td>Postgraduate experience □</td>
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<tr>
<td></td>
<td>General practice experience □</td>
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<tr>
<td></td>
<td>In-service training □</td>
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<tr>
<td></td>
<td>Other □ ___________________</td>
</tr>
</tbody>
</table>

**B**

*Please indicate on a scale of 1-5 the extent to which you agree with the following statements with 1 indicating strong agreement and 5 indicating strong disagreement.*

1. Mothers know instinctively how to breastfeed.

   1 □ 2 □ 3 □ 4 □ 5 □

   Strongly Agree □ Strongly Disagree □

2. Exclusive breastfeeding is the most beneficial form of nutrition during the first six months of life.

   1 □ 2 □ 3 □ 4 □ 5 □

   Strongly Agree □ Strongly Disagree □
3. Supplementing with formula in the first two weeks causes breastfeeding failure.

1 2 3 4 5
Strongly Agree Strongly Disagree

4. It is my role as a health professional to promote breastfeeding.

1 2 3 4 5
Strongly Agree Strongly Disagree

5. Breastfeeding is not feasible for a working mother.

1 2 3 4 5
Strongly Agree Strongly Disagree

6. A breastfed infant has increased immune function compared with a bottlefed baby.

1 2 3 4 5
Strongly Agree Strongly Disagree

C
In the following situations please indicate yes/no/unsure as to whether you would advise a mother to stop breastfeeding.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The mother has mastitis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. The mother has insufficient milk supply</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. The mother has a breast abscess</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. The infant is teething</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. The infant has frequent loose stools</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. The baby does not seem satiated</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Of the following breastfeeding support skills which are applicable to your work please rate your confidence from 1-4 with 1 being very confident, 2 fairly confident, 3 not very confident, 4 not at all confident or N/A not applicable.

<table>
<thead>
<tr>
<th>Provision of information and support</th>
<th>Confidence (1-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding physiology of lactation</td>
<td></td>
</tr>
<tr>
<td>Encouraging breastfeeding antenatally</td>
<td></td>
</tr>
<tr>
<td>Prescribing medicine to a breastfeeding woman</td>
<td></td>
</tr>
<tr>
<td>Showing a woman how to use a breast pump</td>
<td></td>
</tr>
<tr>
<td>Helping a mother with correct positioning and attachment of the baby to the breast</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dealing with specific problems</th>
<th>Confidence (1-4)</th>
<th>Dealing with specific problems</th>
<th>Confidence (1-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk insufficiency</td>
<td></td>
<td>Thrush</td>
<td></td>
</tr>
<tr>
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**Confidence**

1 = very confident
2 = fairly confident
3 = not very confident
4 = not at all confident
N/A = Not applicable
In the following situation what advice would you give a breastfeeding woman.

Mother perceives that her baby is getting insufficient milk

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

To which of the following statements do you Agree (A) or Disagree (D) or are Unsure (U) (please tick 1)

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<thead>
<tr>
<th>Statement</th>
<th>Health professionals</th>
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<td>Question</td>
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<td>Was the training adequate for you to be confident to deal with breastfeeding issues?</td>
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<td>If no why not?</td>
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<tr>
<td>Other please state</td>
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<td>Are there any areas of breastfeeding in particular which you would like</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>training on?</td>
<td></td>
<td></td>
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<tr>
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<tr>
<td>What do you think would help to increase</td>
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Thank you for taking the time to fill in this questionnaire
**Study title: Knowledge, attitudes and training needs of health professionals towards breastfeeding**

*All the information in this questionnaire is strictly confidential*

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<td>Yes □ No □</td>
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<td>-------------</td>
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<td>In what form do you give information about breastfeeding:</td>
<td></td>
</tr>
<tr>
<td>written □</td>
<td></td>
</tr>
<tr>
<td>verbal □</td>
<td></td>
</tr>
<tr>
<td>other □ (please state)</td>
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<table>
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<tr>
<th>Do you have any formal breastfeeding qualification?</th>
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<td>If yes which one?</td>
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</tbody>
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<tr>
<th>Which of the following has been the greatest source of your breastfeeding knowledge? (please tick 1)</th>
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<td>Undergraduate training □</td>
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<td></td>
<td>General practice experience □</td>
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<tr>
<td></td>
<td>In-service training □</td>
</tr>
<tr>
<td></td>
<td>Other □ __________________</td>
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**B**

*Please indicate on a scale of 1-5 the extent to which you agree with the following statements with 1 indicating strong agreement and 5 indicating strong disagreement.*

1. Mothers know instinctively how to breastfeed.

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<tr>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
</tr>
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<tbody>
<tr>
<td>Strongly Agree</td>
<td>Strongly Disagree</td>
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2. Exclusive breastfeeding is the most beneficial form of nutrition during the first six months of life.

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<td>Strongly Agree</td>
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3. Supplementing with formula in the first two weeks causes breastfeeding failure.

   1  2  3  4  5
Strongly Agree                      Strongly Disagree

4. It is my role as a health professional to promote breastfeeding.

   1  2  3  4  5
Strongly Agree                      Strongly Disagree

5. Breastfeeding is not feasible for a working mother.

   1  2  3  4  5
Strongly Agree                      Strongly Disagree

6. A breastfed infant has increased immune function compared with a bottlefed baby.

   1  2  3  4  5
Strongly Agree                      Strongly Disagree

C

In the following situations please indicate yes/no/unsure as to whether you would advise a mother to stop breastfeeding.

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tbody>
<tr>
<td>1. The mother has mastitis</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>2. The mother has insufficient milk supply</td>
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<td>3. The mother has a breast abscess</td>
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<td>□</td>
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<tr>
<td>5. The infant has frequent loose stools</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. The baby does not seem satiated</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
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</table>
Of the following breastfeeding support skills which are applicable to your work please rate your confidence from 1-4 with 1 being very confident, 2 fairly confident, 3 not very confident, 4 not at all confident or N/A not applicable.

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<th>Provision of information and support</th>
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<th>Dealing with specific problems</th>
<th>Confidence (1-4)</th>
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<tbody>
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<td>Milk insufficiency</td>
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<td>Thrush</td>
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<table>
<thead>
<tr>
<th>Usually within what time do you visit a mother and baby after discharge from hospital?</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes how many women on average attend the clinic weekly?</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Is there a breastfeeding support group held in your clinic?</th>
<th>Yes ☐ No ☐</th>
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In the following situation what advice would you give a breastfeeding mother.

1. Mother perceives that her baby is getting insufficient milk

To which of the following statements do you Agree (A) or Disagree (D) or are Unsure (U) (please tick 1)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
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<td>Mothers are given conflicting advice about breastfeeding from</td>
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<td>family members</td>
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<td></td>
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<tr>
<td>friends</td>
<td></td>
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<td></td>
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<td>There is no policy document on breastfeeding for the Northern Area Health Board</td>
<td>A</td>
<td></td>
<td></td>
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<tr>
<td>There are problems keeping up to date with current infant feeding recommendations</td>
<td>A</td>
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<tr>
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<td></td>
<td></td>
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<tr>
<td>Question</td>
<td>Yes □</td>
<td>No □</td>
<td>Additional Information</td>
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<td>If yes what are their names?</td>
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<tr>
<td></td>
<td>Other □ please state…………………………………………</td>
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Are there any areas of breastfeeding in particular which you would like training on?

What do you think would help to increase

1. Breastfeeding initiation rates in your area

What do you think would help to increase

2. Breastfeeding duration rates in your area

Thank you for taking the time to fill in this questionnaire
### Study title: Knowledge, attitudes and training needs of health professionals towards breastfeeding

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If yes, do you promote breastfeeding Yes ☐ No ☐

In what form do you give information about breastfeeding:
- written ☐
- verbal ☐
- other ☐ (please state)

_______________________________

Do you have any formal breastfeeding qualification? Yes ☐ No ☐

If yes which one?

Which of the following has been the greatest source of your breastfeeding knowledge? (please tick 1)
- Personal experience ☐
- Undergraduate training ☐
- Postgraduate experience ☐
- General practice experience ☐
- In-service training ☐
- Other ☐ ____________________________

B

*Please indicate on a scale of 1-5 the extent to which you agree with the following statements with 1 indicating strong agreement and 5 indicating strong disagreement.*

1. Mothers know instinctively how to breastfeed.

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<td></td>
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2. Exclusive breastfeeding is the most beneficial form of nutrition during the first six months of life.

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<td></td>
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<td>Strongly Disagree</td>
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3. Supplementing with formula in the first two weeks causes breastfeeding failure.

   1  2  3  4  5
   Strongly Agree   Strongly Disagree

4. It is my role as a health professional to promote breastfeeding.

   1  2  3  4  5
   Strongly Agree   Strongly Disagree

5. Breastfeeding is not feasible for a working mother.

   1  2  3  4  5
   Strongly Agree   Strongly Disagree

6. A breastfed infant has increased immune function compared with a bottlefed baby.

   1  2  3  4  5
   Strongly Agree   Strongly Disagree

C

In the following situations please indicate yes/no/unsure as to whether you would advise a mother to stop breastfeeding.

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</tr>
<tr>
<td>2. The mother has insufficient milk supply</td>
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Of the following breastfeeding support skills which are applicable to your work please rate your confidence from 1-4 with 1 being very confident, 2 fairly confident, 3 not very confident, 4 not at all confident or N/A not applicable.

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<td>Helping a mother with correct positioning and attachment of the baby to the breast</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confidence (1-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advising a mother with gestational diabetes about breastfeeding</td>
</tr>
<tr>
<td>Advising about weaning from breast to formula and/or solids</td>
</tr>
<tr>
<td>Advising about returning to work</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dealing with specific problems</th>
<th>Confidence (1-4)</th>
<th>Dealing with specific problems</th>
<th>Confidence (1-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milk insufficiency</td>
<td></td>
<td>Thrush</td>
<td></td>
</tr>
<tr>
<td>Mastitis</td>
<td></td>
<td>Inverted nipples</td>
<td></td>
</tr>
<tr>
<td>Cracked/sore nipples</td>
<td></td>
<td>Engorgement</td>
<td></td>
</tr>
<tr>
<td>Slow weight gain in the baby</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 = very confident
2 = fairly confident
3 = not very confident
4 = not at all confident
N/A = not applicable
In the following situation what advice would you give a breastfeeding woman.

Mother perceives that her baby is getting insufficient milk

To which of the following statements do you Agree (A) or Disagree (D) or are Unsure (U) (please tick 1)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers are given conflicting advice about breastfeeding from health professionals</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>family members</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>friends</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>There is no policy document on breastfeeding for the HSE Dublin North East region</td>
<td>A</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>There are problems keeping up to date with current infant feeding recommendations</td>
<td>A</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Staff levels in my organisation are too low to provide adequate support to breastfeeding mothers</td>
<td>A</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I have sufficient skills to provide breastfeeding support</td>
<td>A</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>My colleagues in my organisation have sufficient skills to provide breastfeeding support</td>
<td>A</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Question</td>
<td>Yes □</td>
<td>No □</td>
<td>If yes what are their names</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Do you know of any breastfeeding support groups in your area?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you know how to put a mother in contact with a breastfeeding support group?</td>
<td>Yes □</td>
<td>No □</td>
<td></td>
</tr>
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</table>

D

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes □</th>
<th>No □</th>
<th>If yes what training?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of any training on breastfeeding which is provided by the HSE Health Promotion Department?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you attended any training on breastfeeding in the past 2 years?</td>
<td>Yes □</td>
<td>No □</td>
<td></td>
</tr>
<tr>
<td>Was the training adequate for you to be confident to deal with breastfeeding issues? Yes □ No □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no why not?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes □</th>
<th>No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you like to attend training on breastfeeding in the next year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much time would you be willing to spend on training?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Through what medium would you like to have training?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self study training packs □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill based workshops □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 hour breastfeeding management training □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical observation and mentorship □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Online information □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other □ please state....................................................................</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any areas of breastfeeding in particular which you would like training on?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do you think would help to increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Breastfeeding initiation rates in your area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do you think would help to increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Breastfeeding duration rates in your area</td>
</tr>
</tbody>
</table>

Thank you for taking the time to fill in this questionnaire
Appendix VIII

The cover letter which was sent with each of the questionnaires
Dear

I am writing to inform you about a study which I am conducting in Dublin Institute of Technology for the Health Promotion Service (HSE), Dublin North East.

The title of the study is ‘Knowledge, Attitudes and Training Needs of Health Professionals around Breastfeeding’.

The main aim of the study is to determine the training needs of health professionals with regards to breastfeeding so that current systems can be improved. The study will involve collecting information from general practitioners, practice nurses, public health nurses, midwives, obstetricians and paediatricians in the North Dublin area.

Currently there is a complete lack of data regarding the training needs of health professionals around breastfeeding. Therefore I would really appreciate if you could take the time to fill in the enclosed questionnaire. It should take you no longer than 15 minutes to fill in. Please return the completed questionnaire in the enclosed stamped addressed envelope.

The final results of the study may be published in a peer reviewed medical journal.

Your responses will be treated with complete confidence and anonymity is assured when the results are being analysed.

If you have any questions please do not hesitate to contact me.

Once again your participation would be greatly valued.

Yours sincerely,

Barbara Whelan

Contact details:
Ph:
E-mail:
Appendix IX

Letter of invitation to participate in the qualitative study with health professionals
Re: Barriers to breastfeeding and an analysis of training that health professionals would like: A qualitative study of the views of different health professional groups

Dear

I am writing to inform you of the above mentioned study which I am conducting at Dublin Institute of Technology for the Health Promotion Unit, HSE Dublin Northeast. The aim of the study is to determine the barriers which prevent health professionals from adequately supporting breastfeeding women and the training they would like relating to breastfeeding. This study follows on from a quantitative study which was conducted last year and which explored ‘knowledge attitudes and training needs of health professionals around breastfeeding’.

If you agree to participate in this study you will be asked to take part in an individual interview at a time and place suited to you. The discussion will be recorded, with your permission, and all information given will remain anonymous and confidential.

The results of this study will make up part of my Ph.D. thesis and also may be published in a medical/nutrition peer reviewed journal.

You are under no obligation to join the study and if you do agree to participate you will be free to withdraw at any stage. If you would like to take part in the study please contact me. Alternatively I will give you a ring in the next few days to see if you are interested in participating. In addition, if you would like further information about the study, please feel free to contact me.

Regards,

___________________________

Barbara Whelan
Contact details:
Appendix X

Information sheet about the qualitative study with health professionals
I am a postgraduate research student at Dublin Institute of Technology and I would like to invite you to take part in a study entitled ‘Barriers to breastfeeding and an analysis of training that health professionals would like: A qualitative study of the views of different health professional groups’. The aim of the study is to determine the barriers which prevent health professionals from adequately supporting breastfeeding women and the training they would like relating to breastfeeding.

If you agree to participate in this study you will be asked to take part in an individual interview at a time and place suited to you. The discussion will be recorded, with your permission, and all information given will remain anonymous and confidentiality is assured.

The results of this study may be published in a medical/nutrition peer reviewed journal. Please note, however, that the name of participants will not be used in the results and you will maintain your anonymity at all times.

You are under no obligation to join the study and if you do agree to participate you will be free to withdraw at any stage.

If you would like any further information about the study please feel free to contact me.

Regards,

____________________________
Barbara Whelan
School of Biological Sciences,
Dublin Institute of Technology
Ph: E-mail:
Appendix XI

Interview guide for interviews with health professionals

Opening question
What are your views on infant feeding?

Practice
What do you see is your role in providing support to a breastfeeding woman?
How do you help/support women to breastfeed?
Do you discuss breastfeeding with the women that you see?
What is your experience of providing breastfeeding support?
What do you do if you can’t resolve a problem that a breastfeeding woman has?
Do you find your colleagues are supportive of breastfeeding?
Are there any barriers to you providing support?

Training
What training have you received on infant feeding?
How was this training?
What form of training has been beneficial for you?
Is it easy for you to access training?
How would you like training to be provided?
What topics do you think should be dealt with during training?
Are there any barriers to you attending training?
Which health professionals do you think should receive training?

Is there anything else you would like to add?
Appendix XII

Consent form for study qualitative study with health professionals pp. 363
Demographic questionnaire pp. 364
**Consent form**

**Researcher’s Name:** Barbara Whelan  

**Title of Study:**  
Barriers to breastfeeding and an analysis of training that health professionals would like:  
A qualitative study of the views of different health professional groups

**To be completed by the interviewee:**

Have you been fully informed/read the information sheet about this study?    **Yes/ No**  
Have you had the opportunity to ask questions and discuss the study?     **Yes/ No**  
Have you received satisfactory answers to all your questions?     **Yes/No**  
Have you received enough information about this study?     **Yes/ No**  
Do you understand that you are free to withdraw from this study?  
- At any time  
- Without giving a reason for withdrawing  
- without affecting your future relationship with the Institute **Yes/No**  
Do you agree to take part in this study the results of which are likely to be published?     **Yes/No**  
Have you been informed that this consent form shall be kept in the confidence of the researcher?     **Yes/No**  

Signed ___________________________    **Date__________________**

Name in block letters__________________________

Signature of researcher __________________  **Date__________________**
Questionnaire

Please could you fill out the following information

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
</tr>
<tr>
<td>Nationality:</td>
</tr>
<tr>
<td>Profession:</td>
</tr>
<tr>
<td>Area of work:</td>
</tr>
<tr>
<td>Number of years of clinical experience:</td>
</tr>
</tbody>
</table>
Appendix XIII (A)

An example of two codes ‘social barriers’ and ‘key people to call on’ and the descriptions for the codes

![Image of Free Node Properties dialog boxes for Social barriers and Key people to call on codes]
Appendix XIII (B)

Coding stripes illustrate to which nodes the text was coded
Appendix XIII (C)

Excerpt from the journal which was written within NVivo 8

I wonder once again after interviewing GP4 today and reading through CM1 and PHN1’s scripts whether GPs should be involved in breastfeeding hardly at all. I know they have to be from the point of view of prescribing medicine but after that should their breastfeeding care be almost nil. Perhaps that is unfair as some are interested in breastfeeding and do provide good support but does it come into their remit or more so should it come into their remit?

20/08/2008 13:16
PHN 6 illustrates again the commitment of PHNs to breastfeeding and their commitment in providing support. I use again the word ‘commitment’ to breastfeeding as it comes into my head a lot. I feel that mothers need to be ‘committed’ to breastfeeding as do perhaps health professionals. I know that this has been an idea that I have had for a while and so I will see what comes up in the interviews to follow on this. I think of commitment particularly in terms of community health professionals. Perhaps this is not the case.
I describe the commitment of PHN6 to breastfeeding because she talks about giving her phone number to mothers to contact her if they need her. I think this shows a huge effort to support breastfeeding mothers.

20/08/2008 16:00
Another interesting thing too is that often when I ask about training, people often reply with information about personal experience. This is interesting as having personal experience it seems is considered by some as training.

Need to consider: Effect of top ups (La Leche League conference, mention of negative effects of top ups). Are top ups a necessary evil?
Appendix XIII (D)

An example of a memo which was written for the interview with PHN3 and which includes a reference to the literature

This memo for PHN3 includes a reference to the literature and is linked to what PHN3 said (as can be seen in her transcript above, shaded in pink)
Appendix XIII (D)

An example of a memo which was written after conducting an interview with GP5

I found this GP interesting from different aspects. Firstly the clinic that she worked in had a website that made me feel the clinic would be very modern and have lots of support information for patients. That of course is quite a subjective view but I felt from the website that they would be very supportive of breastfeeding.

I noticed first in the waiting room that there was no mention of breastfeeding in the waiting area. This was something that I had taken to notice in clinics and found it interesting how some would have a poster and information and others would have nothing. This GP did not know anything about breastfeeding support groups and wasn’t even aware that such groups existed. This was the first time that I had come across this and it quite amazed me as breastfeeding support groups are a great resource that is available and all health professionals should be aware of them.

Another interesting thing from this interview was that the GP acknowledged that by participating in the interview she thought again about her role in providing support and said how sometimes they take it for granted that women know about breastfeeding or that they don’t need to be encouraged to breastfeed. However, by doing the interview it reminded her of the role she can play. I was really happy with this.

This GP like others cited time and having other priorities as being a reason for not attending training on breastfeeding. She had never received any training on breastfeeding which amazes me. How can students be let leave education without having received any training on breastfeeding, especially in the case of them working as GPs.

As I begin reading through the dialogue and coding I really get the sense that this GP had very
Appendix XIII (E)

Memo describing the concept “issue of time”

The issue of time was discussed most by midwives and this was in relation to not having adequate time to help and support women. This was a point of frustration for midwives as they wanted to give more time to women but were unable. Public health nurses also discussed the issue of having a lack of time. Supporting breastfeeding was considered a time-consuming activity and especially women with complications needed a lot of time. Some health professionals recognised that women needed some extra time and they discussed the benefit of giving them this, even if it was just five minutes. There was a sense however that time was at a premium and that it was not something that people had to give. In contrast to the issue of having a lack of time as described by a lot of midwives, the Domino midwives that were interviewed described the advantage of having time to give to women and being able then to support them as much as they wanted. This was in contrast to the frustration described by midwives in not having enough time to give support. This was also described by the community midwife who said she loved that she could give plenty of time to women who needed it. There was a sense from one obstetrician that their role was of someone who would come in and help a woman if she has a particular problem but that midwives were there to play the role of all rounder - i.e. someone who supported a woman in a practical sense but also emotionally, spending time with her. This contrasted the role of both, one being medical and the other holistic whole. In a metasynthesis of qualitative breastfeeding studies, Nelson (2006) found that women considered the availability and time that a health professional could give them as one of the most important characteristics of a health professional. In the literature breastfeeding has been described as an “engrossing, personal journal” with the importance of individualised care for each woman being recognised (Nelson, 2006). Surely the lack of time
Appendix XIV

Information sheet about the qualitative study with women
This study aims to look at women’s experience of infant feeding support in the first year postnatally.

The objectives are to look at:
- What are women’s expectations and perceptions of professional support for infant feeding.
- How is communication about infant feeding perceived by mothers.

Investigators
The study is being conducted by myself, Barbara Whelan. I am currently doing a PhD looking at the environment, health and social issues around infant feeding in Ireland and this study will add to the research I have already done for this. The research is being supervised by Dr John Kearney, Dublin Institute of Technology.

Procedures
You will be eligible to participate if the following apply to you:
- You are age 18 years or over
- You had a healthy, term (≥37 weeks gestational age), singleton baby, weighing ≥2.5kg (5.5lbs) at birth, in the past year
- You initiated breastfeeding and have either continued to exclusively breastfeed, mix feed (both formula and breast milk) or give formula.

If you choose to take part in the study, you will be asked to:
- Take part in an individual interview at a time and place suited to you. With your permission the interview will be recorded to ensure all information is collected.
- Fill in a questionnaire with information about you such as your age, occupation, education and information about your baby such as where you had your baby and his/her age.
- Comment (if you would like) on the findings of the study, which will be sent to you by post.
All information that you give will remain confidential and your name will not be published or disclosed to anyone other than the principal investigator, Barbara Whelan. Questionnaires and signed consent forms will be kept in a locked filing cabinet. All transcripts of the interviews will be coded and no other person other than the principal investigator will be able to link the code with the person, so that no participant can be identified.

Voluntary participation
If you decide to participate in this study, you will be asked to sign a consent form indicating that you are willing to take part. Your participation is entirely voluntary and you are under no obligation to participate and you may withdraw at any time without question.

Permission
Permission to undertake this study has been given by the Research Ethics Committee, Dublin Institute of Technology.

Results of the study
The results of this study will make up part of my PhD thesis and it is also hoped that the study will be presented at conferences and published in a medical/nutrition peer reviewed journal.

Thank you for considering taking part in this study. If you would like further information or if you would like to participate, please contact me on Ph. number or e-mail.

Thank you for your time.
Barbara Whelan Room 329 School of Biological Sciences
Dublin Institute of Technology
Kevin Street
Dublin 8
Appendix XV

Interview guide for qualitative interviews with women

Opening Question
Tell me about your experience of infant feeding

Antenatally
When did you decide to breastfeed?

Why did you decide to breastfeed?

Did any health professional speak to you about breastfeeding? Was what they said helpful?

Hospital
What was your experience in hospital?

Were you shown how to breastfeed? Who showed you?

Did you feel confident with breastfeeding?

Did any health professional observe you breastfeeding?

Postnatally
What was your experience when you were discharged and came home?

What kind of support did you find helpful/unhelpful?

When/If you were having problems with breastfeeding, who would you go to?

Did any health professional in particular play a significant role in helping you with breastfeeding?

What role does/did your GP play?

Considering the different health professionals, midwives, public health nurses, obstetricians, paediatricians, general practitioners and practice nurses, who do you think play an important role in supporting breastfeeding?

General
What do you think would help to increase breastfeeding rates?
Appendix XVI

Consent form (pp. 376) and demographic questionnaire (pp. 377-378) for the qualitative study with women
Consent form

Title of Research: Women’s experiences of infant feeding support in the first year postnatally

Researchers Name: Barbara Whelan

Address: School of Biological Sciences, Dublin Institute of Technology, Kevin Street, Dublin 8.

Please tick the box if you agree:

• I have been fully informed about this study

• I have had an opportunity to ask questions and discuss the study

• I have received satisfactory answers to all my questions

• I understand that I am under no obligation to participate in this study

• I understand that I am free to withdraw from this study at any stage, without having to give a reason for withdrawing

• I understand that the results of this study are likely to be published

• I agree to take part in this study

Signed _______________________________ Date _______________________________

Signature of Researcher __________________________
Title of Study: Women’s experiences of infant feeding support in the first year postnatally

Thank you for taking the time to fill in this questionnaire. Please remember that all information will remain confidential

What is your age?
24 years or under
25 – 29 years
30 – 34 years
35 years or more

What is the highest level of education you completed?
Primary
Secondary
Third level

What is your marital status?
Single
In a relationship
Married
Separated/divorced
Widowed

What is your occupation (job)?

If applicable, what is your partner’s occupation (job)?

What age is your baby?
What type of birth did you have?
- Vaginal delivery (normal birth)
- Assisted vaginal delivery (vacuum equipment/forceps used to assist birth of baby)
- Planned caesarean section
- Unplanned or emergency caesarean section

In which kind of care did you have your baby?
- Midwifery led unit
- Domino midwives
- Community midwives including home birth service
- Combined antenatal care
- Public care
- Semi-private care
- Private care
- Home birth with independent midwife
- Early transfer home scheme

In which hospital did you have your baby?

Was your baby:  Premature  or  Full-term

How many children do you have?
### Examples of initial codes

```
<table>
<thead>
<tr>
<th>Name</th>
<th>Sourcea</th>
<th>Referencea</th>
</tr>
</thead>
<tbody>
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<td>Being determined</td>
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</tr>
<tr>
<td>Benefits of breastfeeding</td>
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<td>29</td>
</tr>
<tr>
<td>Breastfeeding support group</td>
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</tr>
<tr>
<td>Conflicting information</td>
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<td>38</td>
</tr>
<tr>
<td>Cuidiu</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Culture of breastfeeding has been lost</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Doing practices that go against evidence</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Experience in hospital</td>
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<td>61</td>
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<td>26</td>
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<tr>
<td>Experience with GP</td>
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<td>Give it a go</td>
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<tr>
<td>Good support from family and friends</td>
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<td>35</td>
</tr>
<tr>
<td>Having the right people at the right time</td>
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<td>22</td>
</tr>
<tr>
<td>Health professionals having expertise</td>
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<td>16</td>
</tr>
<tr>
<td>Health professionals having personal experience of breastfeeding</td>
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<td>29</td>
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<tr>
<td>Health professionals invading personal space</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>If it works it works if it doesn’t doesn’t</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Impression or Opinion of different hospital based health professionals</td>
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<td>29</td>
</tr>
<tr>
<td>Knowing how busy health professionals are</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>La Leche League</td>
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<td>15</td>
</tr>
<tr>
<td>Lack of support from friends and family</td>
<td>16</td>
<td>25</td>
</tr>
<tr>
<td>Mothers maintaining control</td>
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<tr>
<td>Not knowing the ins and outs of breastfeeding</td>
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<td>25</td>
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<tr>
<td>Reasons for knowledge about breastfeeding</td>
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<td>46</td>
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</table>
```
Appendix XVIII

Synopsis of the Play

Scene 1: The delivery: The audience hears a woman in the background screaming and a nurse shouting push. Suddenly a baby (played by a young man), makes his entrance onto the stage and he gives a brief narrative to set the scene. He explains that in order to tell the story he needs to go back to the beginning, to when his mother Lizzie realised that she was pregnant with him.

(Throughout the play the baby plays alongside his mother Lizzie, but does not have a voice. He does, however, communicate his emotions through his expressions and actions and reacts to what he sees and hears. He reacts positively when Lizzie is being encouraged and supported with her pregnancy and with breastfeeding and he looks sad and frustrated when she is discouraged)

Scene 2: Lizzie and her mother: Lizzie is talking with her mother about attending her booking clinic appointment the following day. She expresses how she is nervous about the pregnancy but expects to get answers to all her questions the following day at the booking clinic. Her mother tells her that she will be fine and that she and her father will fully support her. She mentions that she will be able to help with taking care of the baby and with feeding the baby, but will not do any of the night feeds.

Scene 3: The booking clinic: Two old acquaintances, Heather and Sally bump into each other at the booking clinic. They discuss the yoga class that they used to attend together. Lizzie then enters and takes her place in the queue beside Sally and Heather, looking quite apprehensive. She looks around the clinic and comments on how they really ‘push the breastfeeding around here’, having noticed all the posters. This leads the three women to discuss how they are planning to feed their babies. Heather is very enthusiastic about breastfeeding and says that she wants to breastfeed for six months. Sally says that she would like to give it a try too but doesn’t know yet for how long. Lizzie says that she never thought about breastfeeding and really doesn’t know anything about it. While they are talking a midwife comes to them looking for urine samples and
later comes back to check an address. The atmosphere in the clinic is one of being very hectic. Heather and Sally are then called for their appointments and just as they are leaving Heather tells Lizzie that they are planning to do a pregnancy yoga class and wonders if Lizzie would like to come too. They swap telephone numbers and leave.

**Scene 4: Yoga:** This scene sees the three women once again meeting up, for the pregnancy yoga. They are stretching and suddenly collapse on their mats laughing at themselves. Heather says that one particular pose is very good when you’re breastfeeding because it strengthens your shoulders. The women once again discuss breastfeeding a little, but Lizzie says how she is still really unsure about how she will feed her baby. Sally says that she has decided she will do it for 6 weeks but then wants to get back to normal. Heather says that she can be normal and breastfeed and that she knows from her friend that once it gets going it’s a breeze. The scene ends with the three women realising they have just missed one of the poses which is Heather’s favourite.

**Scene 5: Nightclub:** This scene begins in a nightclub with two of Lizzie’s friends waiting for her. She arrives and they mention how much bigger she has gotten and they ask her if she has chosen any names for the baby yet. They also say how they can’t wait for her to have the baby and be back out with them drinking and partying. She says that she might breastfeed so drinking will be out for a while. They think she’s mad to consider that and look at her in disgust. When they are getting up to dance Lizzie gets a text to say that Heather has just had her baby. She looks worried and says it will be her turn next.

**Scene 6: Hospital:** This scene is with Heather in the hospital after having her baby. She is distraught as she is tired and she isn’t having much success with breastfeeding her new daughter. The baby won’t latch on properly. Heather is frustrated and upset that it is not working. She calls the midwife but she is really busy and says that she will be back again as soon as she can. Heather asks her to help and she quickly latches the baby on but then leaves and the baby comes off again. The midwife reappears and Heather explains that she cannot get the baby to latch on. The midwife says that it has been a few
hours since the baby fed and that she will go and get her a ‘top up’. Heather is left looking deflated and wondering what a ‘top up’ is.

**Scene 7: Midwives:** The midwife is signing off her shift and tells the next midwife about the day. She explains that she feels bad that there was a woman (Heather) trying to breastfeed but she just didn’t have the time to help her. She explains that the other midwife needs to bring her a top up. The other midwife just listens and says there is nothing they can do, that they do the best they can with the resources and time available.

**Scene 8: Café:** It is six weeks since Heather has had her baby and life is beginning to get back to normal. She goes to a café and orders a cappuccino and muffin. She is happy that she is out with her baby for the first time. She begins to breastfeed. An old woman sees the baby and comes over to admire her but when she realises that Heather is breastfeeding she turns away in disgust and complains that such a thing would never have been done in her day. In the meantime two teenagers come into the café and sit near Heather. When one of them realises that she is breastfeeding they start pointing and laughing. The waitress is not happy with the commotion and asks Heather to leave. She says that doing ‘that’, pointing to her breastfeeding, is not acceptable. Heather explains that she wants her cappuccino and muffin and the waitress says she can put it in a bag for her but that she will have to leave.

**Scene 9: Heather at home:** It is later on in the evening and Heather is at home unhappy and tired after her experience in the café. Her husband is on his way out to football practice and doesn’t have much time to listen to her go on about her tiredness and experience earlier. He shows some sympathy but says that he told her not to breastfeed in public, that she would only be drawing attention to herself. She gets annoyed and says it is the same when his mother calls to the house, that he prefers her to feed the baby upstairs. He says that he doesn’t understand what the big deal is and why she just can’t give the baby a bottle. He says that later he will feed the baby and she can have some rest. He leaves for football and Heather is feeling unhappy and unsupported. Suddenly Heather receives a text to say that Lizzie has had her baby.
Scene 10: Lizzie in hospital: The play returns to the start. Lizzie has just had her baby and the midwife brings her down to the ward. She asks her whether she’s going to feed ‘breast or bottle’. Lizzie looks confused. The play ends.
Appendix XIX

Postcard survey

<table>
<thead>
<tr>
<th>Please help by filling this in and placing it in the box as you leave</th>
<th>What do you think was the main message of the play?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Are you male or female</td>
<td>M</td>
</tr>
<tr>
<td>What is your job?</td>
<td></td>
</tr>
<tr>
<td>Did you enjoy the play?</td>
<td>yes</td>
</tr>
<tr>
<td>Do you think the play was:</td>
<td></td>
</tr>
<tr>
<td>Interesting</td>
<td>yes</td>
</tr>
<tr>
<td>Informative</td>
<td>yes</td>
</tr>
<tr>
<td>Professional</td>
<td>yes</td>
</tr>
<tr>
<td>Do you think the things discussed in the play are relevant to you?</td>
<td>yes</td>
</tr>
</tbody>
</table>

Do you think the play is a good way of discussing breastfeeding?

<table>
<thead>
<tr>
<th>Why?</th>
<th>yes</th>
<th>no</th>
</tr>
</thead>
</table>

Thank you.
Appendix XX

Observations made during delivery of the play in each of the four different organisations.

<table>
<thead>
<tr>
<th>Organisation 1</th>
<th>Youthreach: This is a training programme for unemployed young early school leavers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venue</td>
<td>The performance was held in a large room with just enough space for everyone. The acoustics were good and the play could be seen and heard without difficulty.</td>
</tr>
</tbody>
</table>
| Audience       | Female: 16  
                  Male: 5  
                  Eighteen of whom were students and three teachers. Sixteen were under 20 years, three were 21-30 years and one was 31-40 years. |
| Reception and engagement of the audience | The audience were attentive and laughed at funny scenes. Some moved position to have a better look at the play and also some sat forward which would indicate interest in what was happening. The audience responded really well. They got particularly animated when their friends in the audience got up and participated in the drama. |
| Interventions  | 1. The hospital scene: A young man said that the scene in the hospital could be changed. He got up and introduced a new character, Heather’s husband/partner and called her on her mobile just at the point where she was beginning to despair over not being able to feed and not getting the support from the midwife. He supported Heather in two ways. First on the phone he offered her |
support and then in the hospital he said to the midwife that she wanted to breastfeed and needed help. This in turn empowered Heather to ask if she could see the lactation midwife.

2. **The café scene:** One young woman said that the old person was from a generation where breastfeeding was the norm and so this was not her fault that she found it disgusting. However, with a little encouragement she got up and took the part of the waitress and told the young people who were laughing that they were ‘gobshites’ and should have more respect and that they could lump it or leave. She then turned to Heather and asked her if she was ok and showed her support.

3. **Booking clinic:** One woman from the HSE got up for the booking clinic scene and she took on the part of Lizzy. She insisted on getting information about breastfeeding from the midwife and the midwife then gave her a little more time. By asking for help this empowered Heather and Sally and they responded that they would like information too.
**Organisation**

| 2 | **College of Further Education**: This college is run by one of the Vocational Education Committees and offers a diverse range of courses for Post Leaving Certificate and mature students. |

**Venue**

The performance was held in the school gymnasium. It was a large hall. The performance was on the floor at the top of the hall. This made it difficult for some people to see, however, acoustics were great and there was no difficulty in hearing what was being said.

**Audience**

| Female: ~55 |
| Male: ~10 |

The vast majority of those that attended were students, most of whom were under thirty years of age. The students came from childcare, performing arts and social studies.

**Reception and engagement of the audience**

The audience received the play well. There was complete silence in the room during the play. They laughed at various parts.The audience also showed interest by craning their necks to see what was happening in the yoga scene, and café scene.

**Interventions**

1. **Café scene**: Almost immediately when the drama facilitator asked how things could be changed a woman said that the café scene had happened to her a few years before. She got up and played the part of Heather. When the granny was admiring the baby and suddenly looked shocked the woman said ‘I am breastfeeding her why, it is perfectly normal’. The granny said ‘well not in my day dear’. And the woman replied ‘well you can have your opinion’. The waitress then asked her to leave and said that she would put a brownie in a bag for her. She said that she didn’t want a brownie in a bag and then she asked to see
the manager. The audience laughed at her persistence. Someone in the audience commented how breastfeeding should be a cultural norm and the drama facilitator asked how this could be. One woman said that support was needed. A young woman said that she was 17 years when she had a baby and that there were no support groups for young people. She said that the group near her was attended by older women and so didn’t suit her. A woman from the HSE said that there are support groups but they are universal and drop in. There was a suggestion that there should be support groups for young people.

Someone then made the point that it was against the law to ask a woman to stop breastfeeding in public and that it was the proprietor’s responsibility to protect the woman from discrimination. The audience didn’t know this.

2. Hospital Scene: A young woman took the role of Heather while the midwife was hurriedly trying to advise her how to breastfeed. She went to leave her and the young woman said ‘oh hang on, I’ve never done this before, please can you just hang on?’. The midwife then suggested giving a bottle and the woman said no, that she wasn’t giving her a bottle. The midwife suggested getting the lactation consultant. The woman was still not happy and asked if there were any other mothers who were breastfeeding that she could talk to. The midwife said yes there were. The woman was happier. Someone from the audience said that mother could have been more prepared and could have researched things before the baby was born and this might have prepared her more for breastfeeding.

3. Heather at home: A member of the audience took on the role of Heather’s husband. Heather wanted to talk to him about her experience earlier in the café and was exhausted. The husband was on his way out
to football and the young woman from the audience playing the part of the husband, explained that he needed some time with his mates and suggested that Heather ring her friends from the booking clinic. Heather decided to ring Sally and they chatted and Sally offered support – they decided to meet the following day and joked about going back to the café the next day and breastfeeding together.

The drama facilitator asked them how it felt playing the new scene and Heather said much better.

4. There was a brief discussion about the booking clinic and the idea of having support by other mothers at the initial appointment at the booking clinic. One of the actresses mentioned that there already was La Leche League and Cuidiú volunteers but a woman in the audience got up and said that they were only volunteers and that they would love to be going into hospitals but that they didn’t have the resources.

5. **Booking clinic scene:** A woman from the HSE took on the role of Lizzie and asked for the information on breastfeeding to be explained to her. She said ‘you can’t just give me stuff like this’. She asked questions like where the support groups were etc. and the midwife showed her at the back of the booklet where they were listed. She got her questions answered, however, in a very hurried fashion. She then asked for information on bottle feeding and the midwife went and got her some.
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Traveller Training Centre: This centre provides education for women aged 15 years and upwards.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venue</td>
<td>The performance was held in a family resource centre, in a small brightly lit room. There was sufficient room for everyone to be seated and everyone had a good view of the performance.</td>
</tr>
<tr>
<td>Audience</td>
<td>Female: 22 Sixteen of whom were students, one a tutor and five public health nurses. Members of the audience ranged from 18-60 years.</td>
</tr>
<tr>
<td>Reception and engagement of the audience</td>
<td>The reception from the audience was really good. They laughed at various parts and engaged well with the play. They responded quickly once the drama facilitator opened it up to the audience as to what Lizzie was going to do and what her dilemma was.</td>
</tr>
<tr>
<td>Interventions</td>
<td>1. <strong>Lizzie and her mother scene:</strong> A woman in the audience asked if there was any midwife that could explain things to Lizzie individually. She said how Lizzie was a young girl and that the midwife should have taken her in and explained the different feeds to her. The girl’s mother could also have explained to her, her different options and how to ask for advice. With some persuasion she got up and played the role of Lizzie’s mother. She told Lizzie that when she goes to the booking clinic, to ask the midwife if she could speak to her in confidence and she told her to ask her what she should drink and eat, and how to control her weight and she asked her if she would like her to go with her to the booking</td>
</tr>
</tbody>
</table>
2. The Booking clinic scene: Another woman then took over the role of Lizzie’s mother in the booking clinic. She was slow to ask the midwife for information but then did interrupt her and ask her. The midwife said how busy she was and the woman asked if they could talk in private. The midwife said it wouldn’t be possible as she was too busy. She persisted and finally the midwife agreed that she would see her at the end of the clinic when it was a little quieter. The drama facilitator asked them if it was ok for them to wait. They said yes but then the mother said maybe it would be better to go to their family doctor about it instead as the hospital was so busy. The drama facilitator asked Lizzie how she felt about the change in the scene and she said how she really liked getting the support from her mother.

3. The yoga scene: There was a discussion about yoga as a woman in the audience asked what it was. Two of the actors discussed how good it was during their pregnancy and they explained how relaxing it is. One woman in the audience joked about how the actors didn’t looked so relaxed playing the yoga scene and there was laughter. A public health nurse got up from the audience and played the role of Lizzie. The yoga scene was repeated and she took over as Lizzie. She asked about the antenatal class and made specific arrangements with Sally to meet her at the Dart station the following week because they would go together to the class. Sally said that she would call her the day before they went to finalise arrangements.

4. Disco Scene: One woman said that the disco would be too noisy for the baby. Someone else said that Lizzy was responsible in not drinking
alcohol and instead having water. Someone said that she needed more support and the drama facilitator asked how she could get support for herself. Someone said she could talk to her friends and go to dinner instead of the nightclub. She could bring a book with her to show her friends at dinner.

A telephone conversation was then acted with two members of the audience, one playing Lizzie and the other her friend. The friend asked Lizzie if she was going out for a drink and Lizzie said that she didn’t know as she was pregnant. With a little persuasion from her friend she agreed.

The scene was replayed again, however, this time Lizzie said that she would like to go for a quiet meal instead of going for a drink and her friend agreed.

5. There was a brief discussion then about breastfeeding rates in Ireland and how they had decreased since the 1920s. One woman in the audience said that it had not been encouraged and that everything was hidden.

6. **Hospital scene:** When Heather was having difficulty in the hospital one woman in the audience suggested that she call one of her friends from the yoga class. The woman played the role of Sally, and Heather called her, telling her how difficult she was finding it. Sally asked if there was any nurse she could ask and she told Heather to insist that she needed help. She offered her support.
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Maternity Hospital: Dublin City Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venue</td>
<td>The performance was held in a small lecture theatre in the hospital. The play could be viewed and heard easily.</td>
</tr>
</tbody>
</table>
| Audience (Spect-actors) | Female: 44  
Male: 4  
The audience was a mixture of dietitians, administration staff, engineers, midwives, student nurses, members of voluntary breastfeeding organisations, healthcare assistants and other. They ranged in age from 20-60 years of age. |
| Reception and engagement of the audience | The audience received the play very well. They smiled and laughed and were attentive throughout. |
| Interventions | 1. **Lizzie and her mother scene:** One woman in the audience said that the mother could have said that she would help her daughter with the baby. (instead in the play the mother said how she would help with the baby and that she could help with the bottle feeds). The woman got up and the scene was replayed. She said to Lizzie that herself and her husband would help with everything and she also mentioned about breastfeeding. The drama facilitator asked the audience if that worked better and they agreed.  
2. **Booking clinic scene:** Someone in the audience said that Lizzie’s feelings could have been acknowledged and the drama facilitator asked who could have done that? Someone said that an introduction could have been made to the young mum. A woman
gets up from the audience and immediately stopped the scene when the midwife asked very hurriedly for the urine samples. She took over the role of the midwife and came out less rushed, politely and in a friendly manner asking for the urine sample and said that she would get someone to talk to the women because it was their first time.

Someone in the audience mentioned how it would be great to have one nurse whose job is specifically to support breastfeeding. The drama facilitator asked if that was a realistic solution and asked the midwives in the audience. One person said they do a team clinic and they can tailor, to some degree, support for women. Someone else mentioned that because that week was National Breastfeeding week, voluntary counsellors were invited into the antenatal clinics to speak to women. The drama facilitator asked if that could happen again and someone said that they were going to look into it. One woman from a voluntary breastfeeding organisation said that she had done a stand that morning and she felt there was a great need for such a thing and that people needed information in a non-threatening way. She said that there was something awful about the way in which Lizzie had just been handed leaflets about breastfeeding by the midwife in the booking clinic.

3. Booking clinic scene: This was replayed again, this time with a woman from the audience playing the role of a member of a voluntary breastfeeding organisation. She approached the three women (Lizzie, Heather and Sally) in the booking clinic and said that she was from a voluntary organisation and that the women were welcome to come along to a breastfeeding support group and that they could come along when they were pregnant.
4. Someone from the audience made the point that balance was needed about feeding and that while breast is best a little more is needed on bottle feeding.

5. A member of the audience asked Lizzie if a buddy system would have worked in supporting her.

6. **Booking clinic scene:** a care assistant said that she would like to redo the booking clinic. She played the role of someone walking around and talking to the women and she asked them if they had considered breastfeeding. She said that breastfeeding was good and that there were breastfeeding midwives to help and that if they couldn’t breastfeed they couldn’t, but that they should at least give it a try. She introduced herself and said that she was always there and she would help the women and make time for them.

She made the point that if the care assistants had more knowledge they could help and said that training in breastfeeding would help them. She felt that care assistants could be good to help with antenatal care and in getting mothers together as support for each other.
Appendix XXI

Information about the study evaluating the forum theatre production and consent form
Evaluation of the drama Milk it! Much a do about nothing?

Researcher: Barbara Whelan, School of Biological Sciences, Dublin Institute of Technology.

I am doing a research study to find out whether a theatre production, which you will have the opportunity to see, will have any effect on your thoughts and ideas of infant feeding. If you would like to be in this study you will be asked to take part in a group discussion which will last about 1 hour, before and after you see the drama. The discussion will be recorded.

You do not have to be in the study and if you decide not to be that is fine. If you do decide to take part, you are free to stop at any stage you want.

When this study is finished a report will be written however your name will never be used in the report. A paper may also be published with the results but again you will never be personally identifiable.

If you have any questions please ask me.

Please tick the following boxes if you agree

I understand that my name will not be used in any reports or publications arising from this research ☐

I understand that I can withdraw from the research at any time ☐

I am willing to participate in the study ☐

I am willing for the discussion to be audio taped ☐

__________________  ________________  ________________
Name                  Signature                  Date

__________________  ________________  ________________
Researcher’s name    Signature                  Date
Appendix XXII

Research Paper (Pages 399-408)
Promoting breastfeeding through drama: a preliminary study

Barbara Whelan and John M. Kearney
School of Biological Sciences, Dublin Institute of Technology, Dublin, Ireland

Abstract

Purpose – Ireland has one of the lowest rates of breastfeeding in Europe with exclusive breastfeeding rates of 44 per cent at discharge from hospital. Increased awareness and debate on breastfeeding and its issues is needed. The purpose of this paper is to describe an evaluation of the piloting of a forum theatre production in increasing awareness of breastfeeding.

Design/methodology/approach – A mixed methods approach was taken. Research participants were identified through the four organisations in which the play was performed. Approximately 160 people watched a performance of the play. Quantitative data were collected from 110 audience members who completed a postcard survey. Qualitative data were collected from 42 people prior to seeing the play and 47 people after seeing the play, through focus groups and individual interviews.

Findings – Over 90 per cent of participants thought the play was a good way of discussing breastfeeding and they thought it was more effective than usual health promotion of giving out leaflets. Qualitative interviews found that the play heightened people’s awareness of breastfeeding, highlighted the importance of support and engaged people in discussion and debate around breastfeeding.

Originality/value – The concept of promoting breastfeeding through drama is quite novel and this evaluation shows a potential for using such techniques in health promotion on varied nutrition-related topics.

Keywords Promotional methods, Health education, Women, Theatre, Ireland, Drama

Paper type Research paper

Introduction

Despite breast milk being the preferred method of infant feeding, Ireland has one of the lowest rates of breastfeeding in Europe with exclusive breastfeeding rates of 44 per cent at discharge from hospital (Department of Health and Children, 2008). Breastfeeding confers advantages on both mothers and babies, including health, immunological, developmental, psychological, social, economic and environmental benefits (Gartner et al., 2005). In Ireland breastfeeding has become a minority activity and the culture of breastfeeding has been lost. Anecdotal evidence of intolerance towards breastfeeding, especially in public, is not unusual. Breastfeeding does not “take place in a social vacuum” (Bailey and Pain, 2001) and so it needs to be promoted with recognition of the society and culture within which it is occurs. The promotion of breastfeeding in Ireland typically involves the use of leaflets describing the benefits of breastfeeding. However, Fairbank et al. (2000) found that trying to increase knowledge of breastfeeding by leaflets were not successful unless other interventions were used in tandem with it. Tarrant and Kearney (2008) described the need for “more creative national breastfeeding campaigns” that address the negative cultural perception of breastfeeding in Ireland.

The importance of the arts in healthcare has been recognised (Smith, 2002). In particular the arts have been used in the promotion of health (Starkey and Orme, 2001; Peerbhoy and Bourke, 2007; Neumark-Sztainer et al., 2009). Forum theatre is a form of

The authors would like to thank the HSE Dublin Mid-Leinster and the area Breastfeeding Steering Committee who commissioned and funded the evaluation of the play.
interactive theatre which has been used, amongst other things, in nutrition and health promotion (Seguin and Rancourt, 1996; Parker, 1997; Camillin, 2006). Forum theatre originated with Augusto Boal in the late 1970s and his aim was to help people address and find solutions to issues of oppression. Boal aimed to transform theatre from a “monologue” as seen in a traditional theatrical performance into a “dialogue” between the audience and the stage. In a forum theatre production a play is played in full and the audience are then asked to decide which scene/scenes they would like to replay and change. A member of the audience is then invited to take the place of one of the actors and to change the particular scene to the way they would like to see it. Forum theatre has been identified as a “powerful agent for positive change” in both industrialised and developing countries (Seguin and Rancourt, 1996).

Merging the concept of forum theatre with issues around breastfeeding in Ireland, the Health Service Executive (HSE) Dublin Mid-Leinster along with the area Breastfeeding Steering Committee commissioned a drama facilitator to develop and facilitate a forum theatre production called Milk It! Much Ado about Nothing? This paper describes the evaluation of this production, the aim of which was to examine the role of forum theatre in creating an increased awareness of breastfeeding. The specific objectives of the evaluation were to assess the outcome of using drama to engage people in discussion and debate about breastfeeding, to promote breastfeeding as the norm rather than the exception and to allow participants develop solutions to identified barriers to breastfeeding.

**Overview of Milk It! Much Ado about Nothing?**

In line with a forum theatre production, Milk It! Much Ado about Nothing? was developed from women’s true stories of their experiences around infant feeding. These stories were collected from interviews with women who had both breastfed and bottlefed their babies. Once the stories were collected, workshops were held weekly for ten weeks and the process of developing the stories into a play began. In order that the play remained “loyal” to the stories that had been collected, three protagonists were written into the play as opposed to just one, which is the norm for forum theatre. This, along with the fact that two professional actors performed in the play with four “non-actors” were the only concessions made to Boal’s model of Forum Theatre.

The three protagonists were:

1. Lizzie, a young woman of 18-20 years who was pregnant. She had not planned the pregnancy and did not know what to expect. She had not put any thought into how she would feed her baby.
2. Heather, a woman in her early 30s who was very excited about being pregnant and was really looking forward to the experience of breastfeeding and she planned to breastfeed for six months.
3. A midwife who worked in a busy maternity hospital and who was frustrated that she did not have enough time to help and support women.

Some of the issues which were dealt with in the play were: breastfeeding not being a social norm, lack of information on breastfeeding and bottle feeding antenatally, positive and negative attitudes to breastfeeding, lack of support for breastfeeding women from health professionals and family members, and midwives having insufficient time to support women.
**Methods**

The use of questionnaires in evaluating community arts based interventions often do not yield much information and other studies have found that a more qualitative approach to data collection may be preferable (Peerbhoy and Bourke, 2007). While this study used a mixed methods approach with both quantitative and qualitative methods, the main part of the evaluation was qualitative, involving interviews with members of the audience. The quantitative methods comprised a postcard survey which was used to determine the opinions of those that saw the play.

**Sampling**

Research participants were identified through the organisations in which the play was performed. These organisations were a Youthreach group (a training programme for unemployed early school leavers aged 15-20 years), Traveller Training Centre (travellers are Ireland’s indigenous population and oldest ethnic minority), a College of Further Education (for school-leavers and adults returning to education) and a maternity hospital.

**Data collection**

- **Views of the audience.** Some viewers of the play were interviewed before watching the play and again afterwards. This was to ascertain if their attitudes and awareness towards breastfeeding had changed. The views of additional audience members were also sought after seeing the play and this was to ensure that a range of views had been got. Interviews were in the form of individual and group discussions.

- **Postcard survey.** After watching the play, viewers were invited to fill out a short postcard survey. This survey was similar to that used by Orme *et al.* (2006). It contained both closed and open-ended questions and aimed to gather information regarding people’s opinion about the play, the main message of the play and the role of drama in discussing breastfeeding. The postcard was piloted amongst a group of women (*n* = 20) who watched a rehearsal of the play and their feedback was sought on the content of the postcard. Feedback from the piloting was incorporated and the survey was finalised.

Data were collected from face-to-face, audio taped, semi-structured interviews, eight of which were individual and 11 of which were in focus groups. All interviews were recorded with a digital recorder, except for one where the person did not want her voice recorded. In this case, notes were made during the interview and were written up afterwards.

**Data analysis**

All interviews were transcribed and were then thematically analysed using the technique outlined by Burnard (1991). The qualitative data analysis software NVivo 8 was used to aid in analysing the data. Qualitative data from the postcard survey were also transcribed and analysed for themes. Quantitative data from the postcard survey were analysed using descriptive statistics in Statistical Package for the Social Sciences (SPSS) 15.0.

**Ethical considerations**

Permission for this study was granted by Dublin Institute of Technology, Research Ethics Committee. All of the names of those who participated in the study were changed and so quotations cannot be identified to a particular person.
Results

The postcard survey

In total approximately 160 people watched a performance of the play. One hundred and ten people responded to the postcard survey giving a 69 per cent response rate. Participants ranged in age from 16 to 60 years, with the vast majority under 30. Nearly all of those who saw the play thought that it was enjoyable. In addition the majority thought that it was interesting, informative and professional. A total of 78 per cent (n = 86) of those that filled out the postcard survey thought that the things discussed in the play were relevant to them (Table I).

Of viewers, 95 per cent thought that the play was a good way of discussing breastfeeding. Their reasons were broken down into six themes and these were as follows (an example of a quote for each theme is included):

1. The play being different to other ways of promoting health – “It brings a reality to it that reading a leaflet never would. It was a very good portrayal of the benefits and problems with it” (Student nurse, Maternity hospital).

2. Informal and fun way of highlighting issues around breastfeeding – “A great way to be able to discuss breastfeeding. An interesting and friendly way to discuss. You have put on a very good play” (Student, Traveller Training Centre).

3. It was real and shed light on the reality – “Because it showed real life situations as they would happen; situations that might be hard to put into words in a verbal description of situations that could arise” (Student, College of Further Education).

4. Thought provoking – “It highlights different issues e.g. social perception of breastfeeding, family support that all affect breastfeeding” (Student, College of Further Education).

5. Provided opportunity to give own opinion – “I thought it was very good because you could discuss your opinions and also alter the play itself. Thank you!” (Student, Youthreach).

6. Informative – “It is because it explains a lot on breastfeeding and a lot of things I didn’t know and it’s a fun way of explaining it” (Student, Youthreach).

Four different themes were identified as to what viewers felt was the main message of the play (Table II).

<table>
<thead>
<tr>
<th></th>
<th>Yes (%)</th>
<th>n</th>
<th>No (%)</th>
<th>n</th>
<th>No response (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you enjoy the play?</td>
<td>98</td>
<td>108</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Did you think the play was:</td>
<td>95</td>
<td>104</td>
<td>-</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Interesting</td>
<td>91</td>
<td>100</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Informative</td>
<td>85</td>
<td>93</td>
<td>4</td>
<td>5</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Professional</td>
<td>78</td>
<td>86</td>
<td>16</td>
<td>18</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Did you think the things discussed in the play were relevant to you?</td>
<td>95</td>
<td>105</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Did you think the play was a good way of discussing breastfeeding?</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Note: n = 110
The interviews
Focus group discussions and individual interviews were held with some of the members of the audience, in each of the four venues, prior to and after seeing the play. In the case of the Youthreach group and the College of Further Education, the majority of participants were students, under 21 years of age. In the Traveller Training Centre and the maternity hospital, participants ranged from 18 to 55 years of age.

Prior to seeing the play. There was a difference amongst the four groups in their exposure to breastfeeding, meaning some had personal experience of breastfeeding or breastfeeding was something that they saw in their environment. Those that had this exposure were namely in the maternity hospital and College of Further Education and were easier to engage in discussion about breastfeeding, prior to seeing the play.

Some people were very positive and supportive of breastfeeding and made comments such as:

I think it’s brilliant, it’s cheap and it’s healthy, I don’t have any experience of it, any family or anything doing it but I think it’s a good idea to consider it (Michelle, care assistant, Maternity hospital).

For others, breastfeeding was not something they had ever considered:

It never came into me mind to breastfeed. I just didn’t see meself breastfeeding. If I had to just like you know use the pump like but I wouldn’t actually breastfeed (Sharon, student, Youthreach).

Some people described the embarrassment of breastfeeding and of what other people would think:

A lot of people think what will the people think like (Mary, student, Traveller Training Centre).

But I think like if you had your partner with you or if you had a partner, they’d just get embarrassed like and probably tell you to cop on. They would like, they’d probably say what are you doing like making a show of me (Sharon, student, Youthreach).

The students in Youthreach generally felt it was unacceptable to breastfeed in public, although some felt that is was more acceptable if the mother covered herself. One
young woman showed disgust at the idea of breastfeeding in public and someone in the group asked her “What if your child was hungry and you were breastfeeding?” and she replied “Put it in a pump and bring it in a bottle” (Louise, student, Youthreach).

Those in the Maternity hospital and the College of Further Education supported women breastfeeding in public and did not have any issue with it:

It wouldn’t bother me to see someone breastfeed their baby, I think it would be ok (Elizabeth, student, College of Further Education).

After seeing the play. People generally had a positive response to the play, their views differed as to their impression of the play and what they liked/disliked about it. Descriptions of participant’s views of the play are presented below:

- **Realistic.** Participants commented on the play being very realistic and this surprised some of them as they had expected it to be more idealistic and less typical of what actually happens in real life. Other people commented that the play brought the reality to life more than a leaflet would and this made it more enjoyable to watch:

When you’re watching a play it’s like real life because amm it’s just like watching a film there (Mary, student, Traveller Training Centre).

- **Literacy friendly.** Some participants who have worked with disadvantaged groups commented on the fact that the play was literacy friendly:

I thought it was a great way of educating people or young mothers, particularly those who would be coming from disadvantaged areas who mightn’t have literacy skills and I think it’s a great method because basically many of these people aren’t able to read leaflets or interpret them (Jenny, dietitian, Maternity hospital).

- **Promotes awareness about breastfeeding.** In general, participants felt that the play would not change people’s minds as to whether they would breastfeed, but that it would create an awareness around breastfeeding which was very positive for the promotion of breastfeeding. This awareness was demonstrated by the fact that one of the traveller women described how she had gone home and told her daughters about the play hence encouraging a discussion about breastfeeding between them:

I was just explaining to my daughters and all that. They probably wouldn’t still breastfeed but I was just explaining about how good the play was and everything (Mary, student, Traveller Training Centre).

- **Audience participation.** Many people commented on the how they enjoyed the aspect of the audience participation. One student nurse explained how she felt that the interaction with the audience, whereby they had to change scenes and make them as they would like to see them, was empowering and enabled self reflection as to what she herself could do to improve things:

[... because we were made to intervene and interact and change things, oh here’s the bigger picture, I can actually do something, I can help and it certainly made me look at who I can possibly influence in the picture and who I can help from my own knowledge (Shauna, student nurse, Maternity hospital).

- **Criticisms.** Most of the respondents felt that the play was balanced with regards to its portrayal of bottle and breastfeeding. However, there was criticism from one respondent, who felt that breastfeeding was pushed too much in the play:
I personally felt that breastfeeding was being pushed down her throat. I think that, I felt that it wasn’t being very objective, to me I felt it was very much, it’s breastfeeding and nothing else and really I don’t think that’s correct (Jenny, dietitian, Maternity hospital).

- **Different from usual health promotion.** Those interviewed enjoyed the fact that the play differed from normal health promotion in that it was visual and interactive and kept their attention. Many commented on the fact that it was better to watch the play than read a leaflet. Two students from Youthreach said that “I think it’s nicer to have it more as a sketch than having a leaflet. I think it grabs your attention more. “Yeah, you took more note of it. Whereas if it was on a piece of paper we probably wouldn’t even bother looking at it”.

Having watched the play some participants were much more communicative in the group discussions. This was particularly obvious in the Youthreach group where participants had been initially hesitant to talk but after seeing the play they spoke more openly and freely. This change was commented on by one of the tutors in the group and was in reference to a story that one of the students told about being in a maternity hospital a few days before and a woman in the unit wanting the father of another baby to wait outside while she breastfed her baby. The student had told the story in detail and had said that all the woman had to do was cover herself as nothing would be seen. Respondents in other groups discussed how they had talked to friends and family about the play, encouraging discussion about breastfeeding.

One of the young women in Youthreach, who in the first interview had been unsure as to whether she thought it was ok for a woman to breastfeed in public, had less of an issue with it having seen the play. In response to whether she would care if a woman was feeding in public she said “It wouldn’t bother me but I just wouldn’t do it meself like”. This would indicate a change in attitude but also shows that breastfeeding in public was not something that she would consider herself. This was the case with a lot of respondents. While the play certainly raised awareness and more tolerance towards breastfeeding it didn’t change people’s minds as to whether they would breastfeed themselves. Having seen the play, however, this woman did acknowledge that if she had wanted to breastfeed she could have gotten the support. She had not mentioned this in the first interview and it would indicate that the play had created an awareness that support is available and that it is only a matter of seeking it out:

Some of us have kids and we had the option but we just didn’t want to do it like. But we could have done it like and we could have got support but we just didn’t want to (Sharon, student, Youthreach).

It was felt by one respondent that the play made midwives more aware of how women are sometimes treated in hospital and how a little support can really help them:

They were discussing it and they could see as well, they felt they were portrayed very badly and stuff like, so that definitely did register with them, maybe God if I do have an extra two seconds just to help this woman […] (Paula, student nurse, Maternity hospital).

A lot of people felt that the play had raised awareness about breastfeeding and this was in regards to helping people be more accepting of it, being more prepared in the future if they ever had a baby themselves, knowing that the law protects a woman from discrimination if she is breastfeeding in public and also giving an awareness of various issues that breastfeeding women can experience.
People in all of the interviews made suggestions as to how the play could be used in the future. These included it being used in antenatal classes, shown to new mothers in hospital, shown to young people in school and used in the training of health professionals.

Discussion
This project was quite novel in so far as it aimed to get people discussing and debating breastfeeding through the use of drama. It also presented breastfeeding in many different guises and so did not only present the benefits of breastfeeding, but also presented the stories of real women who had experienced both breastfeeding and bottle feeding, hence drawing a more realistic picture that the audience could connect with and believe in. Because the play was presented in the form of forum theatre the audience had the opportunity to change scenes in the play and to discuss and debate the different issues that arose. This resulted in what has been described as the transformation of the audience from passive spectators to engaged spectators (Sullivan et al., 2008). This transformation is empowering because the audience takes control of what happens in the play and this in turn creates an awareness of issues and can also provide the opportunity for a “rehearsal for reality” as described by Boal (2004).

This play was performed in front of four diverse groups, and although each group was different from the other, each audience engaged well with the play and the concept of forum theatre. The response to the play was positive with nearly all of those that responded to the postcard survey saying that they enjoyed the play and agreeing that the play was a good way of discussing breastfeeding. The comments regarding what respondents felt was the main message of the play and were all related to social aspects of breastfeeding, such as challenging attitudes to breastfeeding and cultural norms and highlighting the obstacles that exist around breastfeeding. It is important that such social aspects of breastfeeding are recognised because the social environment has been acknowledged as an important target of a comprehensive policy for breastfeeding promotion (Department of Health and Children, 2005). Societal embarrassment and perceived social isolation have been identified as barriers to breastfeeding (Stewart-Knox et al., 2003). Greene et al. (2003) acknowledge how “breastfeeding is a social decision and not just a nutritional one”. A play such as Milk It! Much Ado about Nothing? can bring these social aspects to the fore and this allows for people to appreciate this aspect of breastfeeding and in turn become more accepting of it.

Studies have described the use of forum theatre being used in the promotion of nutrition-related topics. One such study by Neumark-Sztainer et al. (2009) looked at the effect of a theatre-based, after school program with obesity prevention messages and found that the intervention did help increase awareness of the need for behavioural change but did not result in actual behaviour change. This shows, as did the present study, that there is a potential for forum theatre in making people aware of a particular health-promoting activity but ultimately more is needed to make people actually change their behaviour. Ajzen’s Theory of Planned Behavior (Ajzen, 1991) states that a person’s behaviour is determined by their intention which in turn is determined by their attitude toward the specific behaviour, their subjective norms and their perceived behavioural control. The forum theatre Milk It! Much Ado about Nothing? improved people’s attitudes towards breastfeeding and also got people talking about breastfeeding, potentially improving their subjective norms. The use of forum theatre in health promotion could therefore result in actual behaviour change, if additional interventions were used.
Conclusions
The play achieved its aim of getting people discussing and debating breastfeeding and this was the case for all groups. Using forum theatre to promote breastfeeding is quite novel and as already mentioned, different to usual health promotion. People in this study discussed how they are tired of being given leaflets on different topics and so appreciated the originality of the play. It would seem, therefore, that there is potential for its use in various settings and on varied nutrition-related topics.

References
Department of Health and Children (2008), Perinatal Statistics Report, Health Research and Information Division, Economic and Social Research Institute, Dublin.


About the authors
Barbara Whelan (BSc (hons), MSc, APHNutr) graduated from National University of Ireland, Galway in 1998 with a BSc in Microbiology. While working for seven years in Japan and Spain, she gained a keen interest in nutrition and health and subsequently pursued an MSc in Public Health Nutrition at the University of Southampton, UK in 2005/2006. Following graduation from this course she began studying for a PhD in the School of Biological Sciences, Dublin Institute of Technology. Her PhD involves an investigation of the knowledge, attitudes and training needs of health professionals towards breastfeeding and interventions to increase awareness around breastfeeding. She hopes to complete her PhD in spring 2010. Her areas of interest include health education and the sociocultural, economic, political and ecological aspects of public health nutrition. Barbara Whelan is the corresponding author and can be contacted at: barbara.whelan@dit.ie

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Publications and presentations

Publications


Oral Presentations
Barriers to promoting and supporting breast-feeding amongst health professionals in North Dublin. *Irish Section of the Nutrition Society, Queens University Belfast, Northern Ireland, 17-19 June 2009*.

Unpublished reports
Whelan B & Kearney JM (2007) Knowledge, attitudes and training needs of health professionals in North Dublin toward breastfeeding. *Commissioned by the Health Promotion Unit, HSE Dublin Northeast*.

Whelan B & Kearney JM (2008) Barriers to breastfeeding and an analysis of training that health professionals would like: A qualitative study of the views of different health professional groups. *Commissioned by the Health Promotion Unit, HSE Dublin Northeast*.