

# **Confidence in Initiation of Breastfeeding**

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## Declaration

I declare that this thesis is entirely my own work and has been submitted only for the degree of PhD in the University of Stirling.

Margaret Ellenor Edwards

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Acknowledgements

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## Abstract

### Background

Breastfeeding confers health and social benefits on both mother and baby and is thus a key global public health priority, with exclusive breastfeeding for the first six months recommended. A variety of factors can influence a woman's decision to initiate breastfeeding but a short duration of breastfeeding appears to be common in developed countries. In the UK, promotion of breastfeeding has been government policy since 1974 and gradually the incidence has increased. In Scotland in 2010 the incidence was 74% but by one week 17% of women had given up. A minority of women find that their babies attach easily at birth and more than half report problems at this time. The prevalence of exclusive breastfeeding falls sharply in the first few weeks and the introduction of formula is associated with a shorter duration. It is therefore crucial to understand what happens at this time to enable women to continue breastfeeding effectively.

### Study Aim

To use Social Cognitive Theory (SCT) to explore and help explain the expectations, knowledge and experiences of women and midwives with regard to breastfeeding initiation.

### Methods

A systematic review of qualitative studies synthesised using thematic analysis and SCT was conducted and afforded insight into what had been known before and highlighted further aspects that needed to be explored with a qualitative study. The qualitative study was comprised of five focus groups with ten antenatal women, eight postnatal women and eighteen midwives. Photographs included in a leaflet "Feeding cues at birth", and the chart of "Feeding cues after the first few hours" were developed and used as focussing exercises during the focus groups and interviews. The focus groups and interviews were recorded, transcribed and analysed using a hybrid process of inductive and deductive thematic analysis which integrated data driven codes with theory driven codes based on SCT.

## Results

Twenty one studies were included in the systematic review and identified clear differences in the experiences of women when breastfeeding was going well as compared to when it was going wrong at the start. There were also differences in the midwives' knowledge, experience and confidence when breastfeeding was going well in contrast to when it was going wrong. The synthesis did not identify any qualitative studies relevant to initiation which explored skin contact, instinctive behaviour or strategies to resolve failure to attach in the first few days after birth, from the perspectives of mothers and midwives. These topics were therefore explored in detail in the qualitative study. Few mothers recruited to my study experienced instinctive behaviour and successful attachment (in SCT enactive behaviour) at birth. The majority of mothers did not experience attachment at birth and struggled to persist and maintain their motivation to enable breastfeeding initiation in an unfamiliar environment. Midwives' social expectations and environmental circumstances made women centred care difficult. Midwives considered that sleepy babies who were unable to feed were normal, but women were unprepared for this, compounding the difficulties in initiating breastfeeding. The triangulation of the findings from the systematic review and the qualitative study provide a more complete picture of contributory factors to understanding of difficulties in breastfeeding initiation.

## Conclusion

It is recognised that behaviour interacts with emotions, perceived abilities and the environment, as in triadic reciprocal causation, which affects peoples' decisions, experiences and abilities to enable the successful initiation of breastfeeding. Social Cognitive Theory could be used as a framework to develop strategies and materials to enhance women's confidence both antenatally and in the postnatal period. In a minority of women, breastfeeding goes well and is more likely when the baby is an active participant and the midwife a knowledgeable and confident supporter. This is not the case for the majority of women and babies or their midwives. There is a need to consider strategies to develop appropriate skills and environmental changes that would in turn lead to changes in behaviour and successful interventions. More emphasis should be made clinically on facilitating instinctive behaviour. The current position where babies' sleepy behaviour is considered normal in this particular environment could be challenged. Social Cognitive Theory could be utilised in

research to develop strategies to increase women's and midwives' confidence specifically in initiation.

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## **Chapter 1 Introduction and Overview of Thesis**

### **1.1 Introduction**

This thesis comprises of both a systematic review, and a qualitative study with data from two different population groups. As such, the thesis structure is more complex than many, and each chapter has specific aims and objectives. To enable easier navigation of the thesis, the outline below describes the aims and objectives of each of the chapters. This introductory chapter will provide a background to the study.

#### **1.1.1 The aims and objectives of each chapter of the study.**

### **Chapter 1**

The aim of the first chapter is to provide a background to the study rationale and development. Specifically it will:

1. describe the background to the study
2. define the aims and objectives for the study
3. justify the importance of this research
4. introduce the design of the study
5. provide my personal perspective on embarking on this research project
6. define boundaries for the research

### **Chapter 2**

The aim of the second chapter is to provide a broad overview of the literature in the topics relevant to the underpinning of the thesis in relation to what can be considered 'natural' initiation of breastfeeding and how this physiology can be affected by culture and medical intervention.

Objectives:

1. To outline the search strategy for this chapter.
2. To provide a brief history of infant feeding
3. To explain pre-feeding/instinctive behaviour of the baby at birth, skin to skin contact at birth and the rationale for this being offered to women.

4. To examine maternal physiology and behaviour and the differences in medical intervention.

### **Chapter 3**

The aim of the third chapter is to consider options for basing the data within a theoretical model relevant to breastfeeding.

#### **Objectives**

1. To explore the current background to health promotion in Scotland relevant to pregnancy and breastfeeding
2. To describe the theoretical models most often used in health promotion research
3. To argue which theoretical model would be suitable to explain women and midwives' behaviour in relation to initiation of breastfeeding.

### **Chapter 4**

The aim of the fourth chapter is to provide a background of the situation, current to the timing of the data collection, by synthesising qualitative studies examining what is known about women and midwives' expectations, knowledge and experiences of breastfeeding initiation.

#### **Objectives**

1. To carry out a search of relevant literature
2. To inductively analyse the data using thematic synthesis
3. To apply Social Cognitive Theory deductively to interpret the inductive themes

### **Chapter 5**

The aim of the fifth chapter is to explore the rationale for a qualitative design and describe the development of the methods that were utilised.

#### **Objectives**

1. To explain the ontological and epistemological stance of the research
2. To provide a rationale for a qualitative study and methods of data collection
3. To explain the methods used
4. To explain the hybrid process of inductive and deductive analysis used

## **Chapter 6**

The aim of the sixth chapter is to inductively analyse the women's results then to use Social Cognitive Theory deductively to explore and help explain the expectations, knowledge and experiences of women with regard to breastfeeding initiation.

### **Objectives**

1. To explore the expectations and knowledge of antenatal women of breastfeeding initiation.
2. To explore the expectations and knowledge and experiences of breastfeeding initiation in postnatal women.
3. To apply Social Cognitive Theory deductively to the results of inductive coding
4. To determine if the materials used to facilitate discussion in focus groups were found useful in understanding initiation.

## **Chapter 7**

The aim of the seventh chapter is to inductively analyse the midwives' results then to use Social Cognitive Theory to explore and help explain the expectations, knowledge and experiences of midwives with regard to breastfeeding initiation.

### **Objectives**

1. To explore the expectations, knowledge and the experiences of midwives around breastfeeding initiation.
2. To apply Social Cognitive Theory deductively to the results of inductive coding
3. To determine if the materials used to facilitate discussion in focus groups and interviews were found useful in understanding initiation.

## **Chapter 8**

The aim of chapter eight is to bring all the results together and discuss the findings in the light of the study objectives, which were:

1. To explore the expectations and knowledge of antenatal women of breastfeeding initiation.
2. To explore the expectations, knowledge and experiences of breastfeeding initiation in postnatal women and midwives.

3. To determine if the materials used to facilitate discussion in focus groups and interviews were useful for understanding initiation.
4. To evaluate the use of Social Cognitive Theory as a theoretical tool.

## 1.2 Background to thesis

The background will include the benefits of breastfeeding, clarification of the term initiation of breastfeeding, and an explanation of factors involved in women's intention and initiation of breastfeeding. Further information will include rates of breastfeeding and efforts to promote breastfeeding before explaining physiological aspects of breastfeeding. The chapter will continue with information about the study aims and rationale along with the theoretical framework to be used and the research design. The chapter concludes with a short section on my personal perspectives and the boundaries of the research.

### 1.2.1 The benefits of breastfeeding

Breastfeeding impacts on both infant and maternal health outcomes. The benefits of breastfeeding in developed countries were systematically reviewed by Ip et al. (2007) who found that breastfeeding is associated with a reduction in the risk to infants of acute otitis media, non-specific gastro enteritis, respiratory infections, atopic dermatitis, asthma, obesity, type 1 and 2 diabetes, childhood leukaemia, sudden infant death syndrome and necrotizing enterocolitis. For women, breastfeeding is associated with reduced risk of type 2 diabetes and breast and ovarian cancer (Ip et al. 2007). A review found the long term effects of breastfeeding on participants, that excluded infants, include lower blood pressure and cholesterol, less likelihood of obesity (controlled for socio-economic status), type 2 diabetes and a higher performance in intelligence tests (Horta et al. 2007).

The *duration* of exclusive breastfeeding is also important for a variety of infant health outcomes. For example, if exclusively breastfed for six months, research has found that children by two years of age are less likely to have had respiratory or ear infections than children who had been fed with formula or solids (Hetzner et al. 2009). The risk of sudden infant death is halved at one month with exclusive breastfeeding (Vennemann et al. 2009). Exclusive breastfeeding for the first 6 months enables babies to grow normally compared to WHO standards (World Health

Organization 2012; Nielsen et al. 2011). A high percentage of breastfeeds in the first year results in higher mental development at 14 months (Guxens et al. 2011). Children over six months with paediatric cancer are more likely to have been bottle fed than children who have been exclusively breastfed, the protective effect increased with the duration of full breastfeeding (Ortega-Garcia et al. 2008). Exclusive breastfeeding may also reduce the risk of cardiovascular disease in later life (Khan et al. 2009).

### **1.2.2 Defining 'Initiation' of breastfeeding**

This thesis has a focus on women and midwives expectations, knowledge and experience of the initiation of breastfeeding. It is important to understand and define the range of terms, (and associated measures of success), that are used in the literature and in policy documents. This section will provide an overview of relevant terms and will discuss which ones will be used in this thesis. The terms that are important are:

- Incidence of breastfeeding
- Prevalence of breastfeeding
- Duration of breastfeeding
- Initiation of breastfeeding.

The definitions for three of these terms (Incidence, Prevalence and Duration) are found in the *Infant Feeding Survey 2010* (Health and Social Care Information Centre 2012) and will be used in this thesis for clarity and continuity of concepts.

#### ***Incidence of breastfeeding***

"The Incidence of breastfeeding is defined as the proportion of babies who were breastfed initially. This includes all babies who were put to the breast at all, even if this was on one occasion only".

#### ***Prevalence of breastfeeding***

"Prevalence of breastfeeding is defined as the proportion of all babies who are being breastfed at specific ages, even if they are also receiving infant formula or solid food".

### *Duration of breastfeeding*

“The duration of breastfeeding refers to the length of time that mothers who breastfeed initially continue to breastfeed even if they are also giving their baby other milk and solid foods”.

### *Initiation of breastfeeding*

The definition of initiation of breastfeeding is central to this thesis, but also one which is defined differently by a range of researchers and guidelines. For example, (UNICEF 2011) defines it as “Initiation: That a breastfeed/breastmilk is given as the baby’s first feed”. This definition states that the baby may feed from the breast or is given breastmilk by some other means, for example, expressed breastmilk or by being fed by a wet nurse (World Health Organisation 2008). In comparison, the World Health Organisation defines “Breastfeeding Initiation” as: “Early initiation of breastfeeding: Proportion of children born in the last 24 months who were put to the breast within one hour of birth” (World Health Organisation 2008).

In contrast, in the EU Project on “Promotion of Breastfeeding in Europe” recommends that the status of breastfeeding at birth to be gathered within 48 hours, as the recall period of events at birth over a longer period of time may be more difficult to remember (Cattaneo 2008). In order to clarify what is meant by the term initiation and to focus on the scope required to achieve the aims of this research a brief literature search was carried out using the following methods:

Databases searched: Ovid MEDLINE(R) <1946 to January Week 1 2012>, Embase <1988 to 2012 Week 02>, MIDIRS: Maternity and Infant Care

Search Strategy:

(begin\* or start\* or initiat\* or commenc\*).

breastfeed\* or lactat\* or infant feed\*).

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Inclusion criteria; any study with these terms

Data extraction: 386 articles were screened to exclude interventions and 96 remained. These were screened to include in the title, determinants, factors associated and prevalence of initiation of breastfeeding where 30 remained and full articles were read for relevance. Only 5 articles stated their definition of initiation. See Table 1 below.

**Table 1 Definition of Initiation**

<b>Author</b>	<b>Definition of initiation by the study authors</b>
(Ahluwalia, Morrow, & Hsia 2005)	“Breastfeeding initiation was defined as starting to breastfeed in the early postpartum period.”
(Flower et al. 2008)	Initiation of any breastfeeding was defined by mother’s response to the following question: “Has (target child) ever been fed breast milk?”
(Hoddinott & Pill 1999a)	“Breastfeeding initiation was defined as having been put to the breast, even if only once”.
(Ingram et al. 2010)	“Breastfeeding initiation was defined as any attempt to breastfeed, even if only once”.
(Simard et al. 2005)	“Breastfeeding initiation was defined as the suckling of the breasts by the infant to secure its nutrition”.

The term “Initiation of breastfeeding” therefore has no clear agreement or standard definition arising from the literature examined but is different from “incidence” as defined previously, which could also equate to “starting to breastfeed” “ever been fed breastmilk”, “having been put to the breast even if only once”, “any attempt to breastfeed” or “suckling of the breasts by the infant to secure its nutrition”. Initiation of breastfeeding and incidence of breastfeeding seem to be used interchangeably and both have been referred to as the first feed. Breastfeeding needs to continue beyond the first feed therefore a more adequate definition will be sought.

Other literature which defines the process of initiation can contribute more effectively to the definition. Cadwell (2007) explains that the mother and baby learn to breastfeed in two stages. The first stage is when the baby placed skin to skin on the mother immediately after birth, crawls to the breast and attaches to the nipple using instinctive movements (Righard & Alade 1990). The second stage is where the mother and baby learn together how to manage attachment/latching together (Cadwell 2007). Zetterstrom (2003) summarises the importance of acknowledging the physiological aspects of establishing exclusive breastfeeding using the baby’s instinctive behaviour and the psychological and physiological benefits to the mother (Zetterstrom 2003).



In order to examine this process Matthews (1988) developed an instrument, the Infant Breastfeeding Assessment Tool (IBFAT), to assess the infant's breastfeeding behaviour and identified changes in breastfeeding competence over time. The components of breastfeeding behaviour measured were; readiness to feed, rooting, fixing and sucking/ latching on and were given a numerical value by the assessor of the breastfeeding behaviour. The results demonstrated that most babies had lower scores for breastfeeding behaviour in the hours immediately after birth but scored in the effective feeding range of 10-12 points within the first 36-48 hours (Matthews 1988). Using tools to measure how well the baby is feeding is a strategy that may be helpful as it illustrates that it takes time, for the mother and baby to learn how to manage together how to feed (Cadwell 2007).

Initiation of breastfeeding could be seen as a process that starts at birth where the baby initiates the process then both baby and mother learn how to breastfeed over time.

Therefore the term "initiation of breastfeeding" might be best defined as:

"A process that starts at birth and continues until successful latching at the breast is learned by mother and baby, which may take 48 hours or more to achieve".

This is the definition that will be used throughout the thesis, unless stated otherwise.

### **1.2.3 Intention and initiation of breastfeeding**

Whether a woman intends to breastfeed and if she initiates breastfeeding are important considerations in subsequent feeding practices. A variety of factors can influence a woman's ability to consider initiating breastfeeding and carrying out her intention. Dyson et al. (2006) produced an "Effective action briefing on the initiation and duration of breastfeeding" where a number of factors were highlighted. These factors range from politics, psychosocial aspects, culture and demographics. Factors can be interrelated and can be classified as international, national or individual. International and national factors include that the WHO code on Marketing of Breastmilk Substitutes is not adequately implemented (World Health Organization 1981), and the media portrayal of artificial feeding as a norm. National factors include

inadequate education on breastfeeding for health professionals and young people in schools. Individual factors include the age of the mother (younger), lower educational achievement and lower socio –economic status, where breastfeeding rates are lower. Factors that can also have an influence on the decision to breastfeed include; lack of breastfeeding knowledge in the community, attitudes in society, in particular the attitudes of family and friends and whether the mother was herself breastfed (Dyson et al. 2006). Having been breastfed as an infant and having a supportive partner is a significant influence on adolescents' intention to breastfeed (Mossman et al. 2008). Health benefits and encouragement from own mother and partner are the most common influence on intention (Brodribb, Fallon, & Hegney 2007) and seeing a relative or friend successfully breastfeeding has a positive influence on intention (Hoddinott & Pill 1999b; Barona-Vilar, Escriba-Aguir, & Ferrero-Gandia 2009).

#### **1.2.4 Rates of Breastfeeding**

##### **1.2.4.1 Incidence**

Breastfeeding rates vary around the world and in the developing world only 36% of 0-5 month old are exclusively breastfed (UNICEF 2012). Rates vary widely but in general there has been an increase in the incidence of breastfeeding in the last 40 years. This thesis will focus on the context (and rates) most similar to Scotland in the developed world. From 1971 to 1984 breastfeeding initiation at birth rose in the US from 21% to 60% and in 2001 nearly 70% initiated breastfeeding (Foss & Southwell 2006). Later figures in the US indicate the initiation of breastfeeding rose from 74.6% in 2008 to 76.9% in 2009 (Department of Health and Human Services Centres for Disease Control and Prevention 2012). The data for Europe and many industrialized countries are not currently available from UNICEF but data for Sweden are available where “ever breastfed” rates are 98% (World Health Organization 2012). In the UK the incidence of breastfeeding in 2010 was 81% which was an increase in the UK incidence from 76% in 2005. By one week 14% had stopped breastfeeding (Health and Social Care Information Centre 2012).

##### **1.2.4.2 Incidence in Scotland**

In Scotland two sources of data on incidence of breastfeeding are available; one from the Infant Feeding Survey 2010 and the other from the first visit from the public

health nurse/health visitor visits at 10 days old. The incidence of breastfeeding in Scotland in the Infant Feeding Survey in 2010 was 74% an increase from 70% in 2005. By one week 17% of women in 2010 had given up breastfeeding in Scotland (Health and Social Care Information Centre 2012) which was less than in 2005 where by one week 19% had given up (Bolling et al. 2007). However the latest statistics available for breastfeeding in Scotland is for breastfeeding at 10 days old, when the public health nurse/health visitor visits the home for the first time. These data were first published in 2011 by the Information Services Division of the NHS in Scotland (ISD). In 2011/12, a total of 47.0% of babies were breastfed at 10 days a slight increase from 46.8% in 2010/11. This percentage included 35.9% of babies who were exclusively breastfed (a decrease in exclusive breastfeeding from 36.3% in 2010/11) and 11.1% who were fed both breast milk and formula milk (an increase in formula milk from 10.5% in 2010/11) (Information Services Division 2012).

Comparing the Infant Feeding Survey 2010, results with the ISD rates (Table 2) illustrates that 74% of women in Scotland started to breastfeed in 2010 according to The Infant Feeding Survey 2010 (Health and Social Care Information Centre 2012) and in Scotland, by 10 days in 2010/11 this is down to 46.8% with only 36.3% still exclusively breastfeeding (Information Services Division 2012). Despite the difficulty with making a direct comparison with two different data sets, the data gathered by the ISD in 2012 reflect that the question about feeding method was asked directly to each mother by a public health nurse/health visitor at 10 days which may afford accurate recording. The Infant Feeding Survey 2010 was a postal questionnaire which asked for recall of events in the first week, from an unclustered sample, when the baby is six weeks old and had a 51% response rate for the first stage. This may therefore be less accurate than data collected closer to the event. Although slightly more women were recorded as breastfeeding at 10 days in 2011/12 in Scotland, fewer women were exclusively breastfeeding (Information Services Division 2012). This was a disappointing trend and the reasons need to be explored.

**Table 2 Comparison of breastfeeding data**

	<b>2005</b>	<b>2010</b>	<b>2011/12</b>
<b>Incidence of breastfeeding in</b>	70%	74%	

<b>Scotland</b>	(Bolling et al. 2007)	(HSCIC 2012)	
<b>% given up at one week /still breastfeeding</b>	19%/51% (Bolling et al. 2007)	17%/57% (HSCIC 2012)	
<b>Breastfeeding at 10 days in Scotland (ISD)</b>		46.8% <b>(ISD)</b>	47.0% <b>(ISD)</b>
<b>Exclusive breastfeeding at 10 days in Scotland (ISD)</b>		36.3% <b>(ISD)</b>	35.9% <b>(ISD)</b>
<b>Fed both breastmilk and formula at 10 days in Scotland (ISD)</b>		10.5% <b>(ISD)</b>	11.1% <b>(ISD)</b>

(Comparison of Incidence of breastfeeding at birth and one week figures with 10 day figures)

#### **1.2.4.3 Duration**

A short duration of breastfeeding appears to be common in developed countries. One in five women (20%) stops breastfeeding in the first few days after delivery in America (Wilhelm et al. 2008). In Denmark a study reported that 51% of the women who stopped during the study, stopped in the first five weeks (Kronborg & Vaeth 2004). In countries such as Norway with a high prevalence of breastfeeding, at one month 96.6% of babies were breastfed but full breastfeeding (as defined by WHO exclusive and predominant breastfeeding) was 84.6%. The risk of stopping full breastfeeding was associated with supplementation with water, sugar water or formula, caesarean section and breastfeeding problems in the first week (Haggkvist et al. 2010). In Sweden at three months 78.4% were being exclusively breastfed where there were a number of risk factors for short term exclusive breastfeeding of less than four months, including maternal BMI >30, smoking, being a single parent, (Huus et al. 2008).

Although there are a number of reasons given for a short duration of breastfeeding in the UK, 80% of mothers who stopped in the first week and 85% who stopped between the first and second week would have liked to have breastfed for longer (Health and Social Care Information Centre 2012). At one week the most common reason for giving up breastfeeding (33% in 2010) was that the baby would not suck

or rejected the breast. Pain was cited as a reason for 22% of women giving up in 2010 (Health and Social Care Information Centre 2012).

Lower self-efficacy predicted early stopping of breastfeeding and making feeding decisions after becoming pregnant was also a reason for short duration (O'Brien & Fallon 2005). However 60% of the mothers in the 2005 Infant Feeding Survey, who had problems breastfeeding in hospital in the UK, said that the baby would not latch/attach to the breast (Bolling et al. 2007), this was virtually unchanged in 2010 where 59% of babies being breastfed failed to latch (Health and Social Care Information Centre 2012). Although not all women give up, 60% having such problems may contribute to the reduction in breastfeeding in the first week. It was necessary to examine the context of the first breastfeed in order to understand the problems that can arise.

### **1.2.5 Efforts to promote initiation and duration of breastfeeding**

#### ***1.2.5.1 Global promotion and protection***

The World Health Organisation (World Health Organization 1981) published a guide to the practice of marketing of breastmilk substitutes. This was in response to the implication that marketing practices were involved in the decline in world-wide breastfeeding rates. The World Health Assembly was urged to introduce codes and legislation to limit the promotion of breastmilk substitutes in each member country. In 1992 The World Health Organisation set up The Baby Friendly Initiative to promote and implement the Ten Steps to Successful Breastfeeding and to practise in accordance with the International Code of Marketing of Breastmilk Substitutes.

Healthcare settings are encouraged to adopt best practice standards and are assessed in order to achieve the Baby Friendly award which demonstrates adherence to evidence based practice in promoting and supporting breastfeeding (UNICEF UK Baby Friendly 2013). The World Health Organisation set out recommendations for a Global Strategy on Infant and Young Child Feeding in 2002 and this recommends that babies should be exclusively breastfed for the first six months with breastfeeding continuing along with weaning until the baby is two years old or as long as the mother wants to continue breastfeeding (World Health Organization 2012).

### ***1.2.5.2 United Kingdom (UK) Promotion of Breastfeeding***

In the UK, promotion of breastfeeding has been government policy since the report from a Working Party set up to examine how infants were fed in 1974. The report from the Committee on Medical Aspects of Food and Nutrition Policy (1974) advised that breastfeeding until at least four months of age should be encouraged (now six months is the target). Since 1975 an Infant Feeding Survey has been conducted every five years in England and Wales with Scotland being included since 1980 and Northern Ireland since 1990. Now separate information is available for all four countries in the UK (Health and Social Care Information Centre 2012).

For three years between 1999 and 2002, UK government funding was provided to different projects with the aim of increasing initiation and duration of breastfeeding. The National Institute for Health and Clinical Excellence (NICE) in 2008 (updated in 2011) (National Institute for Health and Clinical Excellence 2011) recommended encouraging and supporting breastfeeding using the UNICEF Baby Friendly programme as a minimum standard in the NHS. A number of policy and practice developments have also been introduced which included “The Healthy Start” scheme, introduced in 2006, which provides food vouchers and vitamin supplements for all low income women (Health and Social Care Information Centre 2012).

A UK national breastfeeding awareness week has been held annually from 1993 and various Department of Health policy initiatives are in place to encourage normalisation of breastfeeding in all sections of society (Fyle, Baum, & Entwistle 2009).

### ***1.2.5.3 Scottish Promotion and Protection of Breastfeeding***

The Scottish Government has taken a variety of approaches to breastfeeding promotion. There has been much effort expended in promoting breastfeeding to the public, with public health campaigns and in Scotland TV adverts and a free DVD about breastfeeding given to all mothers attending for antenatal care. The NHS in Scotland has also funded education for health service staff where 78.81% of births take place in a Baby Friendly Hospitals (UNICEF UK Baby Friendly 2012a). The Scottish Breastfeeding Bill (giving mothers the right to breastfeed in public) became law in March 2005 (The Scottish Government 2005).

This promotion has followed developments that have been in progress since 1990 when the “Scottish Joint Breastfeeding Initiative” was set up to encourage cooperation between the health sector and voluntary groups to promote breastfeeding. A National Breastfeeding Advisor was appointed in Scotland in 1995 until 2005 and along with the Scottish Breastfeeding Group, developed policy and promoted best practice. Similar developments took place later in the rest of the UK (Scientific Advisory Committee on Nutrition 2008). The importance of breastfeeding to infant and maternal health is highlighted in Scottish government policy documents that encourage support for breastfeeding. The Scottish Government set out a strategy in 2008 for health promotion to be emphasised in all acute care settings and specifically relevant here, that all maternity units should adopt the Baby Friendly (BFI) award scheme (Public Health and Wellbeing Directorate 2008). Most hospitals in Scotland are working towards or have achieved full BFI accreditation, where they are shown to have adopted internationally recognised standards of best practice for breastfeeding in the care of mothers and babies. These efforts could have contributed in Scotland to the incidence of breastfeeding (defined by the Health and Social Care Information Centre 2012), as the proportion of babies who were breastfed initially, including babies who were offered the breast only once) rising from 63% in 2000 to 74% in 2010 (Health and Social Care Information Centre 2012). UNICEF’s Baby Friendly Initiative UK (BFI) has been shown to increase breastfeeding initiation in accredited hospitals in the UK (Bartington et al. 2006). Del Bono and Rabe (2012) found that in the UK in BF Initiative participating hospitals, women were up to 15 percentage points more likely to initiate breastfeeding at birth and between 8 and 9 percentage points more likely to breastfeed exclusively at 4 and 8 weeks than similar women who gave birth in non-participating hospitals (Del Bono & Rabe 2012).

The Refreshed Framework for Maternity Services (The Maternity Services Action Group: The Scottish Government 2011) aims to promote the role of the NHS in helping to improve the maternal and child health outcomes in Scotland. There are a number of principles to be upheld in providing care and are documented as Service Descriptors. The Service Descriptors detail in relation to antenatal care, that Maternity staff promote health and wellbeing of women (Service Descriptor 4).

Among health issues that are prioritised for service improvement (Service Descriptor 13), are promotion of breastfeeding and that maternity units work towards UNICEF accreditation is detailed (UNICEF UK Baby Friendly 2013b). The policy of the Scottish Government has changed from a direct focus on breastfeeding to promoting health and wellbeing in the whole population of Scotland. The policy document, Improving Maternal and Infant Nutrition: A Framework for Action 2011 encourages the improvement of nutrition of pregnant women as well as nutrition of children to ensure improved health outcomes for children and to reduce health inequalities. The government is taking a more long term and broader view than focusing on breastfeeding alone (The Scottish Government 2011a).

Although repeated targets to encourage an increase in the initiation and duration of breastfeeding have been set in Scotland, they have been continually revised downwards. In 1994 a Scottish national target was set for at least 50% of mothers to be still breastfeeding their babies at six weeks of life by the year 2005 (The Scottish Government 2006). This target was missed with a prevalence of breastfeeding of 44% at six weeks for Scottish mothers in 2005 (Bolling et al. 2007) however there was an increase in prevalence to 50% in 2010 (Health and Social Care Information Centre 2012).

In order to action the latest strategy, HEAT targets were set in relation to maternity care. (HEAT is an acronym for: **H**ealth Improvement for the people of Scotland, **E**fficiency and Governance Improvements, **A**ccess to Services, **T**reatment Appropriate to Individuals and reflects the purposes of the Scottish Government and the NHS Scotland's quality ambitions) (The Scottish Government 2011b). The latest HEAT target is for at least 80% of women to have booked for antenatal care by the 12<sup>th</sup> week of pregnancy by March 2015 in order to ensure improvement in breastfeeding rates and other health behaviours (The Scottish Government 2012a). The HEAT target for breastfeeding in Scotland for 2010/11 was for exclusive breastfeeding and that 33.3% of babies would still be exclusively breastfed at 6-8 weeks in 2010/11 (The Scottish Government 2011b). However the Scottish statistics for 2010/11 suggest that this target has not yet been reached with the rates at 26.5% of babies being exclusively breastfed at the 6-8 week review in 2010/11. In the data for 2011/12 there was a slight decrease in the exclusive breastfeeding rate at the 6-8



week review to 26.2% (Information Services Division 2012). The reasons for this are not clear and in the absence of research to suggest why the breastfeeding targets have not been reached, it may be suggested to be due to difficulties in facilitating change in behaviour and cultural factors. The UNICEF policies have been adopted and there is a focus in hospital on events at birth.

#### **1.2.6 Pre-feeding/instinctive behaviour and Skin to Skin Contact**

When a baby is born in hospital or a facility that has, or is working toward, the Baby Friendly award, the baby should be placed onto the mother's abdomen where it is held next to her skin with a covering over both the mother and baby to maintain warmth for the baby and privacy for the mother. This is encouraged in Step 4 of the Baby Friendly Standards and current recommendation is that the baby should be held by the mother skin to skin until the baby starts to breastfeed (UNICEF UK Baby Friendly 2012c). During initiation of breastfeeding, skin contact is considered to be the biological norm that has evolved in humans as a species and the interaction between mother and baby during this time after birth increases both their wellbeing (Porter 2004). The baby displays pre-feeding/instinctive behaviours, (which comprises of a sequence of movements made by the baby immediately prior to initiating breastfeeding) and has an optimum adjustment to extra uterine life if held in skin contact with the mother. The placenta may be expelled naturally by the movement of the baby's legs against the abdomen (Varendi, Porter, & Winberg 1996) as well as his/her hand movements on the nipple which result in an increase in oxytocin levels in the mother (Matthiesen et al. 2001). This hormone as well as stimulating uterine contractions is suggested to be related to maternal bonding behaviour (Porter 2004).

Babies are more likely to have a successful first breastfeed with skin contact (Carfoot, Williamson, & Dickson 2005; Moore, Anderson, & Bergman 2008). The longer the skin contact in the first few hours after birth the more likely it is that the baby is exclusively breast fed while in hospital (Bramson et al. 2010; Marin Gabriel et al. 2010). The duration of exclusive breastfeeding was significantly increased with skin contact which lasted longer than 20 minutes compared to no contact (Mikiel-Kostyra, Mazur, & Boltruszko 2002).

A number of factors can disturb pre-feeding/instinctive behaviour, including narcotic and epidural analgesia (Matthews 1989; Righard & Alade 1990; Nissen et al. 1995; Nissen et al. 1997; Crowell, Hill, & Humenick 1994; Rajan 1994; Beilin et al. 2005; Volmanen, Valanne, & Alahuhta 2004), separation from the mother (Righard & Alade 1990; Crowell, Hill, & Humenick 1994) and medical practices around the birth (Dewey et al. 2003; Rowe-Murray & Fisher 2002; Zanardo et al. 2010).

Pre-feeding/instinctive behaviours are subtle behaviours and understanding the importance of this behaviour may be difficult for busy staff and new mothers. The mothers have not usually been present at births other than their own and have not watched how babies can behave instinctively at birth when placed on their mother's abdomen or chest. Recognising that the baby may not attach so readily because pre-feeding/instinctive behaviour during skin to skin has been interrupted, for example, because of the effect of drugs, the type of birth or care practices, may not be understood and may contribute to 60% of women having problems where the baby will not latch/attach to the breast (Bolling et al. 2007).

The expectations and knowledge women have about pre-feeding/instinctive behaviours and the initial latch/attachment the baby has to achieve to initiate breastfeeding after birth and the circumstances that may surround this can perhaps be explained.

### **1.3 Study aims**

I wanted to explore women's experience of initiating breastfeeding in a BFI hospital and midwives experiences of supporting them. I was also interested in finding ways to help women have an improved experience at their first attempt to feed their babies. The expectations knowledge and experiences of women and midwives toward pre-feeding/instinctive behaviour of the baby during skin to skin contact after the birth and initiation of breastfeeding have not been adequately researched, these therefore require further exploration.

The aim of the study was to use Social Cognitive Theory to explore and help explain the expectations, knowledge and experiences of women and midwives with regard to breastfeeding initiation.

### **1.3.1 Objectives**

1. To explore the expectations and knowledge of antenatal women of breastfeeding initiation.
2. To explore the expectations, knowledge and the experiences of breastfeeding initiation in postnatal women.
3. To explore the expectations, knowledge and the experiences of midwives around breastfeeding initiation.
4. To determine if the materials used to facilitate discussion in focus groups and interviews were found useful in understanding initiation.

### **1.3.2 Purpose and rationale for the study**

The incidence of breastfeeding in Scotland in 2010 was 74% (including babies who were offered the breast only once) (Health and Social Care Information Centre 2012) and by 10 days only 36.3%, just over half who tried to initiate breastfeeding, were still exclusively breastfeeding (Information Services Division 2012). Since 60% of postnatal women have difficulty in initiating breastfeeding, in particular the very first latch/attachment (Bolling et al. 2007), it is very important to explore the phenomenon around women who have initiated or will be initiating breastfeeding (and those of their main professional supporters) to understand the issue and identify potential solutions. Without understanding the phenomenon, it is unlikely that new interventions or initiatives will significantly increase the number of women who successfully initiate and carry on breastfeeding.

### **1.3.3. Social Cognitive Theory**

Social Cognitive Theory (SCT) was chosen as the theoretical framework for the thesis. Social Cognitive Theory proposes that people act within a concept of “Triadic Reciprocal Causation” (Bandura 1986) where the two core constructs are Perceived Self-Efficacy and Outcome Expectancies (Luszczynska & Schwarzer 2005).

The concept of self-efficacy (SE) attempts to explain how confident a person feels and what they believe about their ability to perform a specific skill in a particular situation (Blyth et al. 2002). Perceived self-efficacy determines how much effort a person will exert in a specific skill/behaviour and how long they will persevere in the face of obstacles. So when faced with difficulties people with self-doubt about their capabilities will reduce their efforts or stop trying (Bandura 1977).

Social cognitive theory will be applied to the experiences around initiation of breastfeeding. A fuller exploration of SCT and breastfeeding will be presented in Chapter 3.

#### **1.4 Importance of research**

The specific area of pre-feeding/instinctive behaviour during skin to skin, the first latch and attempts to achieve initiation of breastfeeding in the first few days is an important area to research. If the specific phases of behaviour of the baby and the corresponding behaviour of the mother and midwife are not understood then it is unlikely that the HEAT targets will be met or self-efficacy of mother and midwife will be raised. Consideration of this area may further the ability to develop interventions to increase breastfeeding duration.

#### **1.5 Introduction to the design of the study**

Deciding on the best way to explore the issues around how women initiate breastfeeding and how midwives support them involved examination of the possibilities for research which are described in the following sections.

##### **1.5.1 Choice of research design**

An exploration of the philosophy and principles of research is required in order to choose the most appropriate design for this stage (qualitative or quantitative) and this will be discussed in Chapter 5. In brief, social research can be conducted using the paradigm of positivism but this was not chosen for this research. Methods are based on using direct observation and are perceived to be objective and unbiased. However positivism in social research is often associated with beliefs that only that which is observable can be classed as knowledge which is developed deductively by collecting facts. Also that, hypotheses are deduced from scientific theories and are tested scientifically (Ritchie & Lewis 2003).

The method chosen for the primary research was qualitative. The characteristics associated with qualitative research are naturalistic and interpretive, distinguished by the need to explore peoples' accounts of social life in order to understand the meanings people give for example to their actions, decisions or beliefs (Holloway 2005; Ritchie & Lewis 2003). The aims of this research focus on the expectations, knowledge and experiences of women and midwives. Key elements of qualitative

research includes having aims that interpret an in-depth understanding of the social world of the participants, using purposively selected small samples to collect data interactively to provide rich detailed and extensive data (Pope & Mays 2006; Holloway 2005) . The analysis provides detail and is able to undergo classification of text data which have retained the original characteristics of the participants (Ritchie & Lewis 2003). In health research qualitative research can be used to explore behaviour and choices and to try to understand how people choose certain behaviours and how behaviour might change in the context in which it happens, which were the aims of this research.

Considering the aims of this current research, there are many different theoretical perspectives but a pragmatic consideration of the research question informed the choice of method rather than a theoretical perspective of methodology (Pope & Mays 2006; Patton 2002). The data collection method chosen to investigate the objectives related to the women was focus groups which are group discussions that use the interaction between group participants to generate data (Kitzinger 2005).

The same stance was taken for midwives with regard to theory and the data collection method chosen was that of interviews. The data collected from an interview are a result of the interaction between the researcher and participant (Seale et al. 2008). Initial work done to prepare for the study indicated that gathering a group of midwives to attend focus groups would be problematic considering the 24 hour nature of their profession. In the proposed study, midwives have had experience and education in relation to pre-feeding behaviour in neonates and of offering skin to skin but what this means to them and what the experience might be like is not known. Basing the questions on the knowledge the midwife has gained should provide an insightful study into these aspects.

## **1.6. Personal perspectives**

As a Teaching Fellow in a University department where student midwives studied on a 3 year programme, I was responsible for the breastfeeding content of their studies. The theory content of my teaching was evidence based and supported the Baby Friendly Initiative guidance. The clinical practice for the students, of supporting mothers to breastfeed their babies, was a collaborative venture with the midwives in the clinical area. I endeavoured to work in the clinical area with mothers and students

at least once a week. In clinical practice I found women in the postnatal ward who were trying to initiate breastfeeding but were having some difficulty and a number of babies who had not attached to the breast at birth and still had not attached in the postnatal ward. This was supported by (Bolling et al. 2007) as stated previously that in hospital 60% of breastfeeding mothers, who had problems breastfeeding, the baby would not latch/attach to the breast (Bolling et al. 2007). Women were upset that their babies were not attaching, they seemed to be helpless and awkward in the way they held their babies. The women seemed to want the midwives to attach the babies but the babies either attached and sucked a few times and came off the breast or did not attach and were sleepy or screamed when the midwife attempted to get them to attach. The women were then required to hand express their breastmilk and give this to their baby as a strategy to tide the baby over until s/he started breastfeeding. Some women just gave up and gave formula. The midwives were flustered and frustrated at times and were always grateful for help with these women.

The BFI guidelines were clear that babies should be held skin to skin after birth for (at that time) at least 30 minutes to encourage the baby to attach to the breast. This did not happen as the babies were still not attaching in the postnatal ward, neither were they usually being held skin to skin.

The problem of the babies not attaching was apparent. The expectations of women before they had their babies and their experience in the labour ward and subsequently in the postnatal ward could be explored in order to help improve their experiences. I was motivated to research what could be done to help the mothers and the midwives who were trying to support them. I was not practising midwifery in the clinical area on a daily basis and continuously witnessing the mothers' and midwives' frustrations and it was difficult to understand the exact problems. I thought that running focus groups with women would help me understand the situation from their perspective. As a midwife and mother who had successful personal experience of breastfeeding I was keen to find out how others viewed the experience of initiating breastfeeding. I considered my experience as a midwife and teacher would equip me to carry out the data collection in an empathetic but unbiased way. Due to the connections with the midwives in the students' practice area and in an effort to

reduce bias the research presented in this thesis was conducted in a different clinical area.

### **1.7 Boundaries to the research**

Exploring the expectations, knowledge and experiences of women and midwives with regard to breastfeeding initiation will be the focus of this research. This will include antenatal women, postnatal women and midwives in all areas of practice.

The situation where the baby does not latch to the breast can continue for an indefinite period of time but this research will be limited to the first week.

### **1.8 Summary**

Although there are acknowledged benefits of breastfeeding and in Scotland 74% of babies are offered the breast initially, a large proportion of women in the UK find that their babies will not attach to the breast after birth. This is the most common reason cited for women in the UK to give up breastfeeding by one week. Efforts are made to encourage breastfeeding at birth and support for breastfeeding is enshrined in policy and practice. A qualitative research project has been designed to explore the expectations, knowledge and experiences of women and midwives with regard to breastfeeding initiation, with a focus on skin to skin contact and using Social Cognitive Theory to illuminate and explain the problems. Prior to this a systematic synthesis of the qualitative literature was undertaken to inform the study questions and the analysis.

## Chapter 2 Background

### 2.1 Introduction

Chapter 1 contained a brief explanation of initiation of breastfeeding and that there are specific behaviours that babies can display while held skin to skin which then progress to attachment to the breast. This review will explore a number of aspects relevant to the study.

The aim of the second chapter is to provide a broad overview of the literature in the topics relevant to the underpinning of the thesis in relation to what can be considered “natural” initiation of breastfeeding and how this physiology can be affected by culture and medical intervention.

#### Objectives

1. To outline the search strategy for this chapter.
2. To provide a brief history of infant feeding.
3. To explain pre-feeding/instinctive behaviour of the baby at birth, skin to skin contact at birth and the rationale for this being offered to women.
4. To examine maternal physiology, behaviour and the differences as a result of medical intervention.

### 2.2 Search Strategy and Terminology

A number of searches were carried out using databases Medline, CINAHL, Maternity and Infant Care.

Terms used were:

Anthropology and breastfeeding

Latching and breastfeeding

Breastfeeding and oxytocin

Oxytocin and bonding

Skin to skin and breastfeed\*

Skin to skin and duration

Skin to skin and infant newborn and breastfeeding



References were followed up from a number of reference lists in articles obtained and database alerts on the topics of interest.

## **2.3 History of infant feeding**

### **2.3.1 Ancient History**

In a study of infant feeding and weaning practices in Roman Egypt (Dupras, Schwarcz, & Fairgrieve 2001), documentary history is traced back to the Pharaonic period, 2686 BC until 332 BC, and it would appear that babies were breastfed then until they were about 3 years old. Supplementary food was introduced such as animal milk and eggs when the baby was several months old. If the mother was unable to feed, presumably because of morbidity or mortality, then a wet nurse could be involved or the baby would be fed animal milk from sheep, goats or cows via a feeding vessel. From the Ptolemaic period, 332 until 27 BC babies were breastfed for 6 months then they were given cows' milk for another 18 months and wet nurses were still being used. The Romans were then in power from 30BC until AD 395 and documents by Soranus and Galen describe infant feeding as breastfeeding until 6 months then gradual weaning with honey and goats milk until 3 years of age (Dupras, Schwarcz, & Fairgrieve 2001). Dupras et al. (2001) used nitrogen and carbon isotope data to study weaning in the Roman period from the skeletons of infants found in a cemetery used about 250 AD along with the documentary evidence from around that time. Dupras et al. confirmed that when the babies died they had been given supplementary food at about 6 months or before and continued breastfeeding until about 3 years. The supplement of goat's milk could have caused megaloblastic anaemia due to the lack of folate and the supplement of honey which can contain *Clostridium botulinum* may have resulted in the fatal infection botulism. The study confirms that weaning was similar in the area at that time described by Galen and Soranus. The authors note that these infant died when they were very young so were maybe not as typical as babies who survived to reach maturity (Dupras, Schwarcz, & Fairgrieve 2001).

### **2.3.2 Early Modern History**

In England in the 17<sup>th</sup> century wet nurses were used as a traditional way of feeding babies. The wet nurse could be a poor woman who fed local babies for an income or if she nursed babies from the Foundling Hospital in London she would be overseen

by inspectors. Some women were privately employed and paid a good income. This sort of employment seems to have increased and declined according to the needs of poor women to have some sort of income and the cultural practices of different sections of society, where for example wealthier men wanted their wives to themselves so would employ a wet nurse. By the mid 19<sup>th</sup> century 80-90% of bottle fed babies died and a third of children under 5 died, which is ascribed to be an improvement because of an increase in breastfeeding in the middle classes at that time (Minchin 1989). Later in the 19<sup>th</sup> century doctors started to devise formulas, then chemists, and one Henri Nestlé started advertising his “scientifically correct” formula (Lawrence 1999).

### 2.3.3 20<sup>th</sup> Century

Sexualisation of the breast and feminism, have played a part in the reduction in breastfeeding rates in the 20<sup>th</sup> century (Haslam, Lawrence, & Haefeli 2003; Henderson, Kitzinger, & Green 2000). Thulier (2009) suggests that bottle feeding typified women’s emancipation in the 1920s and that gradually women saw breastfeeding as being old fashioned. Women took part in the war effort in World War 2 and formula was then seen as acceptable and necessary. After the war, paediatricians such as Dr Spock agreed that breast was best but devised so many rules and restrictions for breastfeeding that breastfeeding became very difficult and babies failed to thrive. Dr Spock seems to have had such an important standing that when breastfeeding failed he then approved of and promoted formula feeding thus actually undermining breastfeeding (Thulier 2009).

### 2.3.4 Effects of Advertising

Advertising and the media have influenced the choices women make in feeding their babies since the 1950’s by telling them about new formula products and associating the idea with motherhood, encouraging women to think they needed that product to be a good modern mother (Foss & Southwell 2006). News reports of breastfeeding were and still are often alarming and problem based (Foss & Southwell 2006). Foss and Southwell (2006) examined the relationship between the content of printed media on infant feeding and breastfeeding. A content analysis, of Parent’s Magazine over the thirty years for which data were available, was carried out. The results found that when the number of adverts for food alternatives such as cereal, solid food or infant formula increased, breastfeeding rates fell. The influence of the media on

infant feeding decisions is therefore suggested to affect breastfeeding rates in the US (Foss & Southwell 2006).

### **2.3.5 Cultural Representation**

A study on how breast and bottle feeding are represented culturally was carried out to find out how the media represent infant feeding and how this might influence women's choices (Henderson, Kitzinger, & Green 2000). The month of March 1999 was identified as the time frame to analyse the representation of breast and bottle feeding in the press and television. There was one scene on television showing breastfeeding as compared to 170 scenes showing the preparation of formula or bottle feeding (Henderson, Kitzinger, & Green 2000). In the press breastfeeding was mostly related to problems but there were three positive descriptions that related to work where the woman had such favourable working conditions that allowed her freedom to breastfeed. Only one mention of the risks of bottle feeding was made during the analysis of television and one during the analysis of the press. No clear reference to the benefits of breastfeeding was made in either. The implication from the media was that breastfeeding was associated with middle class and celebrity women and suggested problems and embarrassment. Bottle feeding was thought of as less problematic, has a high visibility and has been normalised in most sections of UK society (Henderson, Kitzinger, & Green 2000).

### **2.3.6 Summary**

Babies have been breastfed since history began. Supplements were introduced when necessary with sometimes fatal results in Roman times. In the more recent 17<sup>th</sup> century and continuing till the 19<sup>th</sup> century wet nurses were employed or babies could be bottle fed if their mother was not available or willing to breastfeed. There was a high mortality rate when babies were bottle fed. Breastfeeding was even less popular as feminism and women's rights became established. Formula milk was refined and promoted as an easier option and has become normalised in the UK. Despite the scientific clarity of the benefits of breastfeeding cultural issues have a place in reducing the numbers of babies being breastfed in the world today.

## 2.4 Skin to skin and Pre-feeding/instinctive behaviour

### 2.4.1 Mammalian behaviour

To understand how a baby learns to breastfeed at birth and how the mother learns to help her infant feed, exploring research about how other mammals behave may be useful. Alberts (1994) explains that learning is an embodied part of an infant mammal's behaviour and takes place in the infant's habitat, which is the environment in which it lives (Alberts 1994). The Norway rat as an example, has a progression of habitats; firstly the uterus, then outside the mother's body is the area where he spends most time after birth, the nest of siblings, then interacting with siblings before going into the world. The infant's niche in each habitat is how the infant adjusts to life in the different habitats, and how it responds and copes. The Norway rat goes through a number of stages before adulthood. Firstly the rat is adapted to live in utero where he is fed and oxygenated via the placenta, this is the first habitat. The second habitat is found by the rat as he finds the warmth of his mother's body and a nipple in order to feed. The gastro intestinal tract is also specifically designed to deal only with milk at this stage. The pup finds the nipple by smell, which is thought to be familiar from the amniotic fluid and touch. If the mother's nipples are washed the pup will not attach and feed. While sucking behaviour is present at birth it needs experience of sucking to enable its continuation as it is a weak and temporary behaviour (Alberts 1994). These behaviours find parallels in human infants. For example, a human infant's niche immediately after birth is when it is in close physical skin to skin contact with the mother and adapting to extra-uterine life while preparing for the next stage of his/her development e.g. breastfeeding. This will be discussed in more detail in the next sections. Mizuno et al. (2004) have shown that skin contact for at least 50 minutes after birth and effective sucking significantly increased the mouthing movements of babies in response to exposure to their own mother's milk odour at 4 days. This also was related to breastfeeding for a significantly longer time than the group of babies who were removed from their mothers at birth and had their first contact 24 hours later (Mizuno, Misuno, & Shinohara 2004). Significantly more babies found the areola if they made hand from areola to mouth movements than babies who did not show these movements which suggests the significance of taste or smell in finding the nipple (Widstrom et al. 2011).

### 2.4.2 Pre-feeding/instinctive behaviour

Pre-feeding/instinctive behaviour is well documented instinctive behaviour in human babies and comprises of a sequence of movements made by the baby immediately prior to initiating breastfeeding. In well, un-medicated babies held skin to skin, pre-feeding/instinctive behaviour is described as the baby crying at birth, then relaxing on the mother's body, then making hand to mouth movements, gradually rooting and developing sucking activities as the baby moves toward the breast finds the nipple and starts to suck within the first hour (Widstrom et al. 1987). Widstrom et al. (2011), in a more detailed study, found that babies when laid skin to skin on the mother's chest immediately after birth (habitat) went through this sequence of activities to find the mother's breast and rested between periods of activity (niche). This is hypothesised to be an inborn biological programme which is vulnerable to disturbance by handling, washing and narcotic analgesia. This programme has been identified to comprise nine stages of pre-feeding behaviour (Widstrom et al. 2011) Particularly it was noted that the babies touched and shaped the nipple and took up to 45 minutes after reaching the areola to attach. The median number of minutes for the sucking phase to appear was 62 minutes (43.5-90.3). The relevance of this information is that analgesia and/or a midwife physically "helping" the baby to attach would interrupt this sequence (Widstrom et al. 2011) (see Table 3).

**Table 3 Definition of phases/behaviours from birth to first suckle or first sleeping period**

<b>Phases</b>	<b>Behaviours</b>
<b>Birth cry</b>	Intense crying just after birth
<b>Relaxation phase</b>	Infant resting/recovering. No activity of mouth, head, arms, legs or body
<b>Awakening phase</b>	Infant begins to show signs of activity. Small thrusts of head: up, down, from side to side. Small movement of limbs and shoulders
<b>Active phase</b>	Infant moves limbs and head, is more determined in movements. Rooting activity, 'pushing' with limbs without shifting body
<b>Crawling phase</b>	'Pushing' which results in shifting body
<b>Resting phase</b>	Infant rests, with some activity, such as mouth activity, sucks on hand
<b>Familiarisation</b>	Infant has reached areola/nipple with mouth positioned to brush and lick areola/nipple
<b>Suckling phase</b>	Infant has taken nipple in mouth and commences suckling
<b>Sleeping phase</b>	The baby has closed its eyes

Widstrom et al. (2011)

### **2.4.3. Physiological benefits for the infant of skin to skin contact**

There are physiological benefits to the baby of having skin to skin contact. The baby's temperature is higher during skin contact (Moore, Anderson, & Bergman 2008; Carfoot, Williamson, & Dickson 2005). In a study to evaluate how different delivery ward routines influence temperature, babies held skin to skin or clothed on their mother's chest and babies who were clothed but placed in a nursery had a significant rise in their temperature from the first recording at 30 minutes to the end of observation at 120 minutes postpartum (Bystrova et al. 2003). There was however a fall in the foot temperature in the nursery group but an increase in the foot skin temperature if the baby was held skin to skin for up to 120 minutes. This rise in peripheral temperature was sustained during the hospital stay and is hypothesised to be the result of a reduction in sympathetic nervous activity due to the effect of skin to skin on the somatosensory nerves. There is an increase in sympathetic activity at

birth due to the release of catecholamine, which is helpful as it facilitates the baby's adaptation to life outside the uterus, in quicker absorption of lung fluid, increased cardiac performance and release of glucose and free fatty acids (Bystrova et al. 2003). It is proposed that the reduction in sympathetic activity results in dilatation of blood vessels and the consequent finding of warm feet can be explained by a reduction in the stress of birth as a result of skin contact (Bystrova et al. 2003). The heart rate and respiratory rates are slightly slower, blood sugar levels are higher during skin contact and also the baby cries less in skin contact which may facilitate the closure of the foramen ovale and reduce the risk of increased intracranial pressure and subsequent haemorrhage in preterm infants (Moore, Anderson, & Bergman 2008). Heart rates were stable significantly earlier in a group of babies placed skin to skin within a mean of 1.60 minutes than those placed skin to skin later at 26.3 minutes after birth (Takahashi et al. 2011). Salivary cortisol levels were significantly lower between 60 and 120 minutes than at 1 minute after birth if the baby was held for more than 60 minutes. Salivary cortisol levels are an indication of the stress affecting the infant at birth and lower levels during skin to skin suggest that this is beneficial to the baby (Takahashi et al. 2011).

#### **2.4.4 First breastfeed**

Nine babies in a pilot study were placed on the mother's abdomen skin to skin within a minute of birth. Eight out of nine babies had crawled to the breast and attached by 74 minutes after birth. Two of the mothers had an epidural, one had pudendal anaesthesia and six had no analgesia (Walters et al. 2007). Carfoot et al. (2005) demonstrated a tendency for more babies to have a successful first breastfeed, as measured using a modified version of the Infant Feeding Assessment Tool (Matthews 1988), with skin to skin contact (Carfoot, Williamson, & Dickson 2005). Moore et al. found when skin contact was given the baby was more than twice as likely to have a successful first breastfeed (Moore, Anderson, & Bergman 2008).

#### **2.4.5 Duration of breastfeeding**

In a study by DiFrisco et al.(2011) if the mother was able to breastfeed within the first hour after birth she was more likely to still be exclusively breastfeeding at 2 to 4 weeks after discharge from hospital ( $\chi^2 (1, N = 96) = 8,046, p = .005$ ) than mothers who did not breastfeed within the first hour (DiFrisco et al. 2011). The duration of exclusive breastfeeding was significantly increased with skin contact which lasted

longer than 20 minutes compared to no contact (Mikiel-Kostyra, Mazur, & Boltruszko 2002). The longer the skin contact in the first 3 hours after birth the more likely it is that the baby is exclusively breast fed while in hospital (Bramson et al. 2010) and after 2 hours of continuous contact significantly more babies were exclusively breast fed at discharge from hospital than if the baby was examined and wrapped then held by the parents (Marin Gabriel et al. 2010).

#### **2.4.6 Separation and narcotics**

Righard and Alade (1990) in an observational study compared two groups of babies, a contact group (n=38), where the baby was in uninterrupted contact with the mother skin to skin on her abdomen for at least an hour and a separation group (n=34) where the baby was in contact for 20 minutes then removed for measuring and dressing. Observations were made by the researchers during labour until the first hour after birth or until the baby had fed. More babies in the contact group sucked correctly 24/ 38, than the separation group 7/34 but pethidine affected both groups of babies in that 25 of the 40 babies whose mothers had received pethidine did not suck at all. The timing of the administration of pethidine was considered and significantly more babies sucked correctly if pethidine was given less than two hours before delivery. Leaving the babies in skin contact and not being affected by narcotics therefore made attaching to the breast more likely (Righard & Alade 1990).

#### **2.4.7 Supplements**

After a change in quality control (involving cycles of planning, doing, studying, and acting) in a large urban hospital, Hung and Berg (2011) found that the babies who had skin to skin in the operating room after a caesarean section had less formula supplements (33%) than babies who had skin to skin within 90 minutes of birth but not in theatre (42%) and babies who did not have skin to skin in their first 90 minutes of life (74%) (Hung & Berg 2011).

#### **2.4.8 Instinct and emotion**

Women described the experience of skin to skin contact with pleasurable emotion and the theme of natural and instinctive behaviour on the part of the mother was identified, which included smell and the feel of the baby's wet body and the desire to put the baby to the breast (Finigan & Davies 2004). More mothers were satisfied with their care if they had skin to skin than in the group where babies were wrapped



(Carfoot, Williamson, & Dickson 2005). Where mothers had been in skin to skin contact with their baby they had less state anxiety on day three postnatal and were more confident about being able to care for their baby at discharge (Moore, Anderson, & Bergman 2008). In a study in Russia routines were performed after birth before the baby was placed skin to skin, or in arms and clothed Bystrova et al. (2009) found that at 1 year if babies had skin to skin or had sucked in the first 2 hours after birth they were more able to self-regulate and be less irritable and the relationship between mother and baby was better (Bystrova et al. 2009). Colson et al. (2008) found that mothers behaved instinctively to encourage their babies' primitive neonatal reflexes to feed while the mother was lying in a semi recumbent position in the first postnatal month. This has not been applied to position at birth so far (Colson, Meek, & Hawdon 2008).

#### **2.4.9 The practice of skin to skin contact at birth**

Skin to skin contact (SSC) with the mother after birth is described as placing the naked baby prone on the mother's chest covered with a warm blanket. This can be described as "birth SSC", within the first minute, or "very early", beginning 30-40 minutes after birth or "early", which is any time between 1-24 hours after birth (Moore, Anderson, & Bergman 2008).

It is part of the "Baby Friendly Initiative" criteria for Step 3 that midwives explain to women, during antenatal care, the benefits of skin contact with their baby at birth by 34 weeks of pregnancy (UNICEF UK Baby Friendly 2013a). This is explained as giving evidence based information, including physical and emotional benefits. The UK Baby Friendly Initiative incorporates one of the ten steps to successful breastfeeding as Step 4 "Help mothers to initiate breastfeeding soon after birth". This step encourages mothers to have their babies naked on their chest at birth and to continue this contact until the baby feeds (UNICEF UK Baby Friendly 2012c).

#### **2.4.10 Understanding of Pre-feeding/instinctive behaviour**

Women in the UK are not normally present when friends or relatives are giving birth and thus watching how the mother and baby respond after the delivery. However, pregnant women are given information about skin to skin benefits of warmth, cardio-respiratory stability and breastfeeding (Moore, Anderson, & Bergman 2008), early in

their pregnancy. Since health behaviours such as feeding babies are influenced by the attitudes of family and friends, perception of professional support, socio-economic status (Dyson et al. 2006; Bolling et al. 2007) and social comparison where seeing a relative or friend breastfeeding can have a positive influence (Hoddinott & Pill 2000) pre-feeding/instinctive behaviours, that occur before a baby first attaches, may be less well understood.

#### **2.4.11 Summary**

Mammalian behaviour at birth has parallels in small mammals and humans where the infant finds itself in the niche of the mother's body skin to skin and is guided by touch and smell to the nipple and attaches instinctively to the nipple. The sequence preceding attachment to the breast in humans is vulnerable to interruption by handling of the baby, washing and the effects of narcotic analgesia. There is a reduction in stress in the baby with skin to skin, evidenced by reduction of sympathetic nervous activity and lower cortisol levels. There are a number of physiological changes in the neonate that are enhanced by skin to skin contact during adaptation to extrauterine life. Skin to skin contact at birth increased the likelihood of a successful first breastfeed and the duration of exclusive breastfeeding was increased if the baby was breastfed within the first hour and was more likely when the mother and baby had longer skin contact. Babies were more likely to attach to the breast after birth if left in skin contact, not separated from their mother and were not affected by narcotic analgesia. Babies who had skin to skin contact in theatre had less formula supplements than babies who had skin to skin later. Mothers enjoyed skin to skin contact, were more satisfied with their care and were less anxious and more confident about caring for their baby after skin contact. At one year babies were more able to self-regulate and the mother and baby relationship was better with babies who had skin contact or had fed in the first 2 hours. Skin contact is policy in BFI accredited maternity units but although mothers are taught about this policy, breastfeeding behaviours of the baby at birth are not necessarily explained.

#### **2.5 Maternal physiology and maternal behaviour**

Akre (1992) gives a comprehensive explanation of the physiological basis for breastfeeding and the benefits to babies of being breastfed. Colostrum is the first fluid the mother secretes from the breast in the first few days after the birth and has

the right amount of fluid and all the nutrients and protective factors the newborn needs (Akre 1992). Despite this, cultural practices have developed, around the world where newborns are denied colostrum in the first few days. The reasons are many and varied and include clearing of meconium, to learn tastes and to be able to cough up mucus. The babies can be fed by another woman acting as a wet nurse or be given a variety of first foods which include cows' milk, honey beer, and castor oil (Lefeber & Voorhoeve 1999). It may be logical to assume that giving babies unsterile food or fluid may have contributed to infant mortality and may continue to do so.

### **2.5.1 Hormonal interactions**

Rosenblatt (1994) suggests that as in sheep maternal behaviour is primed by oestrogen and set in action by oxytocin. The administration of an epidural blocks the stimulation to the brain of oxytocin and affects maternal behaviour in sheep which is reversed when oxytocin is injected. Although hormones are required for breastfeeding, the mother also reacts to psychological stimulation from the infant, learning how their infant behaves and smells elicits maternal behaviour in sheep (Rosenblatt 1994). Nissen et al. (1995a) wanted to find out what the oxytocin levels are in humans pre- and post-delivery. This was in order to connect human behaviour to that shown in other mammals when there is a sensitive period for bonding maternal behaviour after birth. At 15, 30, and 45 minutes post-partum the plasma levels of oxytocin were significantly higher than immediately pre-partum levels. This has a physiological result in contraction of the uterus and expulsion of the placenta. The authors suggest that there may be a similar release of oxytocin in the human brain as is found in sheep and proposes this may be involved in human maternal behaviour as in other mammals (Nissen et al. 1995a). Widstrom et al. (1990) found that if babies had touched or licked the areola and nipple during skin contact after birth the mothers left the babies in the nursery for a significantly shorter time and talked to the babies significantly more during breastfeeding at four days. The mothers' gastrin levels were also lower indicating an effect on their neuroendocrine function (Widstrom et al. 1990). When babies massage the breast before sucking this is associated with the oxytocin release in the mother that is necessary for the milk ejection reflex and may be important in a "sensitive period" at birth which facilitates mother-infant interaction (Matthiesen et al. 2001).

Uvnas-Moberg et al. (1996) conducted a review of the effects of peptides and oxytocin concerned with the ejection of milk and lactation. Oxytocin is produced in the hypothalamus and is secreted both into the brain and the circulation when the neurons involved are stimulated by delivery or suckling. The breast has peptide substances in the sympathetic nerve fibres supplying the nipple. The epidermis of the nipple has somatosensory fibres and peptides which when released cause an increase in muscle tone and the nipple to become erect. When the baby sucks, the somatosensory nerve endings in the nipple cause the release of oxytocin, milk is ejected and there is also an increase in the blood flow to the breast bringing nutrients to the mammary gland for milk production. At this time there is also a rise in the blood flow to the skin resulting in the nipple being warmer and the temperature of the chest skin being warmer during breastfeeding which may calm the baby. The constituents for milk production are needed in the breast and oxytocin release is associated with a rise in insulin levels, glucagon, and a rise in glucose levels. There are more insulin receptors in the breast and more glucose is then transferred to the breast and is able to be stored and used to make milk. As well as women eating more during lactation, the body breaks down less waste products, increases the ability to digest and metabolise food so saving energy for milk production. Women have a lower blood pressure and cortisol level when breastfeeding and in personality measures the results indicate women are calmer and less anxious and want a calm settled life in the immediate postnatal period. It is suggested that the release of oxytocin causes these effects (Uvnas-Moberg & Eriksson 1996).

### **2.5.2 Differences in hormone release in medical intervention**

Nissen et al. (1996) aimed to find out whether the type of delivery, caesarean section (C/S) or vaginal delivery (VD), affected the way oxytocin, prolactin and cortisol in association with breastfeeding were released on day 2. Also if there was a correlation between the differences between C/S and VD and any differences in release and if there was an association with the release patterns and duration of breastfeeding. Pulses of oxytocin were found when women breastfed after VD but significantly fewer were found in C/S, significantly higher prolactin levels 20-30 minutes after commencing breastfeeding in VD but not in later samples. Cortisol levels fell in both groups and at 60 minutes were lower than basal levels. The first suckling for VD women was at a median of 75 minutes and for C/S at a median of 240 minutes and

there was a significant relationship between the number of pulses of oxytocin and duration of exclusive breastfeeding in the VD group which is suggested as an important mechanism. The most important factors to influence oxytocin were firstly the mode of delivery then the age of the baby at the first suckling then thirdly the level of somatic anxiety. Significantly fewer women who had C/S than VD had a rise in prolactin at 30 minutes. The cortisol levels fell significantly in both C/S and VD groups. There was however no correlation with duration of breastfeeding and early oxytocin release in C/S, leading the authors to propose that other factors that can improve duration may act as a compensatory mechanism to counteract a lack of hormone release (Nissen et al. 1996).

Handlin et al. (2009) investigated the effects of sucking and skin to skin contact on maternal ACTH and cortisol levels on day two postnatal and what was the effect of epidurals and oxytocin on these levels. Both ACTH and cortisol levels fell significantly during breastfeeding in the whole group compared to the value before the baby started to suck and were lowest at 60 minutes after the start of sucking. Although there was no significant relationship between the duration of skin contact and ACTH there was a significant negative correlation between the length of skin contact before the baby started to suck and the median cortisol levels. So the longer the baby was skin to skin the lower the mother's cortisol level. In mothers who had an epidural compared to mothers who also had oxytocin, their cortisol levels were significantly lower but mothers had higher cortisol levels if they had oxytocin without an epidural (Handlin et al. 2009).

### **2.5.3 Bonding and oxytocin**

IsHak et al. (2011) reviewed the role of oxytocin in enhancing wellbeing. The results included references to love and pair bonding studies in non-human mammals and in humans. One study referred to where couples, given intranasal oxytocin and then discussed a conflict situation, had less anxiety and reduced cortisol levels. A peak of oxytocin release is found at sexual orgasm and higher levels of oxytocin are found when a higher level of breastmilk is ejected during breastfeeding with a corresponding level of calm and interest of the mother. Higher levels of oxytocin in the postnatal mother were associated with reports of coping and less depression at 4

days postnatal with these effects being present at 2 months (IsHak, Kahloon, & Fakhry 2011).

Feldman et al. (2007) examined the relationship between oxytocin and maternal bonding in women. The women answered questionnaires and had blood assays in early and late pregnancy then again in the first month postpartum. They found that oxytocin levels did not differ between breastfeeding or bottle feeding women as oxytocin was not sampled during breastfeeding. Oxytocin levels stayed constant from pregnancy to the postnatal period but cortisol levels changed significantly, rising then falling but not to the initial levels. It was found that oxytocin was related to maternal behaviour (maternal gaze, positive affect, affectionate touch, and vocalization) attachment representations and checking behaviour but cortisol was negatively related to maternal behaviour and was not related to oxytocin. Maternal behaviour was able to be predicted by higher oxytocin and lower cortisol levels and is the first study to link levels of oxytocin during pregnancy and the puerperium to bonding behaviours (Feldman et al. 2007).

Jonas et al. (2008) investigated the influence of oxytocin and epidurals on the personality profile of breastfeeding women. Compared to a normative group of 200 non pregnant or lactating women, at 2 days postnatal women in the study group who had no medication, or intravenous (IV) oxytocin or intramuscular (IM) oxytocin had different scores on the Karolinska Scales of Personality and this stayed the case during the study. Their anxiety scales and detachment scales were low and socialization scores were higher than the normative group. In the IM oxytocin group, scores on a number of other scales had lower scores on day two; they included impulsivity, verbal aggression (also in the unmedicated group), indirect aggression, irritation (also in the unmedicated group) at 2 days and 2 months. Suspicion was lower in the IM oxytocin group at 2 days and 2 months. Scores for guilt were lower in the IV oxytocin, IM oxytocin and the unmedicated subgroups. The epidural group had the same scores at 2 days as the normative group. They had significantly higher scores than the other groups at 2 days in somatic anxiety, muscular tension, indirect aggression, irritability and a psychasthenia tendency. Also they had a significantly lower score in social desirability. The higher the dose of oxytocin the scores of inhibition of aggression were significantly lower whether or not an epidural was given.

Over time at 2 months most of these scores were reduced but socialization had increased.

The authors in previous studies have shown that during breastfeeding, mothers had lower levels of anxiety and higher levels of sociability at 2 and 4 days postnatal compared to a normative group of women of the same age but who were not pregnant or breastfeeding. In this study the scores were similar for women who had no medical interventions. However the women who had an epidural did not have these results at 2 days but at 2 months lasting until 6 months some of their anxiety scales were reduced and socialization was increased with doses of oxytocin affecting the results on some of the scales. It is suggested therefore that the changes in personality profile are delayed in women who have an epidural due to the lack of oxytocin released into the woman's brain by a blocking effect of the epidural on nerve endings. This effect has been found in animal experiments. This may affect the mother-baby relationship during the immediate postpartum "sensitive period" which happens in experiments on sheep and cows. This may be compensated for to some degree if the mother has exogenous oxytocin IV and if the woman breastfeeds (Jonas et al. 2008).

#### **2.5.4 Summary**

Maternal behaviour is thought to be influenced by the release of oxytocin which is higher immediately after birth and is released during breastfeeding. Oxytocin brings nutrients to the breast for milk production and warms the skin over the breast thus calming the baby. Hormonal action is involved in milk production and blood pressure and cortisol level are lower resulting in the woman being calmer in the postnatal period.

There were more pulses of oxytocin released in women who delivered vaginally than those who had a caesarean section and this correlated with the duration of breastfeeding in women who delivered vaginally. Cortisol levels fall during breastfeeding and periods of skin contact and if the mother was given exogenous oxytocin her cortisol levels were low if she had an epidural but were high if she did not have an epidural.

Higher levels of oxytocin are associated with lower levels of cortisol and a calm mother interested in her baby and not being depressed. A higher level of oxytocin and lower level of cortisol could predict maternal bonding behaviour. Women's behaviour can be affected by the blocking effect of an epidural on nerve ending which reduce the amount of oxytocin in the woman's brain which may affect the mother-baby relationship at birth. This can be compensated by giving oxytocin or breastfeeding.



## Chapter 3 Theoretical Framework

### 3.1 Introduction

The aim of the third chapter is to consider options for basing the data within a theoretical model relevant to breastfeeding.

#### Objectives

1. To explore the current background to health promotion in Scotland relevant to pregnancy and breastfeeding,
2. To describe the theoretical models most often used in health promotion research,
3. To argue which theoretical model would be suitable to explain women and midwives' behaviour in relation to initiation of breastfeeding.

#### 3.1.1 Background to government policy, midwifery and public health.

NHS Scotland published *A Fairer Healthier Scotland* in 2012 which sets out a strategy for the next five years to reduce health inequalities and improve health in Scotland. Integral to the strategy is that evidence based information will be used to devise policies and inform actions. There will also be a measurement of the amount of improvement it effects and the level of impact of the strategy. This strategy states an intention to promote health in Scotland by involving a variety of agencies out-with the health service to work towards the goal of improving health and wellbeing for all and explicitly includes carrying out research as a foundation for health promotion (NHS Health Scotland 2013).

Age, socio –economic, cultural and environmental conditions are all aspects relevant to the health and wellbeing of women and their families. Where there are inequalities in health, guidance suggests that improving access to antenatal care could improve women and their babies' health and wellbeing and introduce families to wider forms of available support (The Scottish Government, The Maternity Services Action Group 2011). Other recent guidance, the paper *Midwifery 2020: Delivering Expectations* sets out the vision for the development of the role of the midwife (Department of Health 2010). With regard to antenatal care this is provided mainly in the community

by midwives and the guidance states it is important for midwives to develop an increased role with regard to public health and be integrated with the local health and social care providers. It also sets out an aim for midwives to have the choice to increase their contribution to research based practice by pursuing a clinical academic role (Department of Health 2010). There are, therefore, a number of guidelines and policy drivers in place to encourage midwives to be proactive in pursuing improvements in care of women and engage with wider issues than the woman's immediate health in their current childbearing event.

In order to develop an understanding of how interventions or changes in practice could facilitate improvements in care, relevant qualitative research and theory can provide a basis for the way forward. It is planned to use a theoretical model in this study in order to embed the results in recognised theoretical principles. A number of theoretical models of behaviour have been developed to predict or explain peoples' beliefs and perceptions about health and healthcare.

### **3.2 Choice of model for this research project**

The influences on health are multi-factorial including age gender and hereditary factors but, social circumstances and the environment play an important part in the ability to make healthy choices (Bowden & Manning 2006). The study of peoples' behaviour in industrialized countries is based on claims that some behaviours contribute to ill health and that these behaviours can be changed to enhance health (Conner & Norman 2005). Breastfeeding is considered a health-related behaviour in relation to its impact on infant and maternal outcomes. Health related behaviour can be categorised as health enhancing (for example healthy diet or physical activity), protective from disease (by vaccination) or avoidance of harm (as in smoking in pregnancy). It is acknowledged that health related behaviours affect people both in the short term and long term and the person has some control of their own behaviour. Research has been carried out in order to understand the influences on who performs these behaviours and a distinction is made between the issues that are intrinsic to people as in personality, and perceptions and those that are extraneous to the person as in money or other rewards. Extraneous factors, such as using taxation to deter smoking or the banning of harmful substances have also been studied.

However intrinsic cognitive factors are thought to be the most important deciding factors in health related behaviour (Conner & Norman 2005).

Various models of behaviour have been developed by psychologists to provide a representation of a set of ideas that enable analysis of peoples' health related behaviours (Bowling 2007). Darnton (2008) in a review of behaviour change theory makes a distinction between models of behaviour and theories of change. According to Darnton specific behaviours can be understood by the use of models and the factors that influence specific behaviour. Theories of change demonstrate how behaviours can be changed or modified over time. In practice the two concepts of models of behaviour and theories of change are complementary and when considering a future intervention, integration of the two can increase the effectiveness of the change process (Darnton 2008). Models of how cognitive factors affect health behaviour are termed social cognition models (Conner & Norman 2005). These models have increased our understanding of peoples' knowledge and perceptions of health behaviour and it is thought that by influencing cognitive factors, interventions can be designed to influence behaviour (Conner & Norman 2005). Models should however be considered as an "aid to thinking" where a model is used to understand what factors influence behaviour (Darnton 2008). Models are considered best utilised within policies, using the principles of action research including the context of the behaviour and the people involved. So rather than using models as a structure for changing behaviour they can be used to help identify aspects to be involved in an intervention (Darnton 2008). It is proposed to use a model to identify aspects of women and midwives expectations knowledge and experiences with regard to initiation of breastfeeding in this qualitative study in order to eventually inform the design of an intervention.

### **3.3 Social cognition models**

Social cognition models (SCM) have been widely used in research contributing to the understanding of health behaviour. These models fall into two main types: those that explain how people respond to disease, and those that explore features of peoples' perceptions of health in an attempt to predict or determine health behaviour (Conner & Norman 2005). The individual's perception of risk, although directly or indirectly included in Social Cognition models, has only a weak relationship with health

behaviours. Risk may be more likely to be considered at the stage where the person is formulating their goals (Norman & Conner 2005). In the context of breastfeeding however, women may or may not consider the risks of bottle feeding their babies when planning how to feed their newborn baby. According to Stuebe (2009) if presented with the benefits of breastfeeding in health campaigns women agree there are health benefits in breastfeeding but less than 25% agreed that to bottle feed increases the risk of illness in babies. This result was explained by formula/bottle feeding being regarded as the norm (Stuebe 2009).

Examples of social cognition models used in research to predict future health related behaviour and that could be used in order to design interventions are: The Theory of Reasoned Action (TRA) (Ajzen & Fishbein 1980), The Theory of Planned Behaviour (TPB) (Ajzen 1991), and Social Cognitive Theory (Self-efficacy) (Bandura 1986). These models have been applied in research relating to breastfeeding and therefore will be described in more detail in this chapter, along with research relevant to breastfeeding. There are a number of theories of change that are used in interventions called Stage Based Models. They are also considered to be SCM and are premised on the idea that behaviour changes through different stages. One stage based theory/model, the Transtheoretical model will be discussed in relation to breastfeeding (Sutton 2005).

The following section will provide an exploration of each of the models giving an outline of the model and its assumptions. This will be followed by a discussion of their use in health research and in breastfeeding including strengths and limitations of the model.

### **3.4 Theory of Reasoned Action**

The Theory of Reasoned Action (TRA) (Ajzen & Fishbein 1980) aims to predict and understand a person's intentions by measuring his/her attitude and subjective norms and what weight is given to each with regard to behaviour that is within the person's voluntary control. Attitudes towards behaviour are formed by the person evaluating behavioural outcomes of the behaviour and are determined by those beliefs. The influence of social pressure to perform the behaviour combined with attitude forms the intention to perform the behaviour (Darnton 2008).

This model assumes people consider the implications of their actions before they decide to carry out a given behaviour and are quite rational and make careful use of information available to them. What a person knows and believes will therefore influence how he/she thinks and what he/she will do. The intention to perform a given behaviour is what precedes the behaviour and there are two influences on intention, these are personal and social influence. Personal influence is the person's attitude toward the behaviour and they will have a positive or negative attitude toward performing the behaviour. Social influence is the perception of social pressure to perform or not. This is the subjective norm. The relative importance of a person's attitude and of the subjective norms, are important in the situation where the person wants to do something but there are social pressures not to. Sometimes the person's attitude is more important than the normative influences and vice versa (Ajzen & Fishbein 1980). This was found when the weighting of the attitudinal component was found to be larger than the normative component in predicting women's intentions to breastfeed when previous experience was added (Manstead, Proffitt, & Smart 1983).

#### **3.4.1 Utility of TRA**

Although attitudes precede intention the theory does not explain what factors cause attitudes to lead to intention. The theory concentrates on voluntary behaviour but not on skill based behaviour or where resources or opportunities are limited so it is suggested they will be less likely to be predicted by the model (Conner & Sparks 2005). The theory of reasoned action applies when the person can behave of their own free will , for example taking vitamins, but when this is not the case for example having a good night's sleep then Ajzen's Theory of planned behaviour is more relevant (Madden, Ellen, & Ajzen 1992). It has been argued that to increase the predictive power of TRA measurement it should be measured in relation to the specific behaviour (Darnton 2008).

#### **3.4.2 Breastfeeding and TRA**

Two studies illustrate the use of the TRA model in breastfeeding research (Table 4). One study investigated how the theory could be applied to predict and understand intention to breastfeed and to find out the actual duration of breastfeeding (Manstead, Proffitt, & Smart 1983). The findings were that behaviour was shaped by attitudes and subjective norms. However whether the mother had breastfed before was significant in predicting her intentions. This current experience of breastfeeding

influenced the weighting attached to the attitudinal and normative items, with a larger attitudinal weighting in multigravida who had breastfed before. These results suggested that the ability to predict intentions was increased by the addition of previous breastfeeding behaviour with the findings that more emphasis was placed on attitudes than subjective norms. There was however a correlation between attitude and subjective norms with intention in primigravida women (women who had no personal breastfeeding experience) (Manstead, Proffitt, & Smart 1983). Bernaix (2000) measured the characteristics of nurses and external factors that influence nurses' ability to provide effective support for breastfeeding mothers in hospital, and used the TRA as the basis for one of the nurses' questionnaires. The nurses' intentions to provide support were predicted by attitudes and social pressure but their actual supportive behaviour was predicted by their knowledge of breastfeeding. The author criticises the theory's inability to predict the actual behaviour. Instead intention was less influential than attitudes and knowledge in predicting the ability to provide actual supportive behaviour (Bernaix 2000).

Both of these studies highlight shortcomings in the breadth of the utility of the TRA. In Manstead et al. (1983) the previous experience of breastfeeding in multigravida positively affected attitudes to the current experience of breastfeeding and was a new finding. How a negative previous experience affected results was not considered. In Bernaix (2000) the nurses' actual behaviour was influenced by their knowledge scores on a specific knowledge questionnaire. The additional factor of knowledge was important to predict actual behaviour that required the use of skills, where the TRA predicted intention but not behaviour. This was a weakness highlighted by Conner and Sparks (2005); that TRA was more relevant when behaviour was governed by free will, rather than skill based behaviour or where resources are limited (see Table 4).

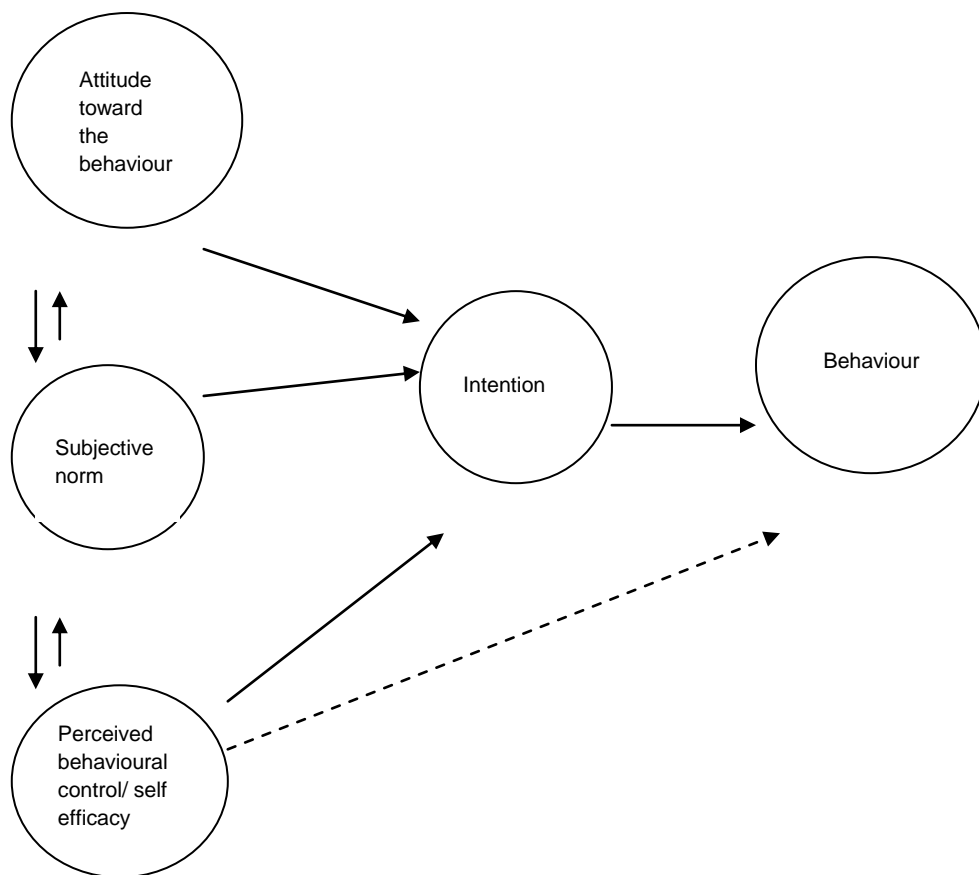
**Table 4 Quantitative breastfeeding research using TRA**

Author, year, country and aim	Methods and sample	Main findings
<p>(Manstead, Proffitt, &amp; Smart 1983) England The theory of reasoned action (TRA) was used as a model to study antenatal intention to breastfeed and the actual feeding method at six weeks postnatal.</p>	<p>An initial questionnaire was completed prenatally then a follow-up questionnaire was sent to the women at six weeks postnatal. A control group of primigravida was sent only the second questionnaire at six weeks after birth.</p> <p>Sample: 123 primigravida 127 multigravida Age 16-40 years At least 24 weeks pregnant Control group of 154</p>	<p>The TRA was useful in predicting and understanding intention. In primigravid women the multiple correlation of attitudes and normative aspects with infant feeding intention was 0.77, accounting for 59.8% of the variation in the intentions. In multiparous women the multiple correlation of attitudes and normative aspects with infant feeding intention was 0.77, accounting for 59.6% of the variation in the intentions, which was almost equal to the primigravidas' results. However when previous behaviour was added, the variance in multiparous women was 65.3% where the weight associated with the attitudinal component was larger than that associated with the normative component.</p>
<p>(Bernaix 2000) USA</p> <p>(1)What are the relationships between postpartum and nursery nurses' attitudes, subjective norms, selected demographic variables, and knowledge about breast feeding and their behavioural intentions to provide support to breast feeding mothers? and (2) What is the relationship between postpartum and nursery nurses' intentions to provide support to breast feeding mothers and the actual provision of that support as perceived by the mothers?</p>	<p>Questionnaire data collected from mother - baby nurses then two weeks later data collected from breastfeeding mothers who had been cared for by a nurse who had participated in the first phase of the study. The women had to have been cared for at least 8 hours by the participant nurse. Support for Breastfeeding Questionnaire based on TRA administered to nurses. Maternal Perceptions of Support Questionnaire coded to relate to the nurse who had cared for the woman, completed by the women. Both devised by author. Lewinski Breast feeding Survey Tool to measure breastfeeding knowledge.</p> <p>Sample 50 Mother –baby nurses 136 Breastfeeding mothers</p>	<p>Intention to provide support predicted by nurses' attitude and social pressures. Attitude score (<math>R^2=.42</math>) and subjective norm score (<math>R^2=.09</math>). The final model explained 72% of the variance in intentions and was statistically significant at <math>P&lt;.001</math></p> <p>Best predictor of supportive behaviour was nurses' knowledge of breastfeeding although influenced by attitudes and social pressures. Knowledge score .29 .39, <math>F(3, 28)=16.3^{**}</math> 2 Attitude score .16 .56, <math>F(4, 27)=17.5^{**}</math> Fifty-six per cent of the variance in supportive behaviour was explained, with 29% attributable to breast feeding knowledge and 16% attributable to attitudes. The final model was statistically significant at <math>P&lt;.001</math></p>

### 3.5 Theory of Planned Behaviour

The Theory of Reasoned Action was developed in the early 1980's and further developed as the Theory of Planned Behaviour in later years (Ajzen & Fishbein 1980; Ajzen 2002). The Theory of Planned Behaviour (TPB) (Ajzen 2002) builds on the Theory of Reasoned Action by adding another dimension, that control felt by a person that he/she can perform a behaviour is on a continuum of having complete control to having no control (see Figure 1).

Figure 1 Theory of planned behaviour (Ajzen 1991)



The TPB reasons that human behaviour is influenced by, and is a result of, beliefs about results and effects of the behaviour (behavioural beliefs), social pressures (normative beliefs), and other issues that may have either a positive or negative effect (control beliefs), on the behaviour. When these concepts are measured individually, behavioural beliefs yield either a positive or negative attitude. Normative beliefs give perceived social pressure (subjective norm) and control beliefs give perceived behavioural control. All of these concepts form the intention of the person



to perform the behaviour. If the person has complete control with regard to the behaviour then they would be predicted to do what was their intention when the occasion arose. Many factors though can influence the amount of real control a person has, so perceived control is considered as well as intention. The concept of perceived control allows for the fact that although a person does everything they can to achieve an aim; the result may depend on another person or opportunity. For example, women may wish to breastfeed their baby and they try, but due to the effects of narcotic or epidural analgesia, or separation from their baby or medical practices around the birth, starting to breastfeed may not result in the expected outcome. In some situations the action (as above) to achieve a goal is dependent on the action of others, so actual control can be seen on a continuum.

Perceived behavioural control (PBC) is similar to self-efficacy theory (SE) (Bandura 1977) as both are to do with what a person understands of his/her ability to perform a specific behaviour. Perceived behavioural control means a person's subjective view of the level of control he/she has of being able to carry out a behaviour (Ajzen 1991; Ajzen 2002). Ajzen (2002) concluded that PBC should be viewed as an overarching structure where there are two lower level components of self-efficacy and controllability and to measure perceived behavioural control should include items to assess self-efficacy and controllability (Ajzen 2002). However Armitage and Conner (2001) in a meta-analytic review conclude that self-efficacy is explained more clearly and is more easily used. Both SE and PBC explain the same amount of variance in behaviour but SE explains more of the variance in intention and should be used instead of PBC (Armitage & Conner 2001). Self-efficacy, or perceived behavioural control sit within a general structure of beliefs, attitudes, intentions and behaviour.

### **3.5.1 Utility of TPB**

This section will outline health research conducted using TPB then focus on the utility in breastfeeding research.

One review of the application of the theory of planned behaviour in health related change interventions (Hardeman et al. 2002) found that TPB was useful to identify cognitive targets for change but less useful in offering suggestions about how might the cognitions be changed. The cognitive methods used as behaviour change

methods were information and persuasion. Most of the studies in the review used methods to change the components of a person's determinants of intention that were behavioural, such as rehearsal of skills, and not based on the cognitive aspects of TPB. The TPB was thought to be useful in changing health behaviour by persuasion and by recognising what are the antecedents of intention as they perhaps could be changed and in turn change intention and may be useful when people's motivation to change is not yet settled (Hardeman et al. 2002). This is the aim of health education strategies where people are given messages in the media or in health care settings for example about the risk of smoking or related to this study, the benefits of breastfeeding. Conner and Sparks (2005) suggest that although TPB may predict intention this does not necessarily predict behaviour being carried out, or the emotional aspects that are involved in a real life situation (Conner & Sparks 2005, pp 180).

Another review of cognitive representations and preventive health behaviour, Abrahams and Sheeran (1997) noted that action-specific confidence (ease or difficulty of achieving a task) has been measured using perceived self-efficacy theory but the general ease or difficulty of the task has been measured using perceived behavioural control. They suggest researchers consider the two constructs of SE and TPB identically but many prefer to measure the self-referent construct of self-efficacy (Abraham & Sheeran 1997).

In relation to initiating breastfeeding there are very real emotional aspects to consider along with the involvement of action specific behaviour where TPB may be less useful in explaining events.

### **3.5.2 Breastfeeding and TPB: Quantitative Studies**

The following section examines research using TPB to illustrate utility of the model in breastfeeding research in order to explain behaviour (see Table 5).

Quantitative studies have been undertaken to assess the predictive validity of the TPB, and to understand preferences, attitudes and intentions.

TPB has been used as a model to:

- Predict and understand how women intend to feed their babies (Kloebler-Tarver, Thompson, & Miner 2002).
- Used in investigations to understand factors involved in influences on intention to breastfeed and on the duration of breastfeeding (Wambach 1997; Duckett et al. 1998).
- Investigation of the influence of social referents on the method of feeding from birth to six weeks of age (Swanson & Power 2005).
- Design and pilot a questionnaire to measure young peoples' attitudes to breastfeeding with a view to designing an intervention to inform a breastfeeding educational programme (Giles et al. 2007).

The results of Kloebler-Tarver et al. (2002), with a convenience sample of low income minority pregnant women in the USA, support the earlier work of Manstead et al. (1983) that previous experience or knowledge is important in predicting intention especially in multigravidae but previous experience did not correlate with intention in Wambach (1997). Wambach (1997) with a convenience sample of pregnant women in the last six weeks of pregnancy, found intention to only weakly be able to predict duration but Duckett et al. (1998), with first-time mothers found intention to be highly correlated with duration. Wambach (1997) found that subjective norms did not link to duration but Swanson and Power (2005) found that subjective norms were influential in both intention and duration with new mothers who were both primiparous and multiparous. Giles et al. (2007) found that in both young males and females the subjective norm was most significantly correlated with intention but their sample was actually too small to be reliable. These results are contradictory and confusing. Conner and Sparks (2005) acknowledge that although TPB has been successful in explaining variation in intention and action there has been significant variation in the findings between the studies. They attribute this however to the differences in the types of behaviours being measured (Conner & Sparks 2005) which does not hold true for the above breastfeeding research.

**Table 5 Quantitative research in breastfeeding using TPB**

<b>Author, year, country and aim</b>	<b>Methods and sample</b>	<b>Main findings</b>
<p>(Kloeblen-Tarver, Thompson, &amp; Miner 2002) USA To assess the influence of breastfeeding attitudes, social norms and prior experience on predicting breastfeeding intention among low income women, controlling for parity. Using aspects of both TRA and TPB</p>	<p>70 item self – report questionnaire. 27% in first trimester, 31% second trimester, 42% third trimester.</p> <p>Sample: A convenience sample of low income minority pregnant American women in a public hospital 367 primiparas and 596 multiparas</p>	<p>The results in primiparas were that attitudes and social norms predicted intention but more variance was explained by attitudes and this was again the case in multiparas with even more emphasis on attitudes. In multiparas adding previous breastfeeding experience and the length the baby had been fed increased the prediction of intention to breastfeed, supporting the importance of prior experience. The three variables of attitudes, social norms, and previous experience accounted for 31% of intention variance.</p>
<p>(Wambach 1997) USA TPB based hypotheses, a) prenatal breastfeeding attitudes, subjective norms and perceived behavioural control will have positive direct effects on prenatal intentions to breastfeed and indirect effects on breastfeeding duration and b) prenatal breastfeeding intentions and perceived breastfeeding control will have positive direct effect on breastfeeding duration.  Also whether there were other variables that would increase the explanatory power of the theory</p>	<p>Prenatal measures: Attitudes measured with Attitudes on Breastfeeding Scale, Subjective norm and Perceived breastfeeding behavioural control measured with scales based on Ajzen’s guidelines. Breastfeeding intentions measured with a 7 point scale.</p> <p>Postpartum measures: Questions re duration, Breastfeeding problems measured using Breastfeeding Experience Scale, and social support measured with Hughes Breastfeeding Support Scale. Data collection either in person or by mail.</p> <p>Sample: Convenience sample of 274 pregnant women recruited as a convenience sample in last 6 weeks of pregnancy. 73% first time breast feeders.</p>	<p>Positive attitudes and high levels of perceived behavioural control influenced the intention to breastfeed but only accounted for 23% of variation. Prenatal intention was the only very slight predictor of duration. Subjective norms did not predict intention and previous breastfeeding experience did not correlate with intention. This study focused on intention and duration with limited support for the model of the theory of planned behaviour</p>
<p>(Duckett et al. 1998) USA To refine a TPB based model for explaining variability in breastfeeding intention and duration</p>	<p>Variables measured: Behaviour, Intention, Attitudes toward breastfeeding and bottle feeding, Beliefs about outcomes of breast and bottle feeding, Subjective norm and normative beliefs, perceived control and control beliefs, Perceived insufficient milk, Stimulus conditions, Measurement and classification of employment status. Data collection the morning after delivery then at 1,3,6,9,12 months post-partum by phone and thereafter if still breastfeeding at 12 months.</p>	<p>A process to develop structured equation models to explain intention and duration in the specific groups was carried out and demonstrated that for “homemakers” intention and perceived insufficiency of milk related to duration and in employed mothers’ knowledge, educational attainment, attitudes and perceived insufficiency of milk related to duration. Intention was associated with attitude to breast and bottle feeding and perceived behavioural control. Intention was highly correlated with duration in all groups.</p>

Author, year, country and aim	Methods and sample	Main findings
	Sample: criteria included being first-time mothers over 18 years of age and English speaking. Of 840, 635 completed the initial data.	
(Swanson & Power 2005) Scotland To measure using TPB changes in the influence of subjective norms on infant feeding method from birth to 6 week follow up for breast and bottle feeders.	Semi –structured interviews in the maternity ward included demographic information, feeding intention prior to birth, and current behaviour. Self – completing scales for TPB components, breast and bottle feeding beliefs, subjective norms and PBC.  Sample: 103 new mothers in one hospital 100 new mothers in another hospital who were both primiparous and multiparous. Data collected during a 3-month period.	Subjective norms were important determinants of initiation and continuation of breastfeeding for breast and bottle feeders. Breast feeders rated their mother as more in favour of bottle feeding and against breastfeeding at 6 weeks. Partner’s and midwives’ views were important at baseline and follow up. 58% responded at follow up and were more likely to have breastfed than bottle fed in hospital.
(Giles et al. 2007) Northern Ireland  To design and pilot a questionnaire to measure young people’s attitude to breastfeeding using the TPB.	Phase 1. Belief elicitation using focus groups. Phase 2. Questionnaire development incorporating all constructs from TPB. Phase 3. Pilot study. Sample/participants: Phase 1. Six Focus groups with 48 young people aged 13-14 years. Phase 3. 121 school children aged 13-14.	For males, the most significant correlation with intention was with subjective norm, followed by attitude, perceived control and self-efficacy. The normative component also produced the most significant correlation with intention for females, followed by attitude, self-efficacy and perceived control. However the sample was too small to draw anything conclusive from these data.  The questionnaire was reliable and analysis provided strong support for the predictive power of TPB

### 3.5.3 Breastfeeding and TPB: Qualitative studies

TPB has been used in qualitative research to examine and explore behaviour and to provide a framework for discussion in focus groups (see Table 6). Using a qualitative design, to explore women’s views on their experience of breastfeeding, Moore and Coty (2006) conducted focus groups to elicit perceptions about barriers and facilitators influencing breastfeeding intention in pregnant women then re-interviewed the women to discover what actual barriers and facilitators were encountered after the birth and their effects on breastfeeding. The researchers then devised an explanatory model of their findings based on TPB. The main conclusion was that while women may intend to breastfeed, if there are problems then their intention can

change and this was open to review on a daily basis depending on progress at the time (Moore & Coty 2006). Heinig et al. (2006) used TPB to guide focus group discussions to understand beliefs, intentions and infant feeding behaviour in low income women with regard to how they intended to feed their babies and how they actually fed their babies. The participants were part of a particularly vulnerable population and their stated intention to breastfeed was readily changed. Despite stated beliefs about the benefits of breastfeeding they formula fed to resolve problems. The normative beliefs the participants were exposed to were very mixed and the women had very poor control beliefs about their own ability to continue breastfeeding (Heinig et al. 2006) (see Table 6).

This qualitative research explained the background to the change in intention in both study examples. This was very helpful for this thesis in explaining women's dilemmas where one study concentrated on changing intention during attempts to perform the skill and the other related to this and the wider influences on intention and behaviour.

**Table 6 Qualitative research using TPB**

Author, year, country and aim	Methods and sample	Main findings
(Moore & Coty 2006) USA To explore women's prenatal attitudes, perception of support, anticipated barriers, facilitators and breastfeeding self-efficacy beliefs and how these aspects changed after postpartum experience with breastfeeding	A prospective descriptive design using qualitative data collection methods. Focus groups were conducted when women were in the third trimester of pregnancy. Groups were repeated at 6-8 weeks postpartum.  Sample: 9 primigravid women, married, college educated, middle-upper class, white, age 22-35. 8 of 9 planned to return to work.	Prenatal themes: benefit of breastfeeding, availability of support, looking toward the future, uncertainty in expectation. Postnatal themes: breastfeeding was both easy and difficult, importance and role of supportive others, receiving conflicting advice, having validating experiences and modifying breastfeeding intentions based on postpartum experiences. Referring to TPB (Ajzen 1991) the authors devised a model where even if the mother is confident her intention may change if she meets problems in the performance. They conclude intention is conditional and more dynamic than previously understood.
(Heinig et al. 2006) USA TPB used to examine relationships among maternal beliefs, feeding intentions, and infant feeding behaviour among English and Spanish-speaking WIC participants.	Focus groups using TPB to structure the focus group guide  Sample: Four groups of English speaking mothers and four group of Spanish-speaking mothers. Mothers were either English speaking (28) or Spanish speaking (37) and had a 4-12	TPB gave a framework for understanding the infant feeding intentions of low income women. The influences were on the women's Behavioural beliefs, Normative beliefs and Control beliefs. The implications are that targeted education interventions are needed to combat inappropriate behaviours while acknowledging the circumstances of

Author, year, country and aim	Methods and sample	Main findings
	month-old baby. Average of 52% still breastfeeding at 8 weeks. All participants in WIC.	the families.

### 3.5.4 Utility of TPB in breastfeeding research

Quantitative and qualitative studies of TPB offer insight into the influences on women’s decisions and adolescents’ attitudes in relation to breastfeeding. While the TPB attempts to predict intention it is less clear if the antecedents of intention can be modified to increase the likelihood of changing intention or behaviour. TPB may be used in changing intentions when people’s intentions are not established in relation to the behaviour or as in the Giles et al. study to devise an educational programme (Hardeman et al. 2002).

Although the TRA and TPB models may be useful in predicting intention when the person is thinking about a behaviour, there is less account in quantitative research of the emotional aspects that are involved in a real life situation (Conner & Sparks 2005). In the studies using qualitative research however TPB does to some extent explain emotional reactions that women have during attempts to initiate breastfeeding and subsequently their intention changing during the process.

This then is a cognitive model that predicts the deciding factors closest to performance of a specific behaviour but may be less useful in explaining behaviour at the point when it is being attempted to be carried out (Conner & Sparks 2005). It is at the point where the behaviour is being carried out, for example after the birth of the baby, that is relevant in my study and TPB would be less useful in explaining influences and changes in behaviour during or around the event.

### 3.6 Stage Theories of Behaviour Change

According to stage theories, a person theoretically moves from one discrete cognitive stage to the next, with certain factors influencing the process of movement through the stages. Different factors are proposed to be important at different stages. As a consequence, stage theories are suggested to be more difficult to test than theories where the probability of certain behaviour is on a continuum with the strength of the intention to perform the behaviour. Examples of stage theories are “The Protection

Adoption Process Model” (PAPM) and the “Transtheoretical Model” (TTM). The PAPM model has seven stages that are said to be involved in the process of adopting precautions against a threat (Sutton 2005). It has been applied to women’s intentions in relation to mammogram screening and an intervention study regarding osteoporosis prevention but not to breast feeding so will not be discussed in this thesis.

### **3.6.1 The Transtheoretical Model of Behaviour Change**

The Transtheoretical Model of Behaviour Change (TTM) is composed of: the Stages of change, the Decisional balance, Confidence and Temptation and the Processes of change. These constructs are the independent variables devised by the “Rhode Island Group” – the group of researchers from the University of Rhode Island who devised the model. The “stages of change” part of the model has five stages, where the Pre action stages are: Pre-contemplation, Contemplation and Preparation. Post action stages are Action (where action has changed overt behaviour for less than six months) and Maintenance. The movement between the adjoining stages are the dependent variables where the independent variables such as “Decisional balance” “Confidence and Temptation” and “Processes of Change” are assumed to influence this movement (Sutton 2005). However there are no specified causal relationships between the variables and Sutton (2005) argues the complexity of the stages make it difficult to test (see Table 7).



**Table 7 Transtheoretical Model of Behaviour Change**

<b>Construct</b>	<b>Description</b>
<p><b>Stages of change</b></p> <p>Pre action stages:</p> <ul style="list-style-type: none"> <li>• Pre-contemplation</li> <li>• Contemplation</li> <li>• Preparation.</li> </ul> <p>Post action stages:</p> <ul style="list-style-type: none"> <li>• Action</li> <li>• Maintenance</li> </ul>	<p>No intention to act in next 6 months</p> <p>Intends to act in next 6 months</p> <p>Intends to act in next 30 days and has started preparation</p> <p>Changed overt behaviour for less than 6 months</p> <p>Has changed overt behaviour for more than 6 months</p>
<b>Decisional balance</b>	Advantages and disadvantages of behaviour change
<b>Confidence and Temptation</b>	The person believes they can undertake the more healthy behaviour in a variety of difficult situations. Temptation relates to continuing with an unhealthy behaviour.
<p><b>Processes of change</b></p> <p>Five experiential processes: e.g. Dramatic relief</p> <p>Raising of consciousness</p> <p>Five behavioural processes: e.g. Helping relationships</p>	<p>The person experiences concealed negative emotions that are involved in behaviour that is unhealthy.</p> <p>The person finds out about ways to help themselves change their behaviour</p> <p>The person looks for and utilizes social support to help change to the healthy behaviour</p>

### 3.6.2 Utility of the Transtheoretical Model

Critics Abraham and Sheeran (1997) explain that some researchers have elaborated “context-related act-specific intention sequences” (such as not buying cigarettes with the morning paper tomorrow) from goal related intention formation (such as stopping smoking). One model the Health Action Approach Model differentiates cognitive processes in intention formation from action phase cognitions where intention changes into behaviour, so is similar to stage models that are behaviour specific. Viewing the evidence for stage models one example was that only 16% moved from one stage of stopping smoking without regressing. Abrahams and Sheeran (1997) conclude the model may not adequately explain behaviour change (Abraham & Sheeran 1997). In a critical review by six academics, comments were made on The

Transtheoretical Model. They argue that interventions based on stages of change are not effective, the validity of the stages has not been established and the case for the model has not yet been made (Brug et al. 2005).

### 3.6.3 Utility of the model (TTM) in breastfeeding research

Few examples exist of TTM being used in breastfeeding research. Humphreys et al. (1998) and Kloeblen et al. (1999) have written up the same data from slightly different perspectives. Their results appear to support the use of a combination of two models TTM and TRA to inform the design of interventions to be developed to improve breastfeeding initiation rates (see Table 8). These examples are limited in scope and critiques of the model suggest lack of applicability for use in this thesis (Brug et al. 2005).

**Table 8 Combined use of Transtheoretical Model with Theory of Reasoned Action**

<b>Author, year, country and aim</b>	<b>Methods and sample</b>	<b>Main findings</b>
(Humphreys, Thompson, & Miner 1998) USA To assess: 1. The feasibility of applying TM and TRA to understanding breastfeeding intention in low income pregnant women. 2. To examine the inter-relationships of the two theories regarding the intention to breastfeed.	70 item self-administered questionnaire based on TM and TRA.  Sample: participants were low income pregnant women of any age, ethnic background or stage of pregnancy in a cross-sectional convenience sample during a two month period.	Significant positive correlations between constructs of TM and TRA.  Encouraging more theoretically based interventions to improve practice.
(Kloeblen, Thompson, & Miner 1999) USA  To examine breastfeeding intention through the constructs of the Transtheoretical model and the modified Reasoned Action model (they state this proposes normative and attitudinal factors are posited to directly influence behavioural intention). To determine the applicability of these constructs to prediction of breastfeeding intention. To differentiate which model is more predictive of intention. To provide an alternative theoretical approach to breastfeeding research	70 item self-administered questionnaire based on TM and TRA.  Sample: Participants were low income pregnant women of any age, ethnic background or stage of pregnancy in a cross-sectional convenience sample during a two month period.	Study findings validated that the Transtheoretical model could predict and explain intention to breastfeed and indirectly the Modified Reasoned Action model explained and predicted breastfeeding intention.

### **3.7 Social Cognitive Theory**

Social Cognitive Theory is a social cognition model developed by Bandura (1986). The model proposes that people act within a concept of “Triadic Reciprocal Causation” (Bandura 1986 pp18) where behaviour, internal personal factors and environmental events interact and affect peoples’ decisions about what they will attempt (Bandura 1989 pp1175). The environment a person constructs for themselves, or finds themselves in, can be viewed on a continuum from positive to negative where they will in preference choose activities and social environments that they judge manageable (Bandura 1989 pp1178). Depending on the aspect of an environment a person chooses, people can have either a helpful or harmful experience. People who believe in themselves and their ability have a sense of control of their environment (Luszczynska & Schwarzer 2005 pp 129) and the more belief or self-efficacy a person has the more they can optimise the environment to their benefit (Bandura 1997 pp 163,294). Self-efficacy (SE) predicts specific behaviour and is a component of Social Cognitive Theory (SCT) (Bandura 1997 pp37). Self-efficacy has been used extensively in breastfeeding research (see Table 9) and as a predictor of health behaviour in wider health behaviour research (Luszczynska & Schwarzer 2005 pp143). SCT offers wider constructs that may offer further explanation of behaviour than SE alone and seems to be the most promising of the models; therefore it will be described in detail here.

There are two core constructs of SCT, Perceived Self Efficacy and Outcome Expectancies. SCT is also concerned with goals and perceived facilitators and barriers to action. These aspects are regulated by forethought and influence peoples’ behaviour (Luszczynska & Schwarzer 2005 pp128).

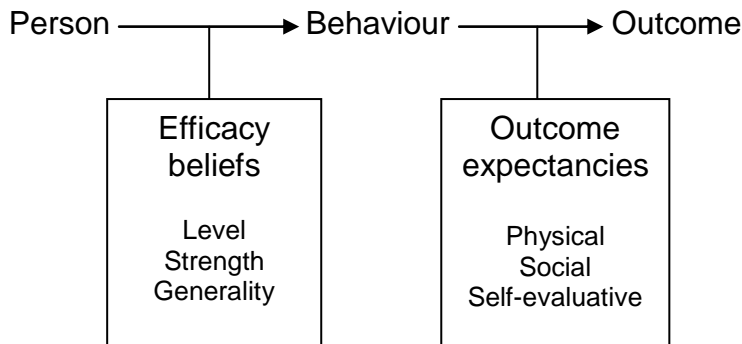
#### **3.7.1 Perceived self-efficacy**

According to SCT, a personal sense of control makes changing or adopting a behaviour possible. Perceived self-efficacy relates to personal agency or action control, concerning what people believe about their ability to carry out an action necessary to achieve an outcome they want (Luszczynska & Schwarzer 2005 pp129). Self-efficacy beliefs determine whether or not the person carries out the action (Bandura 1989 pp1175, 1176).

### 3.7.2 Outcome expectancies

In SCT outcome expectancies are the person's beliefs about effects of the action they take. Outcome expectancies have been recognised in relation to physical, social and self-evaluation aspects (Luszczynska & Schwarzer 2005 pp130) (see Figure 2).

Figure 2. Conditional relationship between Efficacy beliefs and Outcome expectancies (Bandura 1997 pp. 22)



### 3.7.3 The core concept of self-efficacy

The concept of self-efficacy (SE) is defined as *“People’s judgements of their capabilities to organise and execute courses of action required to attain designated types of performances. It is concerned not with the skills one has but with judgements of what one can do with whatever skills one possesses”* (Bandura 1986) and is related directly to behaviour. It attempts to explain how strongly a person believes in their ability to be able to attain a level of performance in a particular situation or whether they avoid the situation if they do not believe they are capable of achieving their desired outcome (Bandura 1986 pp393). This can be the case whether their self-assessment of their capabilities is accurate or not (Bandura 1986 pp393).

Perceived self-efficacy determines how much effort a person will exert in an activity and how long they will persevere in the face of obstacles. If the person has a strong sense of self-efficacy they expect to succeed and they will try harder, but when faced with difficulties people with self-doubt about their capabilities will reduce their efforts or stop trying (Bandura 1986 pp394). Dennis (1999) developed self-efficacy theory in relation to breastfeeding and found evidence that women who were “worried about their ability” or “scared to breastfeed” were more likely to bottle feed (Dennis 1999).

### 3.7.4 Sources of efficacy information

A person's expectations of their own self-efficacy are influenced by four sources of information: 1) performance accomplishments (enactive attainment); 2) vicarious experience; 3) verbal persuasion; and 4) physiological state (Bandura 1977 pp195).

#### *“Performance accomplishments” or enactive attainment*

Enactive attainment is explained as a mastery experience of being successful in an activity (Bandura 1986 pp399). Success raises self-efficacy especially if it is understood to be as a result of skill and not just by chance (Bandura 1977 pp201). These masterful performances are achieved by gradual adjustments during the behaviour and approximating the behaviour to what was previously observed, experienced and given as verbal information. The person also has given it some thought (Bandura 1989 pp1181). The more success the stronger the feeling of efficacy and the more the person may persist even if some problems occur. The feelings then generalise to other activities/tasks, particularly to those that are similar to the successful activity (Bandura 1986 pp399). Development of perseverance is important in helping to raise efficacy expectations as some difficulties that can be overcome teach that some sustained effort is needed (Bandura 1977 pp195). When faced with a complex activity/task which needs various skills, if the person perseveres and has a strong sense of self efficacy, then the skills will contribute to the learning of the more complex activity/task.

Failure lowers self-efficacy, particularly if something goes wrong in the first few attempts despite effort and no unfavourable circumstances (Bandura 1977 pp 195). Failure reduces self-efficacy if it is thought to be caused more by lack of skill than being in an unusual situation (Bandura 1977 pp201). If the person doubts their ability however they may stop trying and give up (Bandura 1986 pp394). When people have self-doubt about their abilities then they are more readily affected by what they perceive as failure (Bandura 1989 pp1189). However when by determination and effort a failure is surmounted, there can be a realisation that mastery is eventually possible (Bandura 1986 pp399).

### ***Vicarious experience***

By watching other people model behaviour especially social behaviour or perform an activity/task, a concept is formed of the behaviour and how the performance of this behaviour affects the other person. Social comparison is important as seeing others performing the activity/task can encourage the person to think that they can do it too. Seeing others coping and persevering can encourage performance. Watching someone like themselves succeeding, who they can identify with, helps (Bandura 1977 pp197). Learning occurs by trying the activity/task, adjusting the results at each attempt according to how well the person assesses his/her performance as being similar to the modelled performance. At first the similarity to others' performance is important; it then becomes more important as to how well each personal attempt compares to the last (Bandura 1997 pp372). This self-evaluation and monitoring of internal standards influences the person's future behaviour (Bandura 1986 pp20). This can shorten the learning time as the way to do something has been seen or visualised and not learned simply by trial and error (Bandura 1986 pp19).

Media sources such as photos, DVDs and television provide a source of symbolic modelling that can influence people's self-efficacy (Bandura 1997 pp93). Similarly if watching another person they identify with and who tries hard but fails at the activity/task then this can reduce feelings of self-efficacy (Bandura 1986 pp399). Watching someone who seems to be able to perform effortlessly is less influential in raising self-efficacy than watching someone overcome difficulty (Bandura 1977 pp197).

### ***Verbal persuasion***

If a person is encouraged to think they are capable of a task they may make more effort but telling someone what to expect may have limited effect on changing behaviour (Bandura 1977 pp198). Verbal persuasion is more likely to help people to believe they can achieve a skill if it is realistic and the conditions facilitate the person's efforts to succeed (Bandura 1977 pp198).

People can be influenced by suggestions that they could perform the activity/task especially by someone they find credible but only if the strategies to help them succeed are also in place. Being told of benefits is less likely to help if the person

does not perceive their other experiences as positive (Bandura 1977 pp198). If the result of the action is unsuccessful then the persuader's reputation will be damaged and the person's self-efficacy will be lowered (Bandura 1977 pp198). Telling people what to expect, with verbal persuasion, may have limited effect as the person has not yet had the experience (Bandura 1977 pp198).

### ***Psychological/physiological state***

A person's "Physiological state" has a bearing on how well they feel able to do something. A person considers how anxious or physically hampered they are when assessing their ability to complete a task (Bandura 1977 pp198). Success is more likely if the person is not highly anxious as the activity/task may increase the anxiety. When people consider that they may not be competent their anxiety can be increased by anticipating the activity (Bandura 1977 pp199). People will not undertake an activity if they believe it to be a risk so they avoid the situation (Bandura 1989 pp1178). If an activity/task is involved that requires physical effort then tiredness or pain can influence feelings of efficacy. Adverse thoughts and feelings can reduce the likelihood of success. Stress can exaggerate feelings of being unable to cope but if the person is afraid and anxious and then is able to successfully perform the behaviour, their fear and anxiety is lowered (Bandura 1977 pp199).

### **3.7.5 The core concept of outcome expectation**

An outcome expectation is the judgement by a person of the likely consequences of behaviour or what the person expects will happen if the behaviour is performed. This influences the choice of what a person may try to do. Behaviour that can be anticipated to be beneficial can increase self-motivation (Bandura 1997 pp122). The outcome is the consequence of the behaviour not the behaviour itself (Bandura 1997 pp22). People can think if they do something it could result in certain outcomes but they don't actually perform the behaviour because they don't think they can do all that is necessary to be successful (Bandura 1986 pp392). For example, by breastfeeding her baby (behaviour) a woman will expect to achieve the health benefits ascribed to breastfeeding for her baby (outcome). Outcome expectation can refer to the anticipation of physical, social, and self-evaluative consequences of behaviour change or action, such as breastfeeding (Luszczynska & Schwarzer 2005 pp130). Physical expectations of the effects of attempting to breastfeed may be

positive or negative such as good milk production or mastitis and short term effects may be difficulties in attachment and painful nipples but in the long term effective breastfeeding. Social outcome expectations in the case of breastfeeding may refer to approval by family and partner but disapproval by some friends. Self-evaluative outcome may refer to the woman anticipating being proud of her ability to breastfeed or alternatively disappointed if she doesn't manage. Outcome expectancies are important in the initial plans or intention to do something but are less important once the behaviour or action is underway (Luszczynska & Schwarzer 2005 pp132).

### **3.7.6 Additional related aspects of SCT**

#### **3.7.6.1 Motivation**

People have an ability to consider future events and are motivated to do something by thinking about how well they might be able to perform and also to anticipate the positive and negative aspects of their actions. A person then plans to do what they think will be worthwhile and highly valued (Bandura 1997 pp122). So people think ahead and anticipate what they are likely to do and how they are likely to perform (Bandura 1989 pp1179). A person with strong self-efficacy beliefs will believe themselves to be capable of achieving their goals and will be determined to do so (Bandura 1989 pp1176). A person's belief in their self-efficacy is a large part of this motivation (Bandura 1989 pp 1180). When someone considers events beforehand, their sense of self-efficacy influences their thoughts. With high levels of self-efficacy people think of positive ways to do things. People who don't think of themselves as efficacious think more of how they will fail and the thought of problems can lead to exaggeration of the anticipated level of difficulty if people doubt their own abilities (Bandura 1989 pp1176). The ability to think analytically and anticipate events affects how well a person achieves a task. If someone is confident in their problem solving ability they will be able to carry on thinking analytically in difficult situations whereas the reverse is true for those who do not believe in themselves (Bandura 1989 pp1176).

Thinking about and anticipating what they plan to do can motivate a person even when the current circumstances are not especially favourable (forethought) (Bandura 1989 pp1179). So people with a strong sense of self-efficacy believe that even if the environment is not favourable if they focus on the opportunities available they can overcome barriers to achievement.



### **3.7.6.2 Self-regulation**

Self-appraisal plays a large part in the actions people take as action is not simply influenced by others. When a person does something they then evaluate their own performance. The self-directed efforts people make include arranging their surroundings to be helpful, having prompts and incentives as well as being influenced by others (Bandura 1986 pp20). People judge how capable they think they are to be able to achieve a level of performance which is their perceived self-efficacy (Bandura 1986 pp391).

### **3.7.6.3 Reflection**

Humans are characterised by being able to be reflective. This is an ability to think through their experiences and their own thoughts of these experiences. This can enable a person to learn about themselves and their surroundings and to modify how they think about things (Bandura 1986 pp21). Having a reflective self-consciousness means that a person can think about what they have done and consider their own thoughts and perhaps change their thinking about something when they develop more understanding (Bandura 1986 pp21). People judge how capable they are or self-appraise how well they might manage to do something. They make a personal efficacy judgement of how well they might manage or avoid the task if they do not think themselves capable (Bandura 1986 pp393).

### **3.7.6.4 Agency and Goals**

Goals incentivise the person and the more immediate specific goals guide behaviour and are similar to the concept of intention in TPB (Luszczynska & Schwarzer 2005 pp131). Outcome expectancies are motivators for the initial goal but reduce in importance when the behaviour is being carried out where self-efficacy is more important in converting the goal/intention into action (Luszczynska & Schwarzer 2005 pp131). In order to achieve a task, a person aims to challenge themselves, then they try to gauge the effort required to complete the task. When the task is achieved with satisfaction, people with a higher sense of self-efficacy will go on to further challenges. The influences involved are self-evaluation, where goals are set with the criteria for satisfactory performance and where increased effort is stimulated to give satisfaction in the performance. The amount of perceived self-efficacy dictates what challenges to attempt, the amount of effort and the length of perseverance when difficulties arise. The goals people set for themselves are affected by the progress

they make especially if the person has doubts about their capability (Bandura 1989 pp1180).

### **3.7.7 Function and effects of Self-efficacy**

#### **3.7.7.1 Choice behaviour**

Efficacy judgements explain what the person believes about their ability to perform the behaviour (Bandura 1986 pp393). Outcomes however are dependent on how well the person performs so they consider their self-efficacy before deciding on an action (Bandura 1986 pp392). If they are not sure they can perform the action then they may not even try, so avoiding the situation (Bandura 1986 pp393).

#### **3.7.7.2 Effort and persistence**

The more self-efficacy a person feels the more effort is made and the longer he/she will keep trying even if the activity/task is not easy especially if they expect eventual success. Someone with a high level of self-efficacy will make increased efforts and persevere where others who doubt their abilities will give up more readily (Bandura 1986 pp394). What happens in the process can change and is dependent on the person's progress where they may continue with the aim, lower their standard or aim even higher. So people then consider whether their level of self-efficacy matches their achievement (Bandura 1989 pp1179, 1180).

#### **3.7.7.3 Thought patterns and emotional effects**

A strong feeling of self-efficacy and actually being unsure of exactly how to do something is a good motivator to try an activity/task but people will not try activities that are felt to be outwith their ability to cope (Bandura 1982 pp123). People can think through situations and solve problems where they succeed in an activity/task or conversely they fail. Success being a positive contribution to the activity/task and the failure a negative influence (Bandura 1989 pp1176). Positive thought patterns of how to succeed helps raise levels of self-efficacy and vice versa (Bandura 1989 pp1179).

The magnitude of efficacy expectations can vary from person to person on the level of difficulty they can achieve. The generality of efficacy expectations can vary from feelings of being able to do a specific activity/task well to a general feeling of self-efficacy in activities in a similar domain of function. The strength of expectation can

also vary where people who have strong feelings of being able to achieve the activity/task will keep trying (Bandura 1989 pp1179). Having a strong feeling of self-efficacy is useful, as people face problems in life, to encourage achievement and good mental health (Bandura 1989 pp1176).

### **3.7.8 Utility of Social Cognitive Theory/Self-Efficacy in Health Research**

After regularly performing a behaviour people become clear about their expectations of the outcome and their ability to perform. It has therefore become accepted that outcome expectancies and perceived self-efficacy are the constructs of SCT that are most commonly tested in research on health behaviours. In SCT, self-efficacy is the most immediate predictor and comes before a person performs a behaviour (Luszczynska & Schwarzer 2005 pp133). A number of developments have occurred due to the utility of the construct. Bandura suggested self-efficacy should refer to the specific behaviour to be predicted. This idea has been developed so that self-efficacy has been conceptualised as general confidence in dealing with most situations but mainly as situation specific. Future research should be particularly applied to the specific point or phase in a health behaviour change or adoption of the behaviour in an intervention (Luszczynska & Schwarzer 2005 pp146, 159).

### **3.7.9 Breastfeeding and SCT/Self-Efficacy Theory**

Dennis (1999) introduced the application of the concept of self-efficacy as a theoretical framework to the study of breastfeeding confidence. Since this commentary article there has been a range of mostly quantitative research using self-efficacy as the theoretical model (see Table 9). Quantitative studies have been done in relation to predicting breastfeeding self-efficacy (Dennis 2006), enhancing self-efficacy (Kingston, Dennis, & Sword 2007), and the effect of self-efficacy on breastfeeding duration (Blyth et al. 2002). Quantitative studies on initiation and duration (Mossman et al. 2008; Wilhelm et al. 2008; Blyth, Creedy, & Dennis 2004; Chezem, Friesen, & Boettcher 2003) and psychosocial factors including duration (Bailey, Clark, & Shepherd 2008; O'Brien, Buikstra, & Hegney 2008; Kronborg & Vaeth 2004) have been carried out (see Table 9).

**Table 9 Quantitative SE research methods**

Author, year, country and Aim	Methods and sample	Main findings
<p>(Dennis 2006) Canada</p> <p>What maternal characteristics predict breastfeeding SE in the first week postpartum?</p>	<p>Questionnaires at 1,4,8 weeks postpartum. Breastfeeding status, Breastfeeding self-efficacy, Maternal characteristics, Social Support, Obstetric variable.</p> <p>Sample: Women aged at least 18 years 522 participants who returned the 1 week questionnaire and who initiated breastfeeding.</p>	<p>Eight variables explained 54% of the variance.</p> <ul style="list-style-type: none"> <li>• Maternal education.</li> <li>• Support from other women with children.</li> <li>• Type of delivery.</li> <li>• Satisfaction with pain relief in labour.</li> <li>• Satisfaction with postpartum care.</li> <li>• Breastfeeding progress.</li> <li>• Feeding as planned.</li> <li>• Inverse relationship between SE and anxiety.</li> </ul>
<p>(Kingston, Dennis, &amp; Sword 2007) Canada</p> <p>To explore the influence of efficacy enhancing experiences on breastfeeding SE</p>	<p>Infant Feeding and Self-Efficacy Experience Questionnaire and Breastfeeding Self-Efficacy Scale. Self-completed in hospital at 48 hours after the birth and then via telephone at 4 weeks.</p> <p>Sample: All breastfeeding women able to speak English, single baby at 37 plus weeks and discharged with their baby. 63 women completed the study</p>	<p>Women who observed breastfeeding role models through video tapes had significantly higher level of breastfeeding self-efficacy at 48 hours than those who had not (<math>t_{(62)} = 2.69, P &lt; .01</math>) Received praise from their partners or own mother had significantly higher BSES-SF than those who had praise from friends (<math>P = .01</math>). If experienced pain or breastfeeding difficulty mothers had significantly lower level of self-efficacy.</p>
<p>(Blyth et al. 2002) Australia</p> <p>To assess the effect of maternal confidence on breastfeeding duration</p>	<p>Antenatal administration of the Breastfeeding Self-Efficacy Scale then at 1 week and 4 months postnatal. The Breastfeeding Status Questionnaire via telephone at 1 week and 4 months.</p> <p>Sample: Pregnant women at least 36 weeks gestation aged over 18 years, understood English with no adverse factors and who intended to breastfeed. 300 women agreed to participate.</p>	<p>Higher antenatal breastfeeding self-efficacy scores were found in women exclusively breastfeeding at 1 week with a significant difference from women who were bottle feeding. The scores at 1 week were more predictive of SE at 4 months than the antenatal scores. Mothers with high breastfeeding self-efficacy scores were more likely to be breastfeeding exclusively at 1 week and 4 months.</p>
<p>(Mossman et al. 2008) Canada</p> <p>To examine the influence of breastfeeding confidence and attitudes on breastfeeding initiation and duration to 28 days postpartum among adolescent mothers</p>	<p>Breastfeeding attitude questionnaire, Breastfeeding self-efficacy scale-short form, Demographic and breastfeeding information questionnaire administered at the antenatal clinic. At 1 week postnatal Breastfeeding self-efficacy scale-short form was re-administered to all who had initiated breastfeeding. Those mothers were contacted again at 4 weeks to determine infant feeding method and if stopped breastfeeding the reason.</p>	<p>84 initiated breastfeeding and 46 continued to breastfeed at 4 weeks. Significantly more who initiated breastfeeding were breastfed as infants, planned to feed significantly longer and decided to breastfeed either before pregnancy or in the first trimester. More mothers who initiated had a partner supportive of breastfeeding. Mothers who initiated breastfeeding (n=84), 57.1% had a high prenatal SE score but was not significant. Significantly more with a high</p>

Author, year, country and Aim	Methods and sample	Main findings
	<p>Sample: convenience sample 103 pregnant adolescents aged between 15-19 years at more than 34 weeks contemplating breastfeeding. Exclusion criteria were applied.</p>	<p>prenatal attitude score initiated breastfeeding (<math>P=.001</math>). Difference in breastfeeding survival based on prenatal confidence is statistically significant (hazard ratio = 2.22 95%CI =1.13-4.17, <math>P=.02</math>) Significantly more mothers in high postnatal confidence group maintained breastfeeding to the 28 day contact period (hazard ratio = 4.19, 95%CI =2.18-8.04, <math>P=.001</math>) Significantly more mothers in the higher attitude group maintained breastfeeding to the 28 day contact period (hazard ratio = 2.17, 95%CI =1.13-4.17, <math>P=.02</math>)</p>
<p>(Wilhelm et al. 2008) USA To explore the relationship of two modifiable factors (intention to breastfeed for 6 months and breastfeeding self-efficacy) with the duration of breastfeeding in primiparous women.</p>	<p>A secondary analysis of data from a pilot study. Sample: Convenience sample of 73 prim breastfeeding mothers 19-38years, exclusion criteria were applied. At two weeks 18 had stopped breastfeeding and were excluded.</p>	<p>Stronger intention (odds ratio = 1.89) and higher SE at 2 weeks postpartum (odds ratio =1.04) were significantly (<math>p&lt;.05</math>) associated with an increased probability of breastfeeding for 6 months.</p>
<p>(Blyth, Creedy, &amp; Dennis 2004) Australia  To assess the effect of modifiable antenatal variables on breastfeeding outcomes.</p>	<p>Single open ended question measured intended duration. Self-report questionnaires on Provision of Breastfeeding Information, Breastfeeding Support, Breastfeeding Confidence completed in the antenatal clinic. Duration of breastfeeding measured at 1 week and in weeks at 4 months.  Sample: Pregnant women at least 36 weeks gestation aged over 18 years, understood English with no adverse factors and who intended to breastfeed. 300 women agreed to participate.</p>	<p>Intended breastfeeding duration and breastfeeding self-efficacy were identified as the most significant modifiable variables predictive of breastfeeding outcomes. Mothers who intended to breastfeed for &lt;6 months were 2.4 times as likely to have discontinued breastfeeding at 4 months compared to those who intended to breastfeed for &gt;12 months (35.7% v 87.5%). Similarly mothers with a high breastfeeding SE were more likely to be breastfeeding than mothers with a low SE (79.3%v 50.0%)</p>
<p>(Chezem, Friesen, &amp; Boettcher 2003) USA  To explore relationships among breastfeeding knowledge, breastfeeding confidence and infant feeding plans</p>	<p>Prospective descriptive design where telephone interviews were conducted antenatally and at 6 weeks, 3 months and 6 months postpartum. Questionnaires were Maternal confidence Survey, Breastfeeding questionnaire, Prenatal Data Collection Tool, Postnatal Data Collection Tool.</p>	<p>Breastfeeding knowledge was strongly correlated with breastfeeding confidence (<math>r = .262</math>; <math>p = .025</math>) and actual lactation duration (<math>r = .455</math>; <math>p = .0001</math>). Women planning to combination feed planned shorter breastfeeding duration (<math>p = .022</math>) and reported shorter actual duration (<math>p = .004</math>) and were less likely to meet their breastfeeding goal (<math>p = .034</math>)</p>

Author, year, country and Aim	Methods and sample	Main findings
and their effects on feeding practices in first-time breastfeeding mothers.	Sample: 74 primigravida who intended to breastfeed. Exclusion criteria were applied.	
(Bailey, Clark, & Shepherd 2008) England  To discover which psychosocial factors influence breastfeeding duration and which factors are different between age groups.	Longitudinal between subjects/repeated measures cohort design. Three phases, one in antenatal period, two in postnatal period one at two weeks postnatal and one at four months.  Sample: Women in third trimester of pregnancy 16-24 years and 25 years plus. 145 questionnaires distributed. 57 completed first phase with 47 completing all phases. Exclusion criteria were applied	Duration ranged from 0 days to 4 months. Significantly more older women had positive attitudes. BSES scores for younger group were significantly lower between phase 1 and 2 ( $t(8) = 3.36$ ; $P < 0.01$ ). 64% of variance in breastfeeding duration was explained in the regression model by age, GSES and BSES where general self-efficacy and breastfeeding self-efficacy from phase one and two were independently predictive of duration when age was accounted for.
(O'Brien, Buikstra, & Hegney 2008) Australia To examine the relationship between women's psychological characteristics and breastfeeding duration, after controlling for socio demographic factors.	Prospective survey based design. Survey completed within 14 days of birth and follow up telephone interview at six months.  Sample: Women who gave birth in two maternity units in a three month period. Exclusion criteria were applied. 375 out of possible 657 completed the questionnaire.	44% of sample reported signs of distress within the first 14 days after the birth. Breastfeeding duration was statistically significantly associated with psychological factors. The probability of continuing to fully breastfeed increased by 36% for every one point increase in the faith in breastmilk score and participants were 1.72 times more likely to cease fully breastfeeding prematurely if they had planned to breastfeed for six months or less. Every one point increase in the breastfeeding SE score resulted in a 5% increase in the likelihood of continuing to breastfeed for 6 months.
(Kronborg & Vaeth 2004) Denmark  To examine to what extent psychosocial factors are related to the length of breastfeeding.	An observational study of a fixed cohort of mothers during a two month period. Self-report questionnaire within three weeks of birth including questions based on TPB and SCT and mothers' knowledge of breastfeeding. The health visitor reported on breastfeeding status until 17 weeks after the birth.  Sample: All Danish mothers of singletons, who lived in the county, were included. 471 participated 187 primis, 279 multips.	Statistically significant positive association with duration of breastfeeding: duration of schooling ( $p = 0.002$ ), Intention to breastfeed ( $p = 0.001$ ), previous breastfeeding experience ( $p = 0.001$ ), SE in breastfeeding ( $p = 0.001$ ), how confident about not knowing amount of breastmilk baby received ( $p = 0.012$ ) and knowledge of breastfeeding ( $p = 0.001$ ). At 17 weeks 59% of women were still breastfeeding but 51% of those who stopped during the study did so within the first five weeks.

One qualitative study using self-efficacy has been carried out (Entwistle, Kendall, & Mead 2010). The study used in depth open ended interviews to explore the breastfeeding support experiences of women using SE as the explanatory framework (see Table 10).

**Table 10 Qualitative SE research methods**

<b>Author, year, country and Aim</b>	<b>Methods and sample</b>	<b>Main findings</b>
(Entwistle, Kendall, & Mead 2010) UK  To explore the experiences in relation to breastfeeding support in the postnatal period described by women from low income groups within the explanatory framework of the self-efficacy theory (Bandura 1982)	Part of a larger study concerned with breastfeeding outcomes for low-income women. In depth open ended interviews between 10 and 18 weeks post natal. Using Bandura's self-efficacy theory to interpret themes.  Purposive sample from 204 women in main study. 7 women from low -income areas were interviewed between 10-18 weeks postnatal. Only 2 women were still breastfeeding at the time of the interview. 3 primigravidae and 4 multigravidae.	Breastfeeding related to: Women's self-confidence where SE theory related to experiencing self-mastery helped confidence. The social environment where vicarious experience gives a source of self – efficacy information. Knowledge of breastfeeding may be transmitted as verbal information but may not be the most effective method. The influence of maternity services on breastfeeding outcomes where heightened emotional arousal and birth trauma can negatively affect SE expectations.

### 3.7.10 Utility of the Self-Efficacy Model in breastfeeding research

These studies offer extensive support for the role of self –efficacy in breastfeeding initiation and duration and using quantitative measures of self-efficacy illustrate that the model has good predictive validity when measuring levels of self-efficacy, enhancement of self-efficacy and initiation and duration of breastfeeding. All the quantitative studies, except Chezem et al. (2003) and Kronborg and Vaeth (2004), used a form of the Breastfeeding Self-Efficacy Scale developed by Dennis and Faux (1999) illustrating the popularity and utility of the scale and the use of the self-efficacy concept in relation to breastfeeding (Dennis & Faux 1999).

Of particular relevance to this thesis Kingston et al. (2007) used a quantitative method to explore efficacy enhancing experiences at 48 hours and 4 weeks after birth. The period of time from birth to 48 hours is most relevant to initiation. They found that if women had previous experience of breastfeeding and the current

breastfeeding experience was going well at 48 hours, women were more likely to feel confident (Kingston, Dennis, & Sword 2007). This could be described as having a mastery experience.

Entwistle et al. (2010) explored experiences of low income women and their breastfeeding support in the postnatal period using in depth open-ended interviews. The study was carried out at between 10 and 18 weeks postnatal. The initiation period, where the women were in hospital, was included along with her self-confidence, social environment, and knowledge. A thematic analysis and an interpretation of the themes was carried out using self-efficacy theory to understand the key issues that might be relevant to future breastfeeding promotion in low income areas. Women who were able to breastfeed experienced a sense of mastery which encouraged them to continue but women who did not have this positive experience were less likely to continue. The women's social environment where the women were familiar with breastfeeding was helpful as the mothers had previous positive vicarious experience. The reverse was true for women who had no previous experience and they stopped trying to breastfeed as they lacked confidence from their social support. The help women had from the midwives after the birth was influential in women's attempts to start breastfeeding where they were supported. If there was a lack of help after a stressful birth experience women felt unsupported and negatively emotionally aroused and they gave up breastfeeding, which demonstrated that women's psychological state affected their progress (Entwistle, Kendall, & Mead 2010). This type of exploration and explanation of the women's experiences was helpful in understanding what encouraged women to continue breastfeeding.

### **3.7.11 Summary**

The social cognition models TRA and TPB were useful in the prediction of intention to breastfeed and concentrate on measurement of variables in the prediction of factors that could be targeted to influence intention and duration of breastfeeding. Perceived behavioural control concerns what a person thinks about their ability to carry out behaviour such as breastfeeding and can be measured by calculating the number of control beliefs by the power of each belief. However Ajzen (2002) concluded that control and self-efficacy should be measured together (Ajzen 2002).



TPB can provide a framework for understanding the influences of beliefs on women's decisions but is less useful in taking account of the potential emotional aspects that a woman may face when attempting to start breastfeeding her baby. The model was less useful when explaining influences on behaviour at the point when behaviour was being attempted.

The TTM may be useful in the design of an intervention to increase women's intention to breastfeed. The theory/model concentrates on changing behaviour as a process through stages. The act of starting to breastfeed, although a change in behaviour for women, is action- and context-specific and post-intention and, like the TPB, this model was less useful when explaining influences on behaviour at the point when behaviour was being attempted.

Social Cognitive Theory proposes that people act within a concept of "Triadic Reciprocal Causation" (Bandura 1986) where the two core constructs are Perceived Self-Efficacy and Outcome Expectancies (Luszczynska & Schwarzer 2005). There are further explanatory aspects in relation to sources of efficacy information, goals and facilitators and barriers to action. Qualitative research as in (Entwistle, Kendall, & Mead 2010) gives a rich explanation of women's dilemmas in their attempts to start breastfeeding after the birth.

Bandura (1997) suggests that SE is "a belief about what one can do under different sets of conditions with whatever skills one possesses" (Bandura 1997). The main influence on perceived self-efficacy is Personal mastery where the person has evidence of their achievement. Vicarious experience where watching someone perform/model behaviour, verbal persuasion, and psychological state can enhance self-efficacy. These constructs provide the scope to focus on women and midwives' experiences during the situation specific attempts to initiate breastfeeding with more emphasis on explaining the influences on specific behaviours during the process rather than prediction of intended behaviour. The additional explanatory aspects afforded by the SCT should allow further development of the understanding of the issues women and midwives face around initiation of breastfeeding.

### **3.7.12 Conclusion**

The central aim of this thesis is to explore and understand the experiences of women and midwives around the initiation of breastfeeding and so a qualitative approach was chosen.

From the literature review described in this chapter, Social Cognitive Theory is the most appropriate model to provide a theoretical framework for analysis of the experiences of women and midwives and explore their interactions.

## **Chapter 4 Systematic Literature Review: Thematic synthesis of women's and midwives' expectations, knowledge and experiences of breastfeeding initiation.**

### **4.1 Introduction**

Few studies will have explored, as a primary aim, women's and midwives' expectations, knowledge and experiences at the very start of breastfeeding.

The aim of the fourth chapter is to provide a background of the situation, current to the timing of the data collection, by synthesising qualitative studies examining what is known about women and midwives' expectations, knowledge and experiences of breastfeeding initiation.

#### **Objectives**

1. To carry out a search of relevant literature
2. To inductively analyse the data using thematic synthesis
3. To use Social Cognitive Theory to deductively interpret the inductive themes

### **4.2 Methods**

#### **4.2.1 Literature search**

A search of key electronic databases was undertaken to identify relevant qualitative studies that included expectations, knowledge and experiences of breastfeeding initiation. The databases were chosen to provide a wide a range of national and international sources and were those which included journals relevant to midwifery, public health and nutrition and thus were relevant to the focus of the search, Inclusion and exclusion criteria specific to the initiation period were identified and a quality appraisal strategy devised.

A search of the following databases was undertaken to identify relevant qualitative studies on 11 January 2012:

MEDLINE(R) <1946 to December Week 4 2011>, Embase <1980 to 2012 Week 01>, MIDIRS: Maternity and Infant Care, CINAHL 1980 to 2012.

Search terms used with all databases:

Infant feeding or breast feed\* or lactat\*) AND AB (begin\* or start\* or initia\* or commenc\*) AND (qualitative or focus group or interview\* or grounded theory or phenomenology)

Limits: Published in English and limited to humans

The details of the search results are given in a PRISMA Diagram (see Figure 3).

#### 4.2.2 Inclusion and exclusion criteria

As the purpose of this review was to inform the qualitative study, it was important to focus on qualitative research that included reference to the precise period of time where the baby was offered the breast for the first and subsequent times in the immediate postnatal period. The research had to address the definition of initiation used in the thesis, i.e.: *“A process that starts at birth and continues until successful latching at the breast is learned by mother and baby, which may take 48 hours or more to achieve.”*

Each study was assessed as to whether it met the following inclusion or exclusion criteria.

##### Inclusion criteria

- Study design: qualitative, using focus groups, in depth interviews or ethnography.
- Population: pregnant or postnatal women and midwives
- Focus of the study: expectations, experiences or knowledge of breastfeeding initiation.

##### Exclusion criteria

Studies that only included:

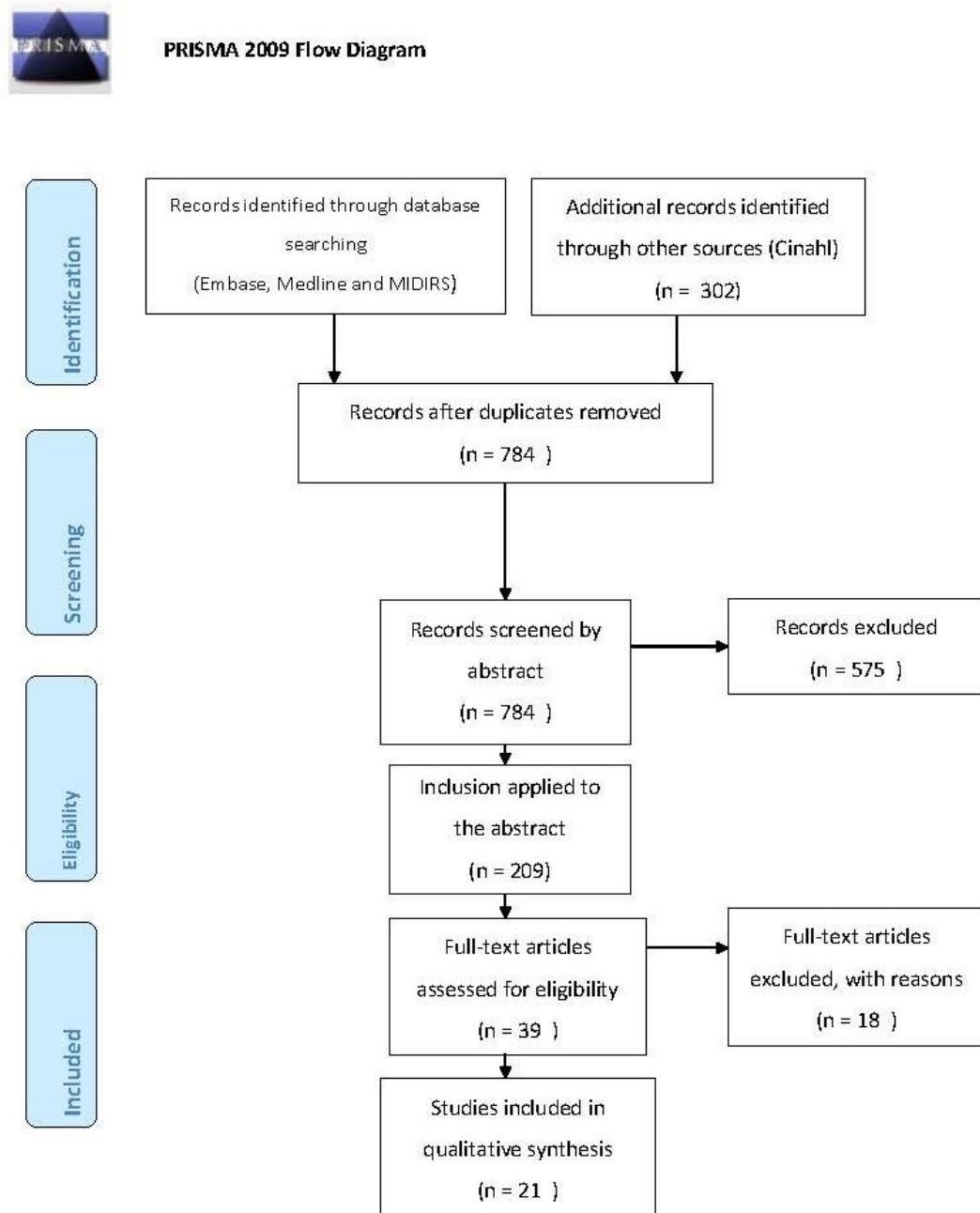
- Women who plan to bottle feed.
- Studies related to premature or ill babies or mothers.
- Survey designs as quantitative questions are not sufficiently in depth to capture meaning.

Studies that focused on:

- Cultural issues specific to local circumstances e.g. in the developing world.
- Devising policy and practice for breastfeeding.

- The influences on women’s intention to breastfeed were excluded. Only those who actually initiated breastfeeding were relevant.
- Women’s support needs in relation to breastfeeding.

Figure 3. PRISMA 2009 Flow Diagram



### **4.2.3 Applying the inclusion criteria and data extraction**

A total of 1099 references were downloaded to Reference Manager. After the duplicates were removed, 784 remained. The titles were scanned for relevance and those clearly not eligible were removed leaving 209 references. The inclusion/exclusion criteria were applied independently by the author and her supervisor to these 209 and differences resolved by discussion. Full copies of the 39 studies that appeared to meet the inclusion criteria were obtained. The studies excluded after further examination, did not focus sufficiently on initiation, were focused on local cultural issues or used quantitative methods. Three dissertations were unavailable and therefore had to be excluded. There were 21 studies remaining. Data regarding the characteristics of the studies were extracted at this point and entered into word documents as tables (Appendices 1 and 2).

### **4.2.4 Quality appraisal**

The assessment tool for the Critical Appraisal Skills Programme (CASP), (Public Health Resource Unit 2006) was used as a basis to evaluate the quality of the papers and modified by the author in conjunction with her supervisor to assess the specific relevance to initiation of breastfeeding in the following ways. The relevance of the study, in meeting individual CASP criteria, was summarised by indicating yes (Y) or no (N). Comments were added to as an aid memoire to critical points about the studies as to importance, use of theories and amongst other points, how thought provoking it was found. The last section in the original CASP questionnaire relates to the value of each paper and this was modified to summarise how well the paper met the criteria and was titled "Assessment of quality" and if the study "met all" of the CASP criteria, "met most" of the criteria, or "met few" of the criteria. I quality appraised all the studies using the tool, and a sample of the 21 studies (20%) was independently appraised by my supervisor (RJ) and differences resolved by discussion. All the studies were judged to be of sufficient quality to be coded in the synthesis. Results of the quality appraisal are reported in Appendix 3.

### **4.2.5 Analysis: Method of Thematic synthesis**

The findings of the studies were synthesised using Thomas and Harden's (2008) method of thematic synthesis. Qualitative research examines peoples' thoughts and experiences and is specific to the group of participants. However reviews of qualitative research can explore findings from relevant papers, maintaining the

essence of the content, but are able to infer new meanings in relation to a specific review question (Thomas & Harden 2008). The research methods used in the studies included in this review varied and included phenomenology, grounded theory and ethnography. Although these methods analyse the data differently it can be argued that thematic synthesis is a process that can be used to synthesise the results of varying methods of primary qualitative research (Walsh & Downe 2005; Thomas & Harden 2008). In order to generate codes and themes the data extracted from the papers were the comments by the author/s of the paper and the participant's quotations under the heading "results" or "findings" specifically pertaining to the process of initiation of breastfeeding. Codes/subthemes were devised and assigned to the comments of the authors and corresponding quotes of the participants (Walsh & Downe 2005) by this author and validated by her two supervisors. The process was then reversed and the codes were reviewed to check the consistency in the meaning of the text. The codes/subthemes from each paper were compared and organised into overarching themes or tree structures by re-reading and considering the aim of the review (Thomas & Harden 2008). This approach was used to examine what is known about women and midwives expectations, knowledge and experiences of breastfeeding initiation. The text and quotations were entered into tables under the headings of: author, author's comments, quotes from participants, sub-themes/codes, and themes (see Appendices 4, 5 and 6).

As in Thomas and Harden (2008) the original intention was to code according to the review aim but coding was done inductively to better demonstrate meaning, as the a priori framework of the question may have precluded trustworthiness of the findings from this analysis. Each comment and corresponding quote was examined and assigned a code with new codes being developed as the process extended. Similarities and differences in these codes were then grouped into descriptive themes and analytical themes. After the analysis had been completed, the subthemes were also assessed to see how closely (if at all) they deductively mapped onto components of social cognitive/self-efficacy theory (the underpinning theoretical framework for this qualitative study).

Dennis (1999) introduced the application of the concept of self-efficacy, a core concept of Social Cognitive Theory (SCT), to the study of breastfeeding confidence.

In this thesis SCT is used deductively to interpret and understand the themes in an effort to conceptualise key areas of the women's experiences. Social cognitive theory explains that people's actions are influenced by the interaction of behaviour, personal factors and the environment. Within this theory, the self-efficacy beliefs that the person holds, helps them to decide whether they carry out the action or not (Bandura 1977). The concept of self-efficacy (SE) is defined as "People's judgements of their capabilities to organise and execute courses of action required to attain designated types of performances. It is concerned not with the skills one has but with judgements of what one can do with whatever skills one possesses" (Bandura 1986 pp. 391), (see Chapter 3 for theoretical background to thesis). The themes and subthemes in the Systematic Review were interpreted within the framework of SCT and an explanation was constructed for the women's experiences. The Relationship of Themes and Subthemes to Social Cognitive Theory is illustrated in Table 11.

### **4.3 Results**

Of the 21 included studies, 13 studies related specifically to women, six papers related specifically to midwives, one paper was an ethnographic study that applied to both women and midwives (Dykes 2005) and one study had results from focus groups from both women and health care workers (Vogel & Mitchell 1998). Three of the 21 studies were part of wider studies: one paper was done in conjunction with a US state wide quantitative survey to investigate breastfeeding practices among adolescent mothers (Tucker, Wilson, & Samandari 2011) and another was part of a larger US Department of Health study whose aim was to increase breastfeeding rates for all women (Avery et al. 2009). One study was carried out as part of a wider study to examine the impact of a UNICEF training programme on midwives' knowledge and attitudes and breastfeeding outcomes for low-income women (Entwistle et al. 2010).

#### **4.3.1 Description of studies**

The studies were analysed in two groups, one for mothers and one for midwives. Appendix 1 provides a description of the 13 qualitative studies with women as participants. The studies were undertaken in four Western Countries. Five were undertaken in the United Kingdom (Hoddinott & Pill 1999; Thomson & Dykes 2011; Entwistle, Kendall, & Mead 2010; Ryan, Todres, & Alexander 2011; Dykes et al. 2003), six papers in the United States of America (Wambach & Cohen 2009; Tucker,



Wilson, & Samandari 2011; Mozingo et al. 2000; Kelleher 2006; Hong, Callister, & Schwartz 2003; Avery et al. 2009), two in New Zealand (Bradfield 1996; Vogel & Mitchell 1998) and one in Australia (McGrath & Phillips 2009).

Women in the studies were from a range of ages, parity, ethnicity and included women who “hoped” (Avery et al.’s terminology) to become pregnant (Avery et al. 2009), women in very early pregnancy before booking for antenatal care (Hoddinott & Pill 1999) and women nine months after the birth (Thomson & Dykes 2011). There were almost an equal number of women having their first baby (primipara) and women having their second or subsequent babies (multipara). In the women’s studies, there were three with teenage participants and four that mentioned specifically low income women.

Half of the studies detailed how many women were still breastfeeding at the time of data collection which ranged from 48 hours after the birth to nine months. Some papers gave information about when exactly women stopped breastfeeding. At 48 hours 2:20 had stopped breastfeeding in Hong, Callister, & Schwartz (2003); at two weeks 9:9 had given up in Mozingo et al. (2000) and 8:13 in Dykes et al. (2003); and at 10-18 weeks 5:7 had given up in Entwistle, Kendall, & Mead (2010). This illustrates that early cessation of breastfeeding is also a problem outwith the UK.

Appendix 2 provides a description of the six studies with midwives as participants. Some also included other healthcare professionals, for example, doctors, maternity and neonatal nurses, lactation consultants, community child health nurses and mothers as well as midwives. Three studies were conducted in the United Kingdom (West & Topping 2000; Dykes 2005; Furber & Thomson 2007). One in the United States of America (Weddig, Baker, & Auld 2011), one in New Zealand (Vogel & Mitchell 1998) and three in Australia (Walsh, Pincombe, & Henderson 2011; Reddin, Pincombe, & Darbyshire 2007; and Henderson, Pincombe, & Stamp 2000).

The participants were from a range of areas of practice in hospital and community with some working in teams. The hospitals were large city hospitals or smaller hospitals with fewer babies delivered. The length of midwifery experience ranged from being newly qualified (Reddin, Pincombe, & Darbyshire 2007; Dykes 2005) to

having 31 years of experience (Furber & Thomson 2007). Only two papers mentioned that the participants had personal breastfeeding experience. In Reddin et al. (2007), 8 out of 9 participants had breastfed their own babies and in Henderson et al. (2000), 72% had personal experience of breastfeeding. Four papers were concerned with BFHI policy or practice (West & Topping 2000; Walsh, Pincombe, & Henderson 2011; Reddin, Pincombe, & Darbyshire 2007; and Weddig, Baker, & Auld 2011).

Six papers of the papers researching women and one researching midwives referred to social/psychological theories being used in the research. These theories (and the studies referring to them) were;

Antonovsky's Sense of Coherence Theory (Thomson & Dykes 2011); Bandura's Social Learning Theory (Reddin, Pincombe & Darbyshire 2007); Bandura's self-efficacy theory (Entwistle, Kendall & Mead 2010); Ajzen's Theory of Planned Behaviour (Tucker, Wilson & Samandari 2011); Feminist theory (Kelleher 2006; Bradfield 1996) and Embodied and emotional dimensions of breastfeeding (Ryan, Todres & Alexander 2011).

#### **4.3.2 Relevance of all studies to the initiation of breastfeeding**

The studies' aims (both for women and midwives) were usually wider than the definition of initiation of breastfeeding referred to previously (see section 4.2.2), so in order to focus on this specific area, relevance to the initiation of breastfeeding was assessed and the nature of that relevance was indicated as either "Main topic of the study", "Topic that ran through the study" or "One of the study's themes". There was no hierarchy in the classification but the nature of the relevance to initiation was captured by these statements (see Appendices 1 and 2). This was in part a subjective exercise where relevance to initiation was interrogated in each paper. The aims of the studies provided a starting point, and the results section of the studies gave the authors' findings and main themes. In the four studies relating to women, initiation of breastfeeding was the main topic (Mozingo et al. 2000; Vogel & Mitchell 1998; McGrath & Phillips 2009; Avery et al. 2009). Initiation was a topic that ran through six studies (Thomson & Dykes 2011; Ryan, Todres, & Alexander 2011; Dykes et al. 2003; Kelleher 2006; Bradfield 1996; Hong, Callister, & Schwartz 2003).

Initiation was just one of the themes in four studies (Hoddinott & Pill 1999; Entwistle, Kendall, & Mead 2010; Wambach & Cohen 2009; Tucker, Wilson, & Samandari 2011).

Initiation of breastfeeding was the main topic in three studies relating to midwives (West & Topping 2000; Vogel & Mitchell 1998 (Vogel & Mitchell related to mothers as well); Henderson, Pincombe, & Stamp 2000). The relevance to some of the studies in this section required an amended descriptor as in “One of the study’s themes but ran though the study” as although this was not the specific aim of the study initiation was the subject of the activities (Walsh, Pincombe, & Henderson 2011; Reddin, Pincombe, & Darbyshire 2007; Dykes 2005; Weddig, Baker, & Auld 2011; Furber & Thomson 2007).

#### **4.3.3 Quality of the included studies**

The purpose of the quality assessment was to explore the quality of the body of research and provide an indicator of better quality studies versus poorer quality. Table 4 reports on quality assessments of the studies. Overall the quality of the included studies was good. Five studies met all the CASP criteria. Thirteen studies met most of the criteria and two met only a few of the criteria (see Appendix 3).

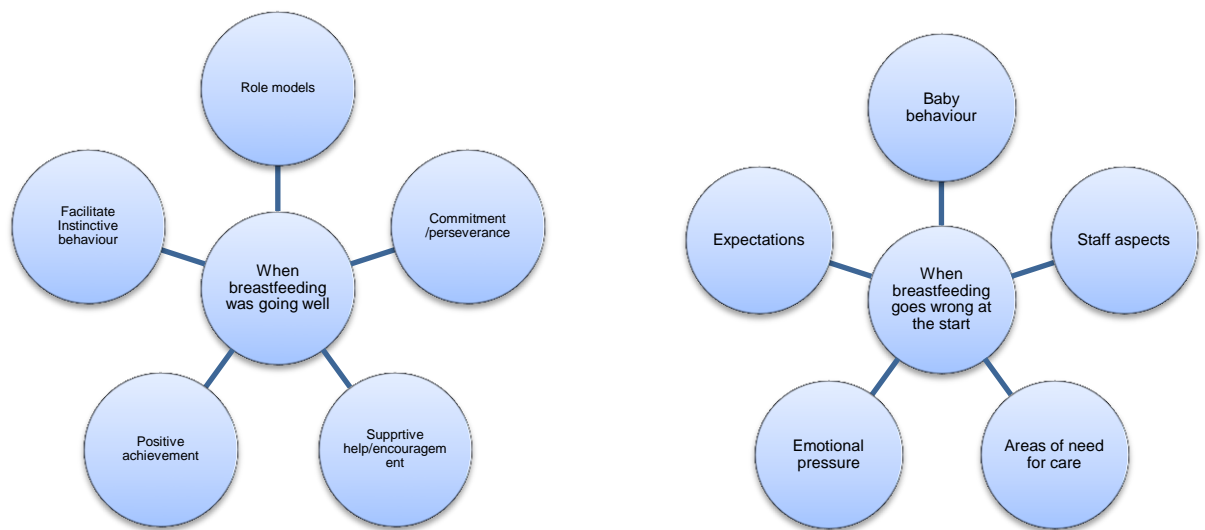
A number of quality criteria areas were not well reported in the studies. For example, the relationship between the researcher and the participants was rarely considered. The personal attributes of the researcher may affect the interview (Britten 2006) and the role and perceived status of the interviewer can influence the responses of the participants (Taylor 2005) so this is an important area. Studies that did consider this relationship were: Hoddinott & Pill 1999a; Entwistle, Kendall, & Mead 2010; Wambach & Cohen 2009; Mazingo et al. 2000; Hong, Callister, & Schwartz 2003; McGrath & Phillips 2009; Furber & Thomson 2007. The analysis was very briefly described in Kelleher (2006) who was reporting on a subset of data collected. Bradfield (1996) was reporting on two of the six areas of the focus of her research and gave a little more information but did not fully explain the theory used in the analysis. The analysis in Vogel & Mitchell (1998) consisted of one line but this paper was part one where the second part covering community factors was obtained but did not contain any information about the analysis. The recruitment strategy could

have been clearer in Bradfield (1996), Vogel & Mitchell (1998) and ethical issues did not always get mentioned.

#### **4.4 Findings from systematic literature review – mothers**

The analysis relating to the inductive codes will be reported first followed by the deductive (SCT) coding as this was applied after the initial inductive coding. It emerged from the inductive coding of the papers that there were some very different views about how initiation of breastfeeding was experienced. Some women in the studies had very positive experiences of starting to breastfeed while others experienced quite major difficulties. In general women did not expect to experience difficulties and were surprised and upset when this happened. The themes and subthemes that emerged from the data are detailed with comments from the authors and quotes from the participants in subsequent sections (see Appendices 4 and 5). The overarching analytical theme from the synthesis was: “When Does Initiation Work?” and described the experiences as a whole and was divided into “When Breastfeeding Initiation was Going Well” and “When Breastfeeding Initiation was Going Wrong at the Start” each with relevant sub-themes (see Figure 4).

**Figure 4 ‘When Does Initiation Work?’ Themes and subthemes identified from the synthesis**



The theme “When breastfeeding initiation was going well” had positive aspects that related to the mother’s experience and aspects relating to the role of the staff in giving support.

In relation to “When breastfeeding initiation was going wrong at the start” there were more negative aspects to consider. The mother’s expectation, of what would happen and of the baby’s behaviour, conflicted with reality, she was distressed, had areas of need for care and the support from the staff was lacking in many aspects. There seemed to be attributes or experiences that were internal or personal to the women and external forces that impinged on the success or failure of the woman and her baby’s ability to initiate breastfeeding.

As the data were being synthesised the subthemes emerging from the data linked closely to components of Social Cognitive Theory (SCT). This link was deductively pursued and the links were highlighted as each sub theme developed (Table 11).

**Table 11 The Relationship of Themes and Subthemes to Social Cognitive Theory – Women’s Results**

Theme	Subtheme	Relationship of themes and sub-themes to SCT theory
<p><b>4.4.1 ‘When Breastfeeding Initiation was Going Well’</b> had aspects that related to the mother’s experience and aspects relating to the role of the staff in giving support.</p>	<p>4.4.1.1 <i>‘Role Models’</i> highlighted that breastfeeding is a natural and accepted way of feeding babies.</p>	<p>Vicarious experience</p>
	<p>4.4.1.2 <i>‘Facilitation of instinctive behaviour’/ ‘Positive achievement’</i> describes the experience of early success in breastfeeding.</p>	<p>Enactive attainment/self-efficacy</p>
	<p>4.4.1.3 <i>‘Commitment/perseverance’</i> demonstrates women’s determination to succeed.</p>	<p>Efficacy expectation, verbal encouragement, mastery experience.</p>
	<p>4.4.1.4 <i>‘Supportive help/Encouraging communication’</i> highlights the benefits of positive supportive care.</p>	<p>Verbal/social persuasion Physiological/ Psychological state.</p>
<p><b>4.4.2 ‘When Breastfeeding Initiation was Going Wrong at the Start’</b> there seemed to be more factors so more themes to consider.</p>	<p>4.4.2.1 <i>‘Baby behaviour’</i> details the effect of the babies’ behaviour and variety of problems that can affect women starting to breastfeed.</p>	<p>Lack of enactive behaviour/efficacy expectations/psychological factors/ triadic reciprocal causation, environment.</p>
	<p>4.4.2.2 <i>‘Expectations of breastfeeding/expectation of support’</i> reveals a mismatch between expectation and reality of what happens.</p>	<p>Efficacy judgements Anticipation</p>
	<p>4.4.2.3 <i>‘Emotional pressure’</i> describes the unexpected variety of emotional pressures women feel.</p>	<p>Physiological/ psychological state</p>
	<p>4.4.2.4 <i>‘Staff aspects’</i> highlights the deficits in sensitive facilitative care that is required</p>	<p>Lack of verbal encouragement/lack of enactive attainment</p>
	<p>4.4.2.5 <i>‘Areas of need for care’</i> highlights an accumulation of adverse factors that affect women at the start of breastfeeding.</p>	<p>Lack of role models/vicarious experience, physical/psychological state, triadic reciprocal causation, environment.</p>

#### 4.4.1 'When Breastfeeding Initiation was Going Well'

There follows the synthesis of the results that suggested that the progress of breastfeeding was going well. This theme had subthemes that link closely to components of Social Cognitive Theory (Table 11).

##### 4.4.1.1 Role Models

It is evident from the studies in the synthesis that it is important to have had role models of breastfeeding during or before pregnancy, and that a background of familiarity with breastfeeding is helpful when breastfeeding initiation is going well. Having family members and friends actively breastfeeding and being able to watch and learn, helps this to be seen as a normal way of caring for a baby, especially in an adolescent's case if this is their own mother (Dykes et al. 2003). For women too when there are role models in the family then they learn that breastfeeding is a natural and accepted way of behaving (Bradfield 1996). Learning is easier when the situation is relaxed and the family culture of breastfeeding is just accepted as normal. Being familiar with the sight of someone breastfeeding was normal for some women and is associated with breastfeeding going well.

*"I wanted my mum around because she's breastfed two children herself ... I can remember her feeding my youngest brother" (Dykes et al. 2003 pp397).*

The visual experience of having seen someone breastfeed helps women to understand the breastfeeding process. In Dykes et al. (2003) there had been a TV broadcast about breastfeeding that women had watched. Bandura (1986) acknowledges with the advent of television, behaviour is influenced by the media as well as by direct experience.

*"You can actually see them doing it on telly, (television) so you know they're not just saying it" (Dykes et al. 2003 pp397).*

Dennis (1999) supports the value of role models for breastfeeding. The explanation is expanded with evidence that the most effective role model is similar in social circumstances and is more competent in breastfeeding than the mother (Dennis 1999), (see section 3.7.4 Vicarious experience).

#### **4.4.1.2 Facilitation of instinctive behaviour/ Positive achievement**

The experience of having the baby instinctively latch at birth seemed to set the scene for breastfeeding to go well. Women felt fulfilled and described an embodied closeness and enjoyable experience of early motherhood when the baby latched at birth.

*“He just latched straight away, and I just remember holding him and just feeling him, and stroking him and looking at him, and just you know having that wonderful magical bonding experience and, just that sort of lovely suckling feeling and, I think he fed for quite some time then just fell asleep. And it was very, very lovely, calm and soothing”* (Ryan, Todres, & Alexander 2011 pp736).

Women who breastfed, after having a caesarean section, felt that to be able to breastfeed, was an achievement that compensated for the disappointment of having an operative delivery. It would seem that the achievement of being able to breastfeed as they planned was a very positive factor in the women’s recovery. Succeeding to attach the baby to the breast may have increased the women’s feelings of self-efficacy.

*“Yes, so if nothing else I have that. So I’m happy about that (laughs).”*  
(McGrath & Philips 2009 pp40)

When breastfeeding is going well and women are confident about breastfeeding, women understand the baby’s behaviour and have a sense of interdependence with the baby (Entwistle, Kendall, & Mead 2010) . Women, whose babies started feeding soon after birth, and those who fed despite having had an operative delivery, were reflecting at the time of the interview on this experience. Their positive feelings had lasted and affected how they felt about initiation and continuation of breastfeeding. They had experienced a positive achievement and were confident about breastfeeding. A focus on positive aspects of breastfeeding helps increase a woman’s feelings of self-efficacy (Dennis 1999) (see section 3.7.4 enactive attainment, self-efficacy).



#### **4.4.1.3 Commitment/perseverance**

Being committed to breastfeeding and being determined to breastfeed was evident in four of the studies (Ryan, Todres, & Alexander 2011), (Avery et al. 2009), (Dykes et al. 2003) (Entwistle, Kendall, & Mead 2010) . Being persistent in learning to breastfeed and overcoming difficulties at the beginning has been a feature for women who succeed in breastfeeding (Dennis 1999). Women who were determined knew that both they and the baby had to learn how to feed, it seemed they created the time and space to encourage their babies and to learn together with the baby how to feed (Ryan, Todres, & Alexander 2011). Even when there was normative pressure not to breastfeed, women could still be committed to persevere (Avery et al. 2009). Some women were determined to learn to feed their babies, for example making a point of disregarding the midwife's advice at the birth.

*“Shall I breastfeed her now?” and they said ‘no, leave her, she’s fine, not yet’... I managed to latch her on okay myself after reading book after book for 9 months and determined to do it and she latched on.”* (Entwistle, Kendall, & Mead 2010 pp237)

Women thrived on encouragement and it helped them persevere in breastfeeding.

*“They (midwives) said ‘you’re doing really, really well,’ and that’s when I really wanted to persevere.”* (Dykes et al. 2003 pp396)

These women found strength in themselves to be committed to learn and persist in breastfeeding even when the support around them was weak. Encouragement was welcome but these women appeared to have high levels of self-efficacy and made more effort as they expected to be able to succeed (see section 3.7 efficacy expectation, verbal encouragement, mastery experience).

#### **4.4.1.4 Supportive help/Encouraging communication**

In hospital, midwives help women learn how to position the baby. When breastfeeding was going well this help was given in a supportive and practical way that enabled the women to learn how to breastfeed for themselves. This support in

learning how to hold the baby was not always confined to just the staff, family members could be helpful too.

Women appreciate staff members being able to stay with them the first few times they feed the baby. There can be difficulties in how the baby latches/attaches to the breast as incorrect attachment can damage the nipple but positive support can prevent this (Entwistle, Kendall, & Mead 2010).

Good communication is valued when the women feel they have the information that they particularly want (Hong, Callister, & Schwartz 2003). This happened when the nurses answered their questions or they had been given an information leaflet after being taught a related skill (Dykes et al. 2003). If the staff gave appropriate practical help and information, this was positive support. When communication was clear and the women were given verbal encouragement, this helped the women persist in their efforts (see section 3.7.4 verbal/social persuasion, physiological/ psychological state).

Emotional support was important to the women and explaining that mother and baby have to learn together was really helpful.

*“The thing that helped me most was when they’d say...‘you’ve got to just be patient...this is her first time doing it. She doesn’t know what you or she’s doing. You don’t know what you’re doing. You both have got to teach each other and learn together’.”* (Hong, Callister, & Schwartz 2003 pp12)

Supportive help was given, where the mother felt she was learning about breastfeeding and seemed satisfied with the help (Bradfield 1996). The emphasis on the mother and baby learning together was constructive and helped women to feel that they were capable of learning to breastfeed. According to (Dennis 1999) satisfaction with care can help raise self-efficacy. A good relationship with the staff seems important to help breastfeeding to go well.

Women are more likely to believe someone they know and respect, such as a familiar midwife or a family member, with regard to breastfeeding (Dennis 1999) (see section 3.7.4 verbal encouragement, psychological state).

**Table 12 Summaries of 4.4.1**

<p><b><i>Role models</i></b></p> <p>Having a background of familiarity where breastfeeding is seen as normal was associated with breastfeeding going well</p>
<p><b><i>Facilitation of instinctive behaviour/ Positive achievement</i></b></p> <p>Women whose babies latched at birth were calm and confident and those who managed to breastfeed after an operative delivery felt a sense of achievement. Women whose babies were breastfeeding well were confident about their relationship with the baby.</p>
<p><b><i>Commitment/perseverance</i></b></p> <p>Some women were committed and persevered and even without support women were determined. Encouragement was helpful when women faced difficulty and these women achieved their aim to breastfeed.</p>
<p><b><i>Supportive help/Encouraging communication</i></b></p> <p>Appropriate supportive help was appreciated and positive calming communication and teaching was helpful. Supportive guidance from a trusted source encouraged persistence.</p>

**4.4.2 ‘When Breastfeeding Initiation was Going Wrong at the Start’.**

Breastfeeding initiation went wrong at the start when the baby did not feed at birth and the natural experience the women had expected did not happen. The support available was not enough for women who were not confident to develop their self-efficacy in breastfeeding. The staff did not seem sympathetic or knowledgeable enough about the women’s situation to be able to give constructive help. There were therefore a number of areas where the women needed much more support than the

staff alone could give. The following section examines the themes of Baby behaviour, Expectations, Emotions, Areas of need for care and Staff aspects. These will be synthesised as above using SCT to explain why the women found achievement of breastfeeding initiation difficult (Table 11).

#### **4.4.2.1 Baby behaviour**

The baby's behaviour affected the way women felt about trying to initiate breastfeeding.

Teenage mothers had a variety of problems initiating breastfeeding. For example in one study 10 out of 23 teenage mothers had problems latching on (Wambach & Cohen 2009). In another study, either their baby being small or having been given a pacifier and formula by the staff before initiating breastfeeding, was thought by adolescent mothers to be the cause of their babies having difficulties in latching (Tucker, Wilson, & Samandari 2011). Mothers could sense a feeling of rejection if the baby didn't latch resulting in distress for mother and baby.

*"She (baby) didn't know how to feed and the baby was screaming and screaming and screaming ... and she would take her little hands and just sort of push me away ... that made me feel rejected."* (Mozingo et al. 2000 pp124)

Breastfeeding requires interaction with the baby and when the baby unexpectedly would not breastfeed then women's belief in their ability and self-efficacy was lowered (see section 3.7.4 lack of enactive behaviour).

In the case of women in the papers in this review, all were delivered in hospital and could not choose their environment or have control over their circumstances, they could only interpret and react to what happened. In social cognitive theory people function as a consequence of triadic reciprocity where behaviour, cognitive and environmental factors interact (Bandura 1986). The environment a person finds themselves in can be viewed positively or negatively (Bandura 1997).

Separation from the baby at birth was associated with negative effects on the baby's ability to latch and on women's attempts to breastfeed (Kelleher 2006). If the baby

needed medical care in a neonatal nursery mothers had to express milk in order that the baby could be fed via a nasogastric tube (which was distressing and difficult).

When women had to have an emergency caesarean section they felt upset and had feelings of failure which were exacerbated by not being able to breastfeed.

*“It was like everything I’d expected had started to go wrong and then I tried to breastfeed and she didn’t---it just didn’t seem to work---it was like everything crumbled.”* (Entwistle, Kendall, & Mead 2010 pp237)

In contrast women had expected to be capable of giving birth themselves without resort to medical intervention. Women felt their performance in labour was inadequate and that the outcome of needing a caesarean was not how they had judged their capability. When a person’s physiological and psychological state is affected by pain or stress, as may be the result of an emergency caesarean section, they become more anxious and less able to perform (Dennis 1999). Being in pain or being anxious reduces feelings of self-efficacy and affects the person’s ability to attempt to breastfeed (Dennis 1999). Women were disillusioned when events turned out to be quite different to what was expected. They had expected breastfeeding to be easier than it was in reality and taking a long time to get the baby to attach was distressing and difficult (see section 3.7.4 psychological factors).

*“I expected it to be automatic---I really wanted to do it. But I just felt like I couldn’t do it---She would fall asleep while she was feeding—and I didn’t feel she was getting enough milk and it was just ---it just wasn’t working”* and *“It would take 15 minutes to get her latched on.”* (Mozingo et al. 2000 pp123, 124)

The person’s level of self-efficacy affects how much effort and persistence they are able to engender about doing something in the face of difficulties and if they feel positive or anxious about doing it in the first place (Bandura 1986). When learning to breastfeed women need be motivated to make an effort and receive support (Dennis 1999).

Breastfeeding attempts were undermined by giving formula by either the midwife or the mother and the baby got confused about feeding. It seemed that women who had wanted to breastfeed who didn't experience the baby latching, lost confidence, and decided to change to bottle feeding.

*“At first, when I went in, I wanted to breastfeed. Then she got used to the bottle.”* (formula-feeding mother) (Avery et al. 2009 pp145)

These are all examples of lack of enactive attainment, where with difficulty latching, for a variety of reasons e.g. the baby being small, separation from the mother at birth, having an operative delivery, having been given a formula feed, women's perception of their capabilities was lowered especially in those who already had a lower self-efficacy (see section 3.7.4, lack of enactive behaviour/efficacy expectations/psychological factors/ triadic reciprocity, environment).

#### ***4.4.2.2 Expectations of breastfeeding and the support they will receive***

Women had expected that breastfeeding would be the natural experience they had seen with other women breastfeeding. They anticipated starting to breastfeed easily when the baby was born and were upset when the baby didn't feed.

*“I had envisioned how easy and wonderful and natural it would be. I just thought it would come naturally, that it was just something that everybody did and there was never any rejection—I just expected it to be automatic. I wanted this to be right.”* (Mozingo et al. 2000 pp122)

The way that midwives taught postnatal women how to hold and feed the baby, could be quite different to the way women imagined breastfeeding to be.

*“The way they are showing you how to do it, it sounds so technical.”*  
(Thomson & Dykes 2011 pp164)

This mismatch between expectation and the reality of what happened when trying to breastfeed at birth was very difficult for women to understand. Many women felt breastfeeding was within their capabilities, however, for a variety of reasons, their

babies would not suck, confounding what they had anticipated would happen after witnessing other women breastfeeding without effort.

*“I was so excited about it. And the big day came and my child was born and I put him to my breast. And he did nothing.”* (Mozingo et al. 2000 pp 123)

Women wanted to breastfeed, but they felt that they were not given information about how demanding the experience of breastfeeding would be at first. The midwives were also so busy they couldn't give women one to one support that women had expected. Staff shortages were a feature of lack of support and distress as the midwives did not seem to have time to help.

*“But you just don't have any individual time with any of the midwives after birth, they're extremely overworked and I really did want to breastfeed but — I just didn't know what to do.”* (Hoddinott & Pill 1999a pp561)

The women had no choice or control of their environment in hospital and could only react as best they could. Women experienced situations that they were not expecting and even when they had felt capable, without help they doubted their ability to continue (see section 3.7.6 efficacy judgement: belief about ability to perform, anticipation about what they are likely to do and how well they are likely to perform).

#### **4.4.2.3 Emotional pressure**

Eight studies reported pain and emotional aspects. Experiencing pain while breastfeeding was not something women expected and having “after pains” (uterine contractions) (Kelleher 2006) or sore nipples (Wambach & Cohen 2009; Mozingo et al. 2000; Kelleher 2006) and the general physical effects were surprising.

*“No one really tells what the body will feel like.”* (Kelleher 2006 pp 2730)

Women expressed fears e.g. of not being able to cope with the responsibility of breastfeeding and that they might reject the baby (Entwistle, Kendall, & Mead 2010) making the baby ill (Dykes et al. 2003) or that they would not be able to produce enough milk (Mozingo et al. 2000; McGrath & Phillips 2009; Avery et al. 2009).

Women felt they had to protect their self-esteem at times in hospital, they could feel self-conscious about their bodies and that their baby was not behaving the way that they expected (Mozingo et al. 2000).

*“I wasn’t used to a lot of people looking at me. I was just not comfortable with it ... and he didn’t do exactly what everyone said.”* (Mozingo et al. 2000 pp123)

One woman described a feeling of being detached from reality when midwives were handling her breasts. It was a shock to have her privacy invaded as her body was being handled by a midwife.

*“So the first time the midwife attached (my baby) for me, it felt like I was a bystander watching. This woman kind of shoved my baby on my breast.”* (Ryan, Todres, & Alexander 2011 pp735)

Women could feel relief at making the decision to bottle feed but others could also still feel guilt about that decision much later.

*“Anyway, it’s funny that even this much later---it still does bother me.”* (Mozingo et al. 2000 pp125)

When women attempted to breastfeed while suffering pain, being tired, concerned, or tense they were likely to experience a reduction in feelings of breastfeeding self-efficacy (Dennis 1999). The consequence of being emotionally upset can also affect hormonal secretions which control the milk supply (Dennis 1999). A woman’s physical and psychological state can be affected by difficulty with breastfeeding and result in lack of confidence in themselves and in their ability to lactate. A loss of self-esteem affected their self-efficacy and breastfeeding progress (see section 3.7.4 Physiological/ psychological state).

#### **4.4.2.4 Staff aspects**

Four studies (Entwistle et al. 2010; Dykes et al. 2003; Wambach & Cohen 2009; Thomson & Dykes 2011) highlighted that communication could be confusing and counterproductive as there was a lack of encouragement and the women often did



not understand what was expected. Women were not taught about the benefits of skin contact at birth and therefore were not prepared (Entwistle, Kendall, & Mead 2010). Teenagers felt ignored or judged and there was a sense of lack of empathy where the staff did not seem to know how the teenagers were feeling (Wambach & Cohen 2009). Conflicting information confused women (Dykes et al. 2003). Mixed messages were in evidence as midwives would covertly offer women strategies that were not promoted as best practice.

*“Eventually one girl (midwife) said, ‘I will be back later on,’ and said, ‘I have got these (nipple shields) for you.’”* (Thomson & Dykes 2011 pp165)

From nine studies it was evident that there were aspects relating to how the staff cared for the women that did not help or encourage (see section 3.7.4 lack of verbal persuasion).

The way women were taught to breastfeed was a recurring topic. Women whose babies did not actively self-attach were taught by midwives or nurses. Teaching women by a physical “hands on” strategy seemed to be the main method used. This quote demonstrates just how disempowered a woman could be in this situation. The woman seemed to reflect on the situation as if she couldn’t believe the way it happened, she was embarrassed and upset.

*“She showed me how to feed her right down to physically taking my breast and her head (the baby) and latching the baby onto the breast and they really go to that extent ... it can be really intimidating when a woman that you don’t know comes in to pinch your nipples. I mean really.”* (Kelleher 2006 pp2733)

The women were passive recipients of mostly physical manoeuvres to attach the baby to the breast which did not help the mothers learn how to breastfeed.

*“She was putting him on for me but not showing me how to do it myself very well,”* (Dykes et al. 2003 pp396) *and “They showed me how to put the breast in his mouth (the baby) but that’s all they really did. So when I came home I didn’t know much about it.”* (Mozingo et al. 2000 pp124)

When peoples' expectations are raised, (as women at the time, expected the midwives' attempts to attach the babies was the way breastfeeding would progress) that they will be able to achieve something that is actually unrealistic in the circumstances that prevail, the reputation of the person giving such encouragement is damaged. The staff were not found to be credible as the babies did not attach and the women did not achieve a feeling of enactive attainment and therefore efficacy in breastfeeding was lowered.

A number of studies mentioned giving the baby formula milk supplements. When the staff gave the baby supplements, the baby seemed less likely to want to attach to the breast. Women realised later that giving formula supplements or pacifiers were self-defeating strategies. This was not encouraging breastfeeding and was undermining of the women's efforts. The women were upset by their lack of knowledge and seemed angry with the staff.

*"I should never have let them give her those bottles of sugar water. I should never have let them give her a pacifier—but at that point I was so naïve."*

(Mozingo et al. 2000 pp124)

When the baby was not attaching to the breast, the midwife was helping the mother by using nipple shields, physically attaching the baby to the breast, giving supplements or pacifiers. "Hands on" was a very upsetting aspect of care during the hospital stay and was reflected in all the themes mentioned previously, Baby behaviour, Expectations, and Emotional pressure (see section 3.7 lack of enactive attainment, reflection).

#### **4.4.2.5 Areas of need for care**

Five studies referred to needs that women had for care and perhaps more knowledge or confidence. Women seemed to be very vulnerable in a number of ways during their time in hospital. Those who lacked experience of breastfeeding were not prepared for how they felt when they were faced with problems (Hoddinott & Pill 1999):

*"I wasn't prepared — I don't know how to deal with my feelings when it doesn't work."* (Hoddinott & Pill 1999a pp560)

Babies have inborn behaviours that do not need to be learned. This includes sucking (when not sedated or suffering adverse conditions as in this case), but as the person grows and develops, learning is a result of direct experience or by watching others. If a woman has not seen anyone breastfeeding they may feel uncomfortable about the thought of trying to breastfeed (Dennis 1999), (see section 3.7.4 vicarious experience).

Being in an unfamiliar environment was difficult for adolescents who missed their family (Dykes et al. 2003) Adolescents looking for help and comfort would have responded to encouragement if it had been offered but they felt uncomfortable with unfamiliar midwives.

*“At the point I decided to bottle-feed there were midwives on there that I had never met and they didn’t know me. Because I didn’t know them—I just felt uncomfortable asking. So I think if I’d stayed with the other ones I would have carried on.”* (Dykes et al. 2003 pp395)

The lack of continuity of staff (Dykes et al. 2003) and the lack of consistency of information was discouraging to women.

*“Just to have someone listen in hospital and to have some consistency in what they tell you. They all tell you something different.”* (Vogel & Mitchell 1998 pp6)

Several women who intended to breastfeed decided to bottle feed, often due to stress or lack of knowledge or confidence (McGrath & Phillips 2009; Avery et al. 2009). It was difficult for women to persist with the complexity of initiating breastfeeding in unfamiliar surroundings with lack of continuity of staff (see section 3.7 psychological state, triadic reciprocity, environment).

**Table 13 Summaries of 4.4.2**

<p><b><i>Baby behaviour</i></b></p> <p>Difficulty in latching affected the mother/baby relationship and the circumstances outwith women's control affected their achievement. Pain and anxiety affected women's motivation and they lacked enactive attainment in breastfeeding</p>
<p><b><i>Expectations and support</i></b></p> <p>There was a mismatch between women's immediate expectations and reality and the staff did not provide sufficient support. When things went wrong women did not feel that conditions were conducive to persisting.</p>
<p><b><i>Emotional pressure</i></b></p> <p>Painful physical effects of childbirth negatively affected women in their attempts to breastfeed and they could lack confidence about their ability to breastfeed</p> <p>A feeling of detachment could arise when physical efforts were made by the midwives to attach the baby but giving up breastfeeding gave rise to long term regret</p>
<p><b><i>Staff aspects</i></b></p> <p>Communication could be confusing and counterproductive and women were taught by ineffective physical efforts of the midwives.</p> <p>The staff's credibility was lowered by mothers' lack of attainment and when the mothers reflected on their experiences they were angry.</p>
<p><b><i>Areas of need for care</i></b></p> <p>Women had a lack of breastfeeding experience and being in an unfamiliar environment was upsetting.</p> <p>It was unhelpful to lack people that were familiar and encouraging. Confidence was lowered by a combination of circumstances.</p>

#### **4.5 Findings of the thematic synthesis-Midwives**

The analysis relating to the inductive codes will be reported first followed by the deductive (SCT) coding as this was applied after the initial inductive coding.

The themes and subthemes that emerged inductively from the data relating to midwives are detailed with comments from the authors and quotes from the participants (see Appendix 6).

Breastfeeding could be seen as being initiated in two stages the first breastfeed in labour ward then mothers learning about attachment. The first breastfeed was expected to happen in the labour ward within a short time after the birth. However the majority of babies did not feed in labour ward. Whether or not the baby had fed in labour ward, the mother and baby were transferred to the postnatal ward. In the postnatal ward efforts to achieve the first feed and mothers to learn to attach the baby to the breast and initiate breastfeeding continued.

Midwives had their personal and professional views about breastfeeding and what they felt was their role in helping women. The support they gave was in some ways dependent on these views but to a large extent positive support was underpinned by knowledge and skills. Some findings were positive about the midwives responses to the first breastfeed and to subsequent attachment but the overwhelming findings were of negativity. There were also aspects of SCT relevant in the findings. Two overarching themes emerged from the analysis pertinent to the midwives. These are “Stages of initiation” and “Realities of care” and both included positive and negative aspects.

1. “Stages of initiation” included two Sub-Themes, “The 1<sup>st</sup> breastfeed” and “Attachment” (see Figure 5).
2. “Realities of care” included the Sub-Themes “Support” and “Midwives views” (see Figure 6).

The way midwives approached initiation of breastfeeding was reported in all eight of the midwife related studies.

Figure 5 Stages of initiation

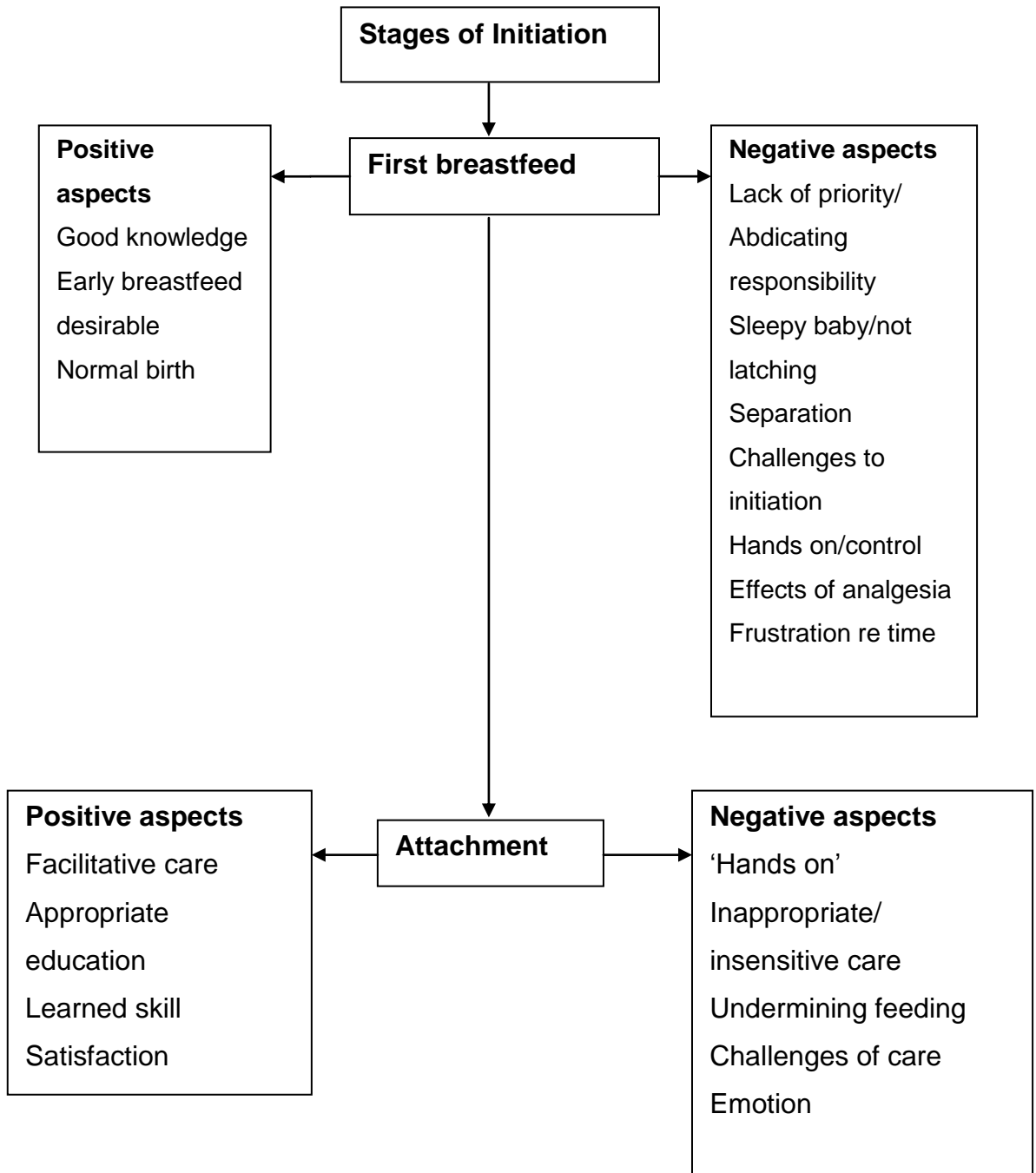
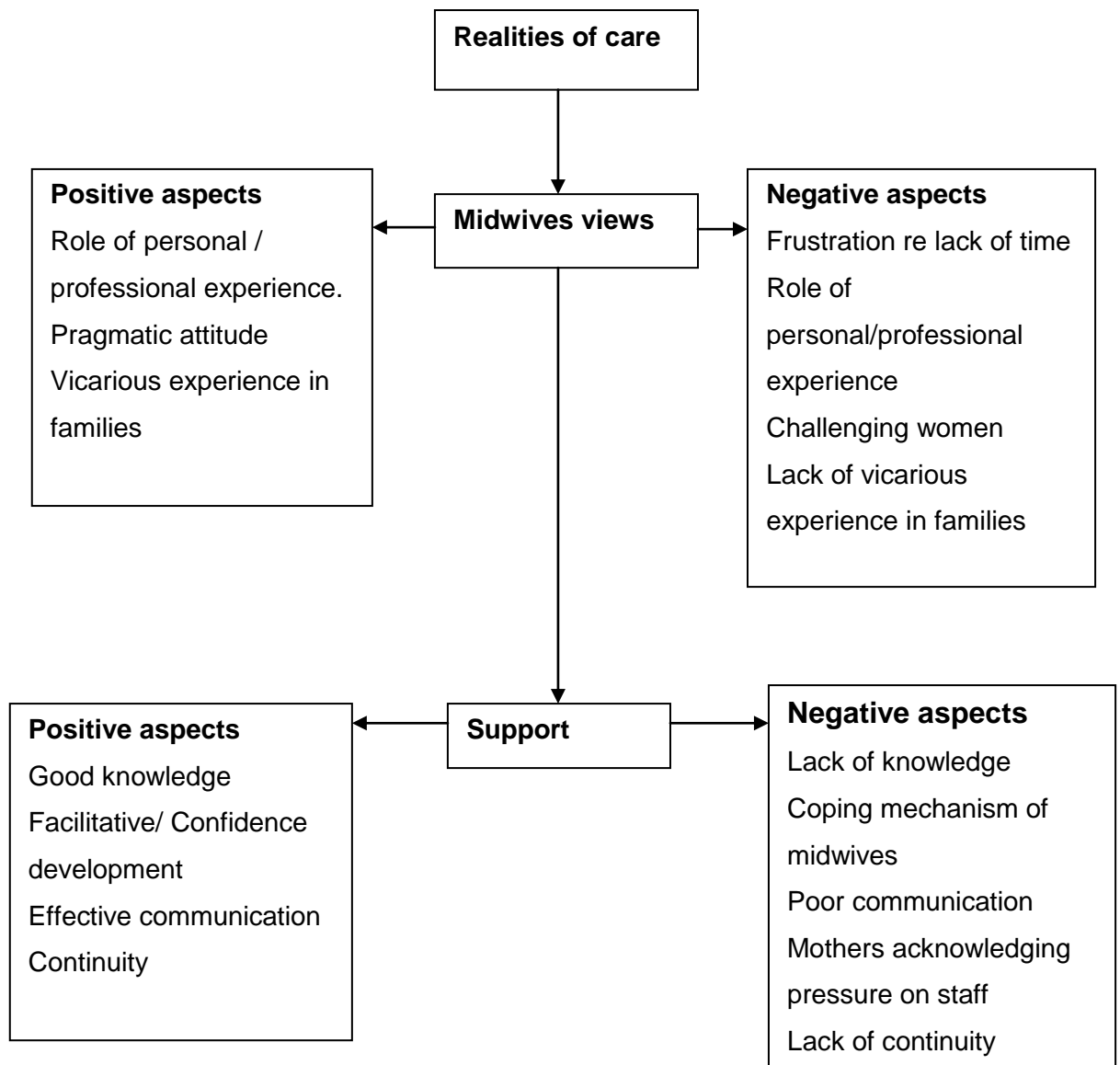


Figure 6 Realities of Care



As in the women's results as the data were being inductively synthesised the subthemes emerging from the data linked closely to components of Social Cognitive Theory (SCT). This link was pursued and it seemed natural to highlight the links as each sub theme developed.

Social Cognitive Theory (SCT) was used deductively to interpret and understand the themes in an effort to conceptualise key areas of the midwives' experiences and an explanation was constructed for the midwives' experiences. The relationship of Themes and Subthemes to Social Cognitive Theory is illustrated in Table 14.

**Table 14 The Relationship of Themes and Subthemes to Social Cognitive Theory – Midwives' Results**

**1. Stages of initiation**

<b>Theme</b>	<b>Subtheme</b>	<b>Relationship of themes and sub-themes to SCT theory</b>
4.5.1.1 The 1st breastfeed: Positive aspects	<i>Good knowledge, Early breastfeed and Normal birth.</i>  Highlighted midwives' knowledge and experience of the start of breastfeeding.	Enactive behaviour, vicarious experience
4.5.1.2 Attachment: Positive aspects	<i>Facilitative care, Appropriate education, Learned skill, Satisfaction.</i> This section explained the midwives role in teaching the women to breastfeed.	Enactive behaviour/verbal encouragement
4.5.1.3 The 1st breastfeed: Negative aspects	<i>Lack of priority/abdicating responsibility, Frustration re time, Hands on/control, Sleepy baby/not latching, Effects of analgesia, Separation, Challenges to initiation.</i>  This described the midwives' perceived negative attitudes, the pressures they felt and the strategies they adopted to cope with their additional responsibility of assisting with breastfeeding.	Lack of self-efficacy, vicarious experience/role models, triadic reciprocal causation (environment), outcome expectancies, reflection
4.5.1.4 Attachment: Negative aspects	<i>Hands on/insensitive/inappropriate care/Undermining behaviour/ challenges of care/emotion</i>  This section described the midwives' impersonal and unsympathetic strategies to deal with breastfeeding women.	Low SE, Poor role models/vicarious experience

**2. Realities of care**

<b>Theme</b>	<b>Subtheme</b>	<b>Relationship of themes and sub-themes to SCT theory</b>
4.5.2.1 Midwives views – positive aspects	<i>Personal/professional experience/Pragmatic attitude/Vicarious experience</i>  This revealed the attitudes of confident midwives.	Higher level of SE
4.5.2.2 Midwives views – negative aspects	<i>Frustration re time available/ Challenging women</i>  This described the frustrations felt by midwives.	Lack of enactive attainment, Lower SE, Lack of vicarious experience



Theme	Subtheme	Relationship of themes and sub-themes to SCT theory
4.5.2.3 Support – positive aspects	<i>Good knowledge/ Facilitative/Confidence development/Effective communication /Continuity</i>  Reveals the benefits of comprehensive knowledge to midwives' attitudes.	Self-appraisal, Higher SE
4.5.2.4 Support-negative aspects	<i>Lack of knowledge/ coping mechanism/ lack of communication/ Pressure on staff/ Lack of continuity</i>  Highlighted the real difficulties faced by midwives and consequently their patients of their lack of knowledge.	Lack of motivation

#### 4.5.1 'Stages of initiation'

The “stages of initiation” in this synthesis refers to the attempts to have the baby latch/attach to the breast shortly after birth where the first breastfeed was expected to happen in labour ward. The mother and baby were transferred to the postnatal ward where attachment was expected to be repeated or indeed be achieved for the first time. There were both positive and negative aspects involved in both stages.

##### 4.5.1.1 The 1st breastfeed: Positive aspects

There were a few comments about the baby successfully latching/attaching at birth but the midwives who stated that latching at birth was important to the success of breastfeeding, seemed to be very much in the minority. Midwives recognised this enactive behaviour was important but it was not clear if this related to success for the mother or actually for the midwives themselves. It was not always clear whether they were describing that the baby latched/attached instinctively or by the midwife using “hands on” but direct reference to this practice was made in four studies :West & Topping (2000), Henderson, Pincombe, & Stamp (2000), Dykes (2005), Vogel & Mitchell (1998). For some midwives, the key knowledge was that the opportunity of an early breastfeed with an alert baby was important to be able to encourage successful breastfeeding.

*“To me I think that’s the biggest thing,”* (Henderson, Pincombe, & Stamp 2000 pp 13) and that if the baby fed early that is *“better and easier.”* (West & Topping 2000 pp39)

The comments generally indicated that success was very dependent on the level of activity of the baby and this was a factor that affected the midwives’ confidence in enabling attachment. There were a few comments in one paper demonstrating insight on the effect of analgesia on the baby’s latching ability. A normal birth where there was little or no analgesia was seen as an advantage for breastfeeding.

*“One of the first things that you need for good breastfeeding is to have a normal birth. It is really important not to be drugged at birth.”* (Vogel & Mitchell 1998 pp7)

This suggested that a vaginal delivery with no instrumental assistance and where the woman perhaps used alternative methods of pain relief was considered essential. The importance of women and consequently the baby not being sleepy was emphasised. A sleepy baby would be due to the effects narcotic analgesia, which was the usual method of pain relief given to the mother in labour, or an operative delivery where analgesia would have been necessary. These midwives had seen babies latch/attach in labour ward and therefore have had this vicarious experience and a few could also discriminate about seeing babies breastfeed at birth when the mother had not had narcotics and had a natural birth.

If the midwives considered it their responsibility to ensure attachment their sense of mastery would be reduced when the baby did not attach. If they perceive this to be a result of their lack of skill, then their self-efficacy would be reduced (see section 3.7.4 vicarious experience, enactive attainment/ behaviour).

Knowledge of good practice in facilitating instinctive behaviour was reported in some policies where the staff followed the BFI strategy of having skin to skin contact between mother and baby until the baby self-attaches at the first then subsequent feeds. This was qualified by “with nurse support if needed” but no detail of this statement’s meaning (Weddig, Baker, & Auld 2011).

*“Our policy actually tries to encourage breastfeeding after a normal vaginal delivery within 20 minutes ... after a C-section (surgical delivery), within an hour. And both of those are very achievable goals.”* (Weddig, Baker, & Auld 2011 pp171)

#### **4.5.1.2 Attachment: Positive aspects**

When the mother and baby arrived in the postnatal ward there started to be a discussion of how breastfeeding works. There was a suggestion in Henderson et al. (2000) that the midwife was the subject of the activity as she said *“If you get it right”*. It was she who seemed to need to get the baby to latch/attach properly, not the mother, whether by using “hands on” or instinctive baby behaviour was not clear. This indicated the midwife personally experienced enactive behaviour as she felt she had got it right.

There were a few examples in the studies of sensitive facilitative strategies being used by midwives in the postnatal ward. In this study the staff were experienced in working in the postnatal ward and the mothers were given information about breastfeeding and how it works, along with an explanation of baby behaviour (Henderson, Pincombe, & Stamp 2000). Some midwives said the first feed on the ward was an important opportunity to teach and support the mother and the midwives felt satisfied when attachment was successful.

*“If you get it right the first time you can watch them, it’s almost magical the way it clicks, and then you’d be guaranteed they’ll continue with that.”* (Henderson, Pincombe, & Stamp 2000 pp13)

Although midwives thought that the women regarded attachment as something that happened naturally, they believed that mothers and their babies had to learn how attachment worked and emphasised how difficult attachment could be. It would seem that the midwives did not think latching usually happened naturally and so may not have facilitated instinctive behaviour. There was one mention in the midwives studies of instinctive behaviour, letting the baby find his/her own way to the breast, in a policy only (Weddig, Baker, & Auld 2011). Henderson et al. (2000) note that even eliciting the rooting reflex was not mentioned in their focus groups.

*“It’s not automatic, mother has to learn and baby has to learn”, and “A lot of women were actually surprised at how difficult it was.”* (Henderson, Pincombe, & Stamp 2000 pp13)

Midwives had differing views about the amount of information women needed to learn about breastfeeding. Some midwives were very facilitative, explaining that it was a learning process for the mother, talking her through how to attach her baby herself without the midwife using hands on physical help. These midwives focused on the mother’s perspective of how breastfeeding works.

*“... and try to get her to do most of the work instead of putting your hands on the baby.”* (Henderson, Pincombe, & Stamp 2000 pp14)

*“Get them to tune into what was happening in their body from their side or what they should be looking for from their point of view.”* (Henderson, Pincombe, & Stamp 2000 pp14)

It could also be inferred that some midwives used a “hands on” approach to latch the baby to the breast and achieve their own enactive behaviour, while others used verbal encouragement without using “hands on”. Although there was no mention of using the baby’s instinctive behaviour, this was positive verbal encouragement. The midwives who controlled the attachment with “hands on” perhaps had less self-efficacy about helping with breastfeeding than midwives who were able to encourage the woman’s own efforts (see section 3.7.4 enactive behaviour, verbal encouragement).

#### **Table 15 Summaries of 4.5.1**

##### **First breastfeed: Positive aspects**

A few midwives mentioned successful attachment and the importance of an alert baby attaching at birth with ambiguity about the midwives responsibility for attachment.

Only one paper overtly acknowledged the effect of analgesia on attachment.

One policy reported encouraging skin to skin and breastfeeding.

##### **Attachment: Positive aspects**

Achieving a successful latch was important for midwives in the postnatal ward.

Midwives did not expect instinctive behaviour and were either facilitative or directive with those who were facilitative perhaps having more self-efficacy.

#### 4.5.1.3 The 1<sup>st</sup> breastfeed: Negative aspects

One study reported that breastfeeding can be seen as something the junior staff should be involved with and if the baby doesn't feed in labour ward it was expected that s/he will feed when in the postnatal ward (Reddin, Pincombe, & Darbyshire 2007). Midwives had an apparent lack of interest or empathy with breastfeeding mothers and students. A student explained that a midwife admitted to lacking in skill with regard to breastfeeding.

*“The midwives get the students to handle the breastfeeding ... it was kind of like a job for the students because after the birth they (midwives) would be busy with the paperwork and the student can help the mother with their attachment and it was considered a lesser job or something.”* (Reddin, Pincombe, & Darbyshire 2007 pp74)

It seemed as though midwives were so busy and stressed in labour ward that, perhaps in trying to maintain their ability to cope with the pressures, something had to give and breastfeeding seemed the easiest aspect to avoid. A lack of priority for encouraging breastfeeding shortly after the birth was an issue in a number of the papers. The justification for this was that staff were busy and completion of documentation was more important.

*“Because of time management. . .we are really having to get to grips with is (sic), once the baby is born, to get all the paperwork and computer work done, all the ‘important stuff’ ...I think that breastfeeding hasn't quite made it onto that more important than getting the paperwork done (sic) list just yet.”* (Reddin, Pincombe, & Darbyshire 2007 pp74)

It was acknowledged in BFI hospitals that an early feed was important for future breastfeeding success but that this caused pressure on the staff as the labour ward staff could be very busy at times. The Baby Friendly Initiative guidance for that time was the policy that mother and baby should be able to have skin contact for at least 30 minutes. The guidance was updated subsequently to skin contact for at least one hour or until after the first breastfeed (UNICEF UK Baby Friendly 2012c). The brief periods of skin to skin contact did not comply with the policy of having 30 minutes

contact and were justified as due to lack of time. The midwives interpretation of the policy was that the baby had to feed within the 30 minute time frame but they were dismissive of that being possible. They also interrupted skin contact to carry out clinical treatments and attempted to attach the baby to the breast “hands on”. This sounded very similar to the practice in non BFI hospitals.

*“Getting the baby to feed within 30 minutes, well we know that that’s correct but it puts a lot of pressure on the staff on delivery suite and it’s dependant on the circumstances on delivery suite at the time.” (West & Topping 2000 pp38) (BFI hospital)*

A lack of knowledge and understanding about the benefits of skin contact was illustrated in both BFI and non BFI hospitals. In a non-Baby Friendly hospital as the midwives gave skin contact for five minutes then continued with the post-delivery treatments and assessments before the baby was wrapped and given to the mother to breastfeed. It was clear in a non-Baby Friendly hospital they did not take responsibility of attempting to follow best practice (Weddig, Baker, & Auld 2011). It was evident from the studies that there was a lack of attention to best practice and the time allocated for skin contact was very short. Even when the staff were aware of the recommendation for skin contact there was a culture of rushing to transfer the woman to the postnatal ward.

*“If the labour ward is busy, you can’t do skin to skin contact as much. Because they need the bed. If there is someone waiting for a labour bed, the pressure is on ... You can get into the culture of ‘We’ve got to get this woman to the ward’ even when there is nobody else in labour.” (Furber & Thomson 2007 pp144)*

A number of reasons were given for babies not being able to have skin contact or being able to attach and feed shortly after birth. The baby’s ability to attach to the breast was affected by the mode of delivery, separation from the mother and analgesia given to the mother in labour. After the mother has had an epidural or a narcotic analgesia the baby was too sleepy and would not feed.

*“I’ve noticed that babies that have been exposed to epidural----will suckle for a very short time and then the effect of the epidural starts to work on them and they go off to sleep and they won’t suck, so you’re not getting your vigorous long-term suckling right after birth when it is really crucial.”* (Vogel & Mitchell 1998 pp7)

If the mother had an operative delivery the baby may be observed in a nursery for a few hours to ensure his/her wellbeing despite the knowledge that separation can seriously affect the baby’s ability to attach (Walsh, Pincombe, & Henderson 2011). Challenges to initiation of breastfeeding then were evident. Explicit in these midwives statements was the acknowledgement that if the baby did not feed at birth then they anticipated difficulty with attachment later.

*“If that baby doesn’t get the breast fairly soon after birth, it’s an uphill battle isn’t it?”* (Henderson, Pincombe, & Stamp 2000 pp13)

*“... but if they haven’t (attached at birth) then you know it’s going to be difficult.”* (West & Topping 2000 pp39)

It would seem that midwives physically positioned the baby “hands on” and controlled the feeding. This strategy of physical help may have been to comply with the interpretation of a policy of having the baby feed within a short time after delivery.

*“What I do often, I actually take the baby myself and I’ll go like this (demonstrates positioning of the baby at the breast) and I’ll say this is the way you are going to do it.”* (Henderson, Pincombe, & Stamp 2000 pp15)

Against this background some midwives were very aware if the baby did not feed shortly after the birth then this was a drawback to the progress of establishing breastfeeding.

The attitude of some midwives was quite negative toward breastfeeding indicating perhaps a lower self-efficacy for breastfeeding support and examples of poor role models for junior staff. The busy environment the midwives found themselves was

not of their choosing and perhaps they did not always find it manageable. A midwife can judge the consequences of helping a woman start breastfeeding may result in an outcome of successful attachment but if she anticipates she cannot achieve success then she may not try to help. The social outcome expectancies may also be less conducive to her attempts if her colleagues disapproved of a delay in the woman's transfer to the postnatal ward while the midwife tries to help the woman start breastfeeding. There was however a lack of any attempt to reflect on why such problems arose and there was a culture of not expecting or encouraging babies to instinctively attach. People are able to be reflective, but this did not happen or was not encouraged in the organisational situations in the studies (see section 3.7 Lack of self-efficacy, role models, triadic reciprocal causation (environment), outcome expectancies, reflection).

#### **4.5.1.4 Attachment: Negative aspects**

Physically attaching the baby to the breast for the mother "hands on" would seem to be the default position that midwives used to help women start breastfeeding. "Hands on" was reported by the midwives as being used to "guide" the women but observed as a detached event that undermined the women's confidence. Women seemed to allow midwives to handle their breasts and hand express for them, but the language women used to describe this suggested women were surprised by the force that was used. A person thinks about how anxious or physically unable they are when assessing their ability to do something. When the women considered that they may not be competent their anxiety could be increased by anticipating the activity of having the baby physically attached for them or being hand expressed by the midwife.

When the mother started to learn to attach her baby in the ward the midwives seemed to take it for granted, that the midwife attached the baby to the breast for the mother. There were varying views of using a "hands on" physical method of teaching the mother. This was argued to be necessary.

*"Sometimes you need to put your hands on and actually show her (mother) what to do, and after that guide her if she is having difficulties."* (Henderson, Pincombe, & Stamp 2000 pp14)



“Hands on” was observed in the ethnographic study (Dykes 2005) where the midwives attached the baby then left the mother to attend to someone or to do something else. The women were reported to have their confidence undermined and were not able to learn to attach the baby by themselves. When women could not attach the baby they lacked enactive attainment and their language was emotive.

*“He wasn’t latching on properly so one of the midwives came and said, ‘be a bit more forceful’. She did it herself.”* (Dykes 2005 pp247)

The women used expressive language when describing how the midwives handled their breasts. If a baby was not able to attach to the breast the strategy was to hand express in order to obtain expressed breast milk to give to the baby with a syringe or a cup. This woman recounted her experience in an emotive way.

*“I tried expressing. The midwives tried. They mauled at them but nothing came.”* (Dykes 2005 pp247)

Differences of opinion amongst midwives was evident about the use of “hands on” but it was acknowledged by the midwives that they had experience of babies who in their own words had been “*rammed on to the breast*” and who subsequently would refuse to attach to the breast. Midwives recognised that forceful behaviour by others to attach babies was counterproductive as the baby would then breast refuse (Vogel & Mitchell 1998).

Trying to help the mother establish feeding was fraught with undermining behaviour and conflicting ideas and where new midwifery graduates had expected evidence based practice to be in place, this was disregarded (Reddin, Pincombe, & Darbyshire 2007). The appropriate use of finger and cup feeding to supplement feeding when the baby would not attach was an area of tension. Women had been taught about the Ten Steps to Successful Breastfeeding which is a global programme to promote and learn about breastfeeding (UNICEF UK Baby Friendly 2012a). The majority of maternity units in the study were BFI accredited where they should comply with the ten steps. The senior midwives had a preference for bottles, which was contradicted

by the BFI. A graduate went to see a woman she had delivered and found a distressing situation.

*“... she was sitting sobbing as she was finger feeding her baby ... and the afternoon shift midwife had said ‘you can’t finger feed for more than 20 min, after that you give him a bottle’, and I knew she (the mother) had consciously kept her baby away from having a bottle ... and that midwife walked in when she was feeling really vulnerable and she ended up giving the baby the rest ... in a bottle ... it totally undermined the woman (graduate)”.* (Reddin, Pincombe, & Darbyshire 2007 pp75)

This was a new midwife who was witnessing another senior midwife’s behaviour and although she felt the woman was undermined she perhaps felt undermined too. Another graduate had a similar experience where the midwife did not approve of her cup feeding a baby. This was very undermining for the graduate who was trying to provide evidence based care. The graduate understood that this role modelled behaviour was not best practice. Midwives were observed as being “quite unapproachable’ and providing a very negative role model for students and for junior staff (Reddin, Pincombe, & Darbyshire 2007).

Challenges to care occurred when being busy in the ward was frustrating when the staff could be involved with something else just as a mother wanted help with her feeding (West & Topping 2000). The challenges of care provision were felt by midwives when mothers gave mixed signals about their commitment to breastfeeding and their ability to cope with the difficulties. Midwives were frustrated at having a brief window of time to give help and their perceptions of women’s mixed level of commitment to persevere. Mothers may have had a lower self-efficacy and when faced with difficulties and lack of care stop trying (see section 3.7.4 low SE, poor role models).

*“Day 2 ... they’ve indicated they want to breastfeed ... you want to help them ... they choose to formula feed on day 3 because it’s got all too hard and emotional ... we really do have a responsibility to give them the correct information ... tell them... it may just be better in 24 hours ... then on day 5*

*jeeppers why on earth didn't somebody tell me ... I've given up and no one told me it was best for my baby and the engorgement might go ... that sort of dilemma ... that's what's hard and that's why I think we're getting these comments because you try to do your best."* (Walsh, Pincombe, & Henderson 2011 pp602)

The attitude of some midwives was very negative toward breastfeeding and women in the postnatal ward, where women spent longer attempting to start breastfeeding than in the labour ward. Again as in the labour ward perhaps this indicated the midwives' lower self-efficacy for breastfeeding support. The emotion that could be felt by midwives might be best summed with this quote from a midwife,

*"Attachment – a battle to be won, it's sometimes a lost cause."* (Henderson, Pincombe, & Stamp 2000 pp15)

**Table 16 Summary of 4.5.1.3 and 4.5.1.4**

**The 1<sup>st</sup> breastfeed: Negative aspects**

Midwives had an apparent lack of interest in breastfeeding and due to being very busy in labour ward, skin contact was given for a very brief period after birth. They anticipated that babies would not breastfeed in the first 30 minutes after birth and even when the labour ward was not busy would rush to transfer women to the postnatal ward.

There were a number of reasons for the baby not having skin contact or being able to attach but midwives used 'hands on' to attempt to get the baby to attach to the breast.

Midwives perhaps had low levels of self-efficacy for breastfeeding where the environment and social outcome expectancies were perhaps less conducive for giving breastfeeding support, however there was no reflection on the organisational culture/situation.

**Attachment: Negative aspects**

The effects on the women of the midwives using 'hands on' to attach the babies was very negative but the midwives took it for granted that they would use this method.

Some midwives acknowledged the negative effects of 'hands on' with regard to the effect on the baby's ability to subsequently attach.

There were a number of distressing examples of undermining behaviour by midwives but also very mixed emotions on the challenges in helping women with breastfeeding. The midwives had perhaps a low self-efficacy in their ability to help women breastfeed.

**4.5.2 Realities of Care**

Midwives gave their views in some of the studies that gave an insight into their personal feelings about providing care. The support midwives were able to provide to women was influenced by these views to an extent but knowledge and skills were more relevant.

**4.5.2.1 Midwives' views – positive aspects**

Midwives would seem to rely on their personal breastfeeding experience or their professional experience rather than always complying with a breastfeeding policy or believing causes and effects contained in a policy. This was the case with painful

nipples where the midwives personal experience was that despite having correct positioning women could still have painful nipples.

*“They say you’re only sore because the baby isn’t on right well I know from my own experience that that’s not true.”* (West & Topping 2000 pp38)

Community midwives could combine their experience more confidently with the policy than hospital midwives as they saw that policy was a guide and was not necessarily mandatory to follow. Midwives who from experience were perhaps more knowledgeable or confident, could take a more pragmatic approach and voiced wider views of breastfeeding. Midwives who had a higher level of self-efficacy judged themselves capable of coping with different situations.

*“Yeah, it’s a guide, it’s not written in stone.”* (West & Topping 2000 pp38)

It was mentioned that if someone in the family had breastfed, the women were more accepting of suggestions and the father’s approval was important (Henderson, Pincombe, & Stamp 2000). Going home early was a benefit as the women had less conflicting information and the baby settled more easily. They acknowledged the benefit of family support and the familiarity with breastfeeding, thus the benefits of vicarious experience.

*“Mums who have had their mother (or friend/sister) breastfeed successfully are more responsive to the things that you say to them.”* (Henderson, Pincombe, & Stamp 2000 pp15)

#### **4.5.2.2 Midwives’ views – negative aspects**

Midwives could be very frustrated by their workload and unable to deal with women who asked questions, and were found challenging and time consuming. Frustration was evident when midwives felt they did not have time to deal with the workload (Furber & Thomson 2007). The circumstances where midwives were very busy and felt unable to help women reflected a lack of enactive attainment on their part. Although part of their role was to support women they were failing to help the women achieve attachment and failure lowers self-efficacy and if people have self-doubt about their ability they are more readily affected by failure. This pressure of being

short staffed and having so many women needing help was quite distressing for midwives; they seemed to cry for help.

*“... we’ve got too many women, we’re trying to help 10 women to establish feeding and all the babies are yelling in the night and we’ve got to do something.”* (Furber & Thomson 2007 pp143)

This was made even more challenging for midwives who were trying to help women who had a mismatch in how they thought breastfeeding would work, or who did not understand attachment (Henderson, Pincombe, & Stamp 2000). Midwives also saw women as lacking in confidence and persistence but there was no mention of midwives encouraging persistence which can increase self-efficacy. Women were seen as not being confident enough to persist and midwives were frustrated by not having the time to help.

*“Not prepared to accept the challenge and work at it and deal with things. They don’t give themselves a chance and they are not confident.”* (Henderson, Pincombe, & Stamp 2000 pp15)

Lack of family support was recognised as being unhelpful to women who wanted to breastfeed. Families who lacked knowledge were not helpful and neither were visitors who were present when the midwife was trying to help and teach the woman about breastfeeding (Henderson, Pincombe, & Stamp 2000) (see section 3.7 lack of enactive attainment, lower SE, Lack of vicarious experience).

Table 17 Summary 4.5.2.1 and 4.5.2.2

**Midwives views – positive aspects**

Midwives who were more confident about breastfeeding used their discretion about the use of policies and understood the benefits of family support for breastfeeding.

**Midwives views – negative aspects**

Midwives were so busy that they were unable to help women and therefore lacked enactive attainment of being successful in helping women to breastfeed.

The women's lack of expertise and confidence combined with the midwives lack of time to help created frustration for midwives.

Lack of family support for breastfeeding was unhelpful.

**4.5.2.3 Support – positive aspects**

Effective support seemed to be underpinned in a BFI hospital by a comprehensive knowledge of evidence based practice to encourage breastfeeding in the first 72 hours. This included uninterrupted skin to skin at birth and delaying bathing and physical assessment until after the first feed and continued evidence based practice thereafter in the postnatal ward. This was illustrated by midwives high level of knowledge of the benefits of positive strategies to promote skin to skin and breastfeeding.

*“Skin-to-skin provides thermal regulation, regulates glucose levels in the baby, and promotes a successful breastfeeding experience.” (Weddig, Baker, & Auld 2011 pp171)*

Continuing care is more effective in promoting breastfeeding if the baby is kept in the room with the mother in order for her to learn about feeding. Learning to breastfeed during the first few days was important and well informed information and support was of benefit to the mothers (Weddig, Baker, & Auld 2011). However when the baby doesn't feed for 10 or 12 hours after birth s/he could be supplemented with the mother's own expressed breast milk and if that is not available then human donor milk would be the next choice. A medical order would be necessary if the supplement

needed to be formula milk (Weddig, Baker, & Auld 2011). These are all very positive and helpful evidence based strategies.

In Henderson et al. (2000), midwives discussed that learning to breastfeed was a two-way process between the mother and the baby, mother and father and mother and midwife. In the focus group discussions six roles were identified, supporter, collaborator, communicator, advocator, emancipator and technician that were used in helping the mother learn to attach and feed her baby (Henderson, Pincombe, & Stamp 2000). Learning to breastfeed could be enhanced by effective communication and confidence building. In one study a midwife felt better able to give woman centred care when she was able to give continuity of care because the ward was quiet. The midwife explained how exceptional the situation was as the ward had been quiet she had been able to practice the way she had wanted (Dykes 2005). The midwife went on to explain how this did not happen usually as the ward was so often busy (Dykes 2005).

*“I’ve been involved with Jocelyn from transfer to this ward. It’s one of those lovely situations where she’s had the same person most of the time. I mean so often you see someone one day, you set things in motion and the next day someone else has scuppered it. The thing is; this is the exception. We’ve been quiet over the weekend. I’ve spent hours with her.” (Dykes 2005 pp248).*

Positive support helped the mother learn about breastfeeding and required the midwife to be able to implement helpful evidence based strategies. Recognition of the role of the family, effective communication and empathy with the mother’s situation was predicated on having enough time and the ability to provide continuity of care. There was also an acknowledgement by the midwife that learning to breastfeed can be emotional and can take time to learn and is perhaps not easy to learn as it is a skill that is associated with a new baby and the heightened emotions around that situation (Dykes 2005) (see section 3.7.6.2 self-appraisal ).

#### **4.5.2.4 Support – negative aspects**

Lack of midwives’ knowledge about breastfeeding was counterproductive as they had little motivation to help women breastfeed. Midwives also lacked time to help women and gave the same rehearsed information to each new woman they saw. It was



apparent that in some of the studies the midwives had very little knowledge of effective breastfeeding support and as a consequence their motivation to consider how they could behave just did not arise.

In teaching the mothers how to feed rather than being aware of the baby's feeding cues the staff counted how long the baby fed and advised the mothers of this. The nurses in non BFI hospitals seemed not to hesitate in giving babies a formula supplement if s/he didn't breastfeed, formula feeding at night was normal practice, (Weddig, Baker, & Auld 2011).

The lack of skill was however recognised by some of the midwives, where they had insight into their own lack of knowledge.

*"I think the fundamental problem lies with us midwives. The majority of midwives cannot recognise a good latch."* (Vogel & Mitchell 1998 pp8)

The midwives used didactic teaching strategies where they gave a rehearsed block of information in a way that seemed to distance them from the women. This seemed to be their coping mechanism to deal with the busy circumstances they faced in the postnatal ward. While this information could be helpful, the midwife in this example had physically positioned the baby "hands on" at the mother's breast while as the authors said she "chanted" the information (Dykes 2005).

*"Right, so point the nipple to nose, then you'll see more of the areola above than below and the bottom lip turned down. Look you can see his lips."* (Dykes 2005 pp247)

It was evident that mothers' acknowledged midwives were pressured and this resulted in women feeling that the midwives just did not have time to sit with them and listen to their concerns. Women were upset about the lack of continuity of carer where each gave different information. This led to women wanting an information leaflet (Dykes 2005), suggesting perhaps this might give the consistent information they wanted.

*“I’ve seen different people this morning and they have all had a different approach. There are just so many people. Um, there isn’t a consistent game plan. I find it all so confusing. It leaves me feeling guilty at not following advice. A team front is needed. They should be presenting one approach.” (Dykes 2005 pp247)*

People plan to do something they consider to be worthwhile. If the midwives had little knowledge about breastfeeding and had no personal or professional education on the subject, they would be less likely to be aware of how worthwhile their help might be to women attempting to start breastfeeding. Also people who have a lower SE think of how they can fail and exaggerate the level of difficulty of a task (Bandura 1989) which may have been reflected in the midwives who had some insight into their lack of skill (see section 3.7 lack of motivation).

**Table 18 Summary 4.5.2.3 and 4.5.2.4**

<p><b><i>Support – positive aspects</i></b></p> <p>Good support was underpinned by knowledge and evidence based strategies. Learning to breastfeed was supported by good communication confidence building and continuity of care.</p> <p>The time to be able to give women centred care was important by midwives who were confident about breastfeeding.</p>
<p><b><i>Support – negative aspects</i></b></p> <p>Lack of knowledge of breastfeeding comes with a lack of motivation to help. Midwives may have been aware of their lack of self-efficacy in breastfeeding</p> <p>Midwives coped with teaching in a busy environment by staying detached where women were critical of the lack of care.</p>

#### **4.6 Comparison of mothers and midwives studies**

The results were compared and contrasted under the sub-theme headings of the mothers' results with the midwives' results relevant to each sub-theme.

##### ***'When breastfeeding was going well'***

There were fewer reports that women had positive experiences at the start of breastfeeding than those where breastfeeding was going wrong.

##### ***Role models***

The synthesis revealed that women who were familiar with breastfeeding prior to the birth had a positive approach to breastfeeding. There was a sense of breastfeeding being seen as a normal way of feeding babies and of women already having a support network after their babies were born.

Complementing this sense of normality, midwives, with personal and professional experience and those who practised on the community had more autonomy, took a pragmatic approach to applying policy guidelines and were more confident about giving care. Effective support in the first few days was underpinned by knowledge, evidence based strategies, good communication and the conditions to enable

midwives to give women centred care. There were a few examples of midwives who recognised that family support and familiarity with breastfeeding was helpful when women were starting to breastfeed.

#### *Facilitation of instinctive behaviour*

One of the women's papers (Ryan et al. 2011) gave examples where the baby instinctively latched to the breast and started feeding shortly after the birth. When that happened women were very positive about the experience of breastfeeding. In another paper this positivity included women who had managed to breastfeed after an operative delivery. The women had an interdependent relationship with the baby and in their responses at interview, demonstrated their sense of achievement.

Comparatively few midwives emphasised the importance of the baby latching shortly after the birth or recognised that a normal un-drugged delivery made starting breastfeeding easier. The baby being able to attach shortly after birth was recognised by the midwives to be important for breastfeeding success. Although it was mentioned in a policy the midwives did not expect instinctive behaviour in four of the studies where the first feed was usually physically assisted by the midwives using a "hands on" strategy. Some midwives stated they used "hands on" while others used verbal encouragement to help the women feed their babies. The midwives viewed this process of attachment as much their achievement as the mothers.

#### *Commitment/perseverance*

The synthesis found in some instances women could be committed and determined to learn to breastfeed using their own resources. It was helpful however to be given practical and emotional support by the midwives and family and to have the information they needed. The support resulted in women learning and persisting in breastfeeding when the women trusted the source of help.

Midwives could use their personal or professional experience to be more confident about using support strategies they have found to work and were aware of the importance of social support. Comprehensive knowledge, women centred empathic care using consistent strategies and effective communication encourages perseverance.

### *'When breastfeeding was going wrong at the start'*

The results were compared and contrasted under the sub-theme headings of the mothers' results with the midwives' results relevant to each sub-theme.

The data on the way women found breastfeeding difficult were in themselves upsetting to read.

### *Baby behaviour*

The synthesis revealed that women unexpectedly found it difficult to get their babies to attach and feed from the breast at the start. Women rationalised reasons to explain this including, the staff having given the babies a pacifier or formula and the baby screaming or having an operative delivery. The environmental factors such as separation from the baby, where the women did not have control of the circumstances were difficult. The women found the experience of the baby not being able to feed or apparently rejecting the breast overwhelmingly difficult and when this continued, changed to bottle feeding.

Contrastingly at the very start of the women's attempts to breastfeed there were midwives in labour ward who avoided helping women with breastfeeding, considering this as low on their list of priorities or lacking in their own confidence or being too busy to cope. The BFI guidelines were seen as unrealistic as the midwives were too busy. However some midwives were aware of the effects of analgesia and separation and that early attachment was beneficial. It was evident that some midwives controlled the feeding attempts "hands on" which may have been an attempt to collude with social expectancies of transferring the women to the postnatal ward as quickly as possible. A negative attitude towards breastfeeding in the midwives, the busy environment and an expectation of failure may have contributed to these aspects.

### *Expectations of breastfeeding and support*

The synthesis suggested that women's expectation of starting to breastfeed was not what happened in reality and their confidence very quickly evaporated. They had not expected that their baby would not feed and found the way they were taught to feed technical and unnatural. Women were not prepared for the demands they would face or the lack of assistance available to them. The environment was also unexpectedly unhelpful as the midwives were so busy and even when the women had thought themselves capable, without help it became very difficult.

In contrast, midwives expectation was that the way to teach women to attach their babies to the breast was to use a physical "hands on" strategy. This was argued as necessary but also acknowledged implicitly by a few midwives who disagreed with using such physical methods as in their view it affected the baby's subsequent behaviour. "Hands on" was described by women as being done in a detached and forceful way especially when midwives attempted to hand express breastmilk. Undermining behaviour of midwives to women was witnessed and experienced by students. The students then felt unable to take action to prevent women's resultant distress. However frustration felt by the midwives was evident as they found coordinating the timing of helping women awkward and they said the motivation of those women having difficulties was difficult to assess. Midwives spend longer in the postnatal ward than in labour ward being expected to help women breastfeed where midwives expressed their own feelings of frustration and defeat.

### *Emotions*

The synthesis revealed that a number of women were in pain, lacked confidence and were anxious about their baby's health. There were examples of women being self-conscious and detached from the reality of having their personal space invaded and their breasts manipulated out-with their choice and control. The women's physical discomfort, lack of confidence and inappropriate physical handling of their breasts was all too much and they could stop trying to breastfeed. The easiest way out at the time was to change to bottle feeding which could later be regretted.

In contrast the midwives who were there to provide care were overwhelmed by the workload and knew that they were not able to adequately help women establish

breastfeeding. The midwives defended their self-esteem by moving the explanation of the difficulties to the lack of the women's abilities, persistence and lack of confidence. The lack of explicit family support for the women contributed to the midwives sense that achievement for such women would be an uphill struggle.

### *Staff Aspects*

The synthesis suggested women found communication with the midwives confusing and counterproductive. The relationship directed from the midwives to mothers was lacking in empathy and encouragement. The way the midwife tried to attach the baby to the women's breasts was very distressing for women and the women lost confidence in themselves and respect for the midwives. The women thought the midwives were being helpful by giving the babies bottles at first but when the baby subsequently wouldn't breastfeed the women were even more upset and when they reflected were angry.

For midwives a lack of knowledge of breastfeeding came with a lack of motivation to help. Teaching women became rehearsed and detached while using "hands on". They could also be very busy and with a lack of knowledge, a formula supplement was normal.

### *Areas of need for care*

The synthesis found that women, who lacked experience of breastfeeding and were in an unfamiliar environment when they had difficulty, needed comfort and consistent help. Women changed to bottle feeding when they found it too difficult to persist in their breastfeeding attempts.

With the midwives, lack of knowledge of breastfeeding came with a lack of motivation and was apparent in most of the examples of unhelpful support. The way midwives coped with being too busy was to stay detached from women's needs. However those with some insight may have recognised their lack of knowledge but others lacked insight to understand how worthwhile informed support could be to women who were attempting to breastfeed.

#### 4.6.1 Main summary of literature review

The synthesis of qualitative studies in this literature review has focused on the initiation of breastfeeding and events at the very start of this process. This has provided useful insight into the issues that arise during attempts to initiate breastfeeding. Most studies' aims were wider than the definition of initiation referred to earlier; therefore the relevance to the initiation of breastfeeding of the studies' aims was assessed and captured in three statements devised for this purpose (see Appendices 1 and 2).

In the synthesis, women's and midwives' expectations, knowledge and experiences of this specific area were inductively coded, grouped into analytical themes then deductively analysed using SCT as a theoretical framework.

When breastfeeding was going well this was considered a normal way for the women to feed their babies. The babies were able to feed instinctively or with help and women were determined to persist in learning to breastfeed. Midwives who were confident about their knowledge and expertise were able to provide the most effective support.

When breastfeeding initiation was going wrong there were a number of reasons put forward for the baby failing to attach. The women found this situation difficult and could become very anxious. They could also be in pain or discomfort. Women wanted consistent help and comfort but found the midwives lacking in empathy and skills and changed to bottle feeding. The midwives expected to attach the baby "hands on" and to transfer the women quickly to the postnatal ward although they could be aware of the effects of separation and analgesia on the baby's ability. The midwives lacked motivation and were overwhelmed by difficulties e.g. being too busy, considering guidelines as unrealistic, lack of knowledge and had an expectation of failure. They could display undermining behaviour, frustration and lack of knowledge, questioning women's motivation and staying detached from women's needs.

The synthesis and the use of SCT as a theoretical framework provided useful insight into women's and midwives' expectations knowledge and experiences of breastfeeding initiation. Conducting the synthesis will contribute to the development



of my research aims and understanding of the data generated from the analysis of my findings. This strategy using SCT will be followed in the analysis of my data.

## Chapter 5 Rationale for Methodology and Methods

### 5.1 Introduction

In this chapter the rationale for a qualitative research strategy and the specific research methods used to gather data in relation to the problems identified in the research questions are detailed.

Methodology

*“The framework of theories and principles on which methods and procedures are based”* (Holloway 2005 pp. 293).

The aim of the fifth chapter is to explore the rationale for a qualitative design and describe the development of the methods that were utilised.

Objectives

1. To explain the ontological and epistemological stance of the research
2. To provide a rationale for a qualitative study and methods of data collection
3. To explain the methods used
4. To explain the hybrid process of inductive and deductive analysis used

### 5.2 Ontological stance

Ontology is a philosophical concept that asks what people believe about the nature of being or what there is to know about the world. A number of questions arise:

*“Whether or not a social reality independent of human conceptions and interpretations exists; Whether there is a common shared social reality or just multiple context-specific realities; Whether or not social behaviour is governed by ‘laws’ that can be seen as immutable or can be generalised.”* (Snape & Spencer 2003 pp. 11)

The three separate positions with regard to whether reality can be captured and how it should be constructed are Realism, Materialism, and Idealism. The position of Realism claims that an external reality exists beyond what people understand or

believe about how the world is. Materialism claims that only material aspects represent reality. Idealism represents reality through thought and meanings that are socially constructed. These positions have been debated. The position of “*Subtle Realism*” says that “*an external reality exists independent of our beliefs and understanding*” and “*reality is only knowable through the human mind and socially constructed meanings*” (Snape & Spencer 2003 pp.16). Accepting this position, the interpretation of participants’ meanings in this thesis, will provide from their diverse perspectives, an external reality that can be conveyed and that illuminates their experiences.

### 5.3 Epistemology

Epistemology is an area of philosophy concerned with the nature of knowledge.

Three issues give rise to debate in social research.

- The relationship between the researcher and the researched: a position can be taken where it is suggested that in adopting a position of “*empathic neutrality*”, the researcher states their position and reflects on their effects on the data collection and analysis. This position sits between mediated results through the researcher and those agreed with the participants. The researcher interprets the social world of participants’ using what is understood by both the participants and researcher. This is an Interpretivist stance (Snape & Spencer 2003).
- With regard to theories about “*truth*”: social reality can be assumed if more than one report arises to confirm a statement so it is a consensual concept.
- The way knowledge is acquired: is either by Induction or Deduction. Induction, where associations and patterns are sought and the evidence is the origin of the conclusion. Deduction involves a process where hypotheses are derived and the evidence is used to support the conclusion.

There is however a debate about whether abiding by a strict epistemological stance of either positivism (quantitative research) or interpretivism (qualitative research) is pragmatic when multi method research using both has been evolving (Snape & Spencer 2003). Avis (2005) also argues that social reality can be both observed and constructed (Avis 2005).

#### 5.4 Rationale for a Qualitative strategy.

In chapter one, the quantitative association between socioeconomic factors affecting the incidence and duration of breastfeeding was illustrated (Health and Social Care Information Centre 2012). The effect of positive professional support (DiGirolamo, Grummer-Strawn, & Fein 2003) and the increase in initiation (Bartington et al. 2006) and duration (Del Bono & Rabe 2012) in Baby Friendly Initiative participating hospitals, were further examples of quantitative research relating to influences on initiation and duration of breastfeeding. The rates of breastfeeding, the incidence of breastfeeding in Scotland and the percentage of women who had problems breastfeeding in hospital in the UK were detailed (Health and Social Care Information Centre 2012).

There were clearly quantitative statistical data highlighting the influences and the numbers of postnatal women starting, then having problems and stopping breastfeeding at a very early stage. However the quantitative data did not explain the expectations, knowledge or experiences of postnatal women and midwives of breastfeeding initiation in hospital. Knowing what antenatal women's previous knowledge was would therefore help understanding of the experience of initiation. In a qualitative study, women from lower socio-cultural groups perceived contradictions in health education messages and were more prepared to consider initiating bottle feeding than women from higher socio-cultural groups (Barona-Vilar et al. 2009). It was important to find out the antenatal and postnatal expectations, knowledge and understanding of the processes of initiation of women and midwives. Without information with regard to these aspects, formulating appropriate strategies to address early problems and discontinuation of breastfeeding would be difficult.

Understanding the problems from a person centred approach would require qualitative research which is about meanings people derive from their experiences in life. The researcher has to find and interpret the meanings that people attach to their actions, decisions beliefs or experiences (Snape & Spencer 2003). This gives rise to the concept of *interpretive* research where interpretation along with observation is important in the understanding of the social world (Snape & Spencer 2003; Pope & Mays 2006; Bowling 2007). Understanding peoples' interactions or behaviour is best done using research techniques that are similar to normal social interaction and

respecting their beliefs. This is termed *naturalism* and is a distinguishing aspect of qualitative research (Avis 2005; Pope & Mays 2006). Qualitative approaches view the research results from the perspectives of the participants and the context of the situation. This means that in qualitative research there is less emphasis on the ability to apply the findings to a wider population but if the results are credible and consistent they may have wider application than the study population (Avis 2005). Key features of qualitative research include aiming to provide an in-depth and interpreted understanding of the participants' experiences and perspectives. The samples are small and purposively selected where the data collection involves close interactive contact with the researcher and provides detailed information. The analysis looks for concepts and ideas which can interpret the social meaning of the participants experiences (Snape & Spencer 2003).

A variety of methods can be used in qualitative research such as observing interactions, interviewing, or analysing documents (Pope & Mays 2006). Qualitative research can be used before quantitative research to clarify meanings of concepts or answer questions about interactions and interpretation of interactions or after quantitative research to interpret or validate the results (Pope & Mays 2006; Bowling & Ebrahim 2005). Holloway and Todres (2005) argue that qualitative research using a person centred philosophy is more socially sensitive than a quantitative approach (Holloway & Todres 2005).

The principles of qualitative ideals may therefore be viewed as naturalistic enquiry, with a holistic perspective and analysed inductively. However there are many different theoretical perspectives with divergent traditions associated with qualitative research (Patton 2002). The use of theory is fundamental to many researchers but the similarities and differences between stances may not always be clear and the link between the research and the theoretical perspective may be implicit or not mentioned. Therefore a pragmatic consideration of the research question is justified and is a reasonable way to inform the choice of method rather than a theoretical perspective (Pope & Mays 2006; Patton 2002).

## 5.5 Rationale for methods of data collection

### Method

*“Method refers to the procedures and strategies for collecting, analysing and interpreting data.”* (Holloway 2005 pp. 293).

In order to gather data that described the specific experiences of women and midwives I chose to use focus groups with women and individual interviews with the midwives. There follows an exploration of both methods.

#### 5.5.1 Focus groups

Focus groups with women provide a method where discussion is generated and stimulated by the combined interaction of the group to gain insight into the aims and objectives of the research.

Focus groups are group discussions that use the interaction between group participants to generate data (Kitzinger 2005). They were first used in studies on communication. Focus groups are used to explore effects and issues, to assess influences, examine public understandings, gain insights of experiences, to explore attitudes, and peoples' views on a wide variety of issues (Kitzinger 2006). The interaction between the participants and the processes that are involved where ideas and experiences are shared and where there are changes in the views of the participants are an essential part of the analysis (Kitzinger 2005). Focus groups are useful to understand differences in perspectives between different groups of people (Krueger & Casey 2009).

Focus groups can give the meanings that inform group views and information on the uncertainties in the processes that lead to these views. They can highlight the normative understandings that people use to make decisions (Bloor et al. 2002). Behaviour is influenced by social and cultural norms where attitudes and opinions are formed and change over time (Carter & Henderson 2007). The influences on breastfeeding behaviour have changed from predominantly local influences, where, for example in the thirties in the UK, women gave birth at home and would help each other to breastfeed. Economic influences then came into play and wealthier women give birth in nursing homes and hospitals where erroneous breastfeeding “rules”

were in place which continued to have a detrimental influence on breastfeeding rates until relatively recently (Royal College of Midwives 2002). People in society today are generally not so constrained by local circumstances and have many more influences on their behaviour such as the media and the internet and are able to decide for themselves how they wish to behave. However although the normative influences on behaviour may have changed from a local focus, behaviour is still influenced by social pressure. The underlying influences on behaviour and opinion are assumed to be shared until something crops up where assumptions are challenged (Bloor et al. 2002).

A focus group can give a wider picture of people's knowledge and understanding than perhaps the narrower response to a question. An interactive discussion can provide insight into people's knowledge and experiences (Kitzinger 2005). A focus group can be supportive of discussion of difficult topics and can illustrate different views of the relative ways of looking at things in a cultural context and explain why gaps in knowledge occur (Kitzinger 2006; Carter & Henderson 2007; Kitzinger 2005). It is recognised when issues are discussed the group meanings emerge. If their interpretation is questioned or the purpose of the discussion changes further discussion may cause the interpretation to change (Bloor et al. 2002).

Purposive sampling was chosen to identify participants for the focus groups as this is a criterion based method of sampling where the participant has knowledge of the phenomenon being researched and has the characteristic/s relevant to the research (Holloway 2005), i.e. pregnant or recently having given birth and willing to discuss breastfeeding. Women from across the socio-economic spectrum and age groups will be selected with particular effort being made to sample lower socio-economic groups and younger women as they have lower rates of breastfeeding (Dyson 2006). Higher maternal education is associated with breastfeeding self-efficacy (Dennis 2006). Breastfeeding knowledge is strongly correlated with breastfeeding confidence (Chezem et al. 2003). When selecting participants to be involved, discussion is easier between participants who have things in common with each other, such as teenagers or pregnant women. This makes it easier to engage in discussion with each other about a shared topic of interest (Seale 2004; Bloor et al. 2002). The decision whether to use pre-existing groups or groups of strangers needs

consideration. People who already know one another may interact in a way that is “*naturally occurring*” and the researcher can access the normative context of ideas and decisions. The attendance may be better as the participants may feel more at ease with each other. Conversely strangers may be more open and willing to talk but may be more ready to challenge each other. It may be more difficult to start a discussion with strangers and attendance may be less likely (Bloor et al. 2002). Informed consent is vital to raise awareness of confidentiality issues, whatever the composition of the group, between themselves and also between themselves and the researcher (Bloor et al. 2002). The size of the group is a consideration that can relate to the topic where if it is complex then perhaps a smaller group may be best. A group size of between four and eight is suggested to be ideal for group interaction (Kitzinger 2005).

If the group comprises young women, their friendship groups tend to be small, so a small group would help make it a more natural experience (Bloor et al. 2002). People who are expert in their field or in authority may prefer the opportunity to speak which is easier in smaller groups. In a large group participants may find it difficult to get their point across amongst a number of people trying to be heard, this can make transcribing difficult (Bloor et al. 2002).

### **5.5.2 Conduct of the focus group**

A focus group needs a quiet private non interrupted venue. In focus groups the intention is that the group engages in discussion and group interaction so that the meanings and social influences can be derived from the subsequent analysis (Bloor et al. 2002). There is a debate about whether to use a topic guide, where there is a list of relevant words or phrases on the topic, or the questioning route, where there is a sequence of questions to be answered. The questioning route was chosen for this research as it would seem to be a more consistent method to ask similar questions across different groups (Krueger & Casey 2009; McFadden & Toole 2006).

### **5.5.3 Materials**

A question guide was devised with sequence of questions to be answered (see Appendices 7 and 8), (Krueger & Casey 2009). Categories of questions were devised to optimise the flow and depth of discussion; five categories were identified. An opening question asking for facts that could be answered quickly and help start people talking and feel relaxed. An introductory question to focus on the topic, this



was open-ended to establish a normative context for their responses. Following this, transition questions to air the participants' views and set the scene for the key questions that were the main focus of the study. Ending questions to bring the discussion together and help in the analysis.

The stimulus for the interaction is not necessarily always a straight question, which would be asked in a group interview, but a "*focusing exercise*" where active participation is encouraged in a group task (Bloor et al. 2002; Krueger & Casey 2009). This was devised for this thesis as an explanation of the activity in a series of photographs, matching text to photos and assessing information leaflets ("Feeding cues at birth", and the chart of "Feeding cues after the first few hours"; see Appendix 9). It is suggested that two exercises are optimum as the second can go over similar ground to the first thus refocusing interest. In this case three activities were devised where one was using the same material with an additional activity. The researcher has to decide how much structure will address the research questions while continuing to stimulate group interaction. The "*props*" (photos) are also a continuing subliminal reminder of the point of the group and at the start act as an "*ice breaker*" (Bloor et al. 2002).

The leaflet "Feeding cues at birth" used in the thesis was developed using photographs of instinctive behaviour (courtesy of Sue Saunders: Lactation Consultant Services, see Appendix 9). The chart "Feeding cues after the first few hours" was of sleep states of babies and the baby's corresponding ability to breastfeed in the first days after birth and was developed from an example by Long (2006). These materials were developed in consultation with local midwives, the breastfeeding support midwife, a volunteer support group leader and women in the pilot study. The content was considered for relevance and ease of reading was assessed by distributing repeated drafts and asking for comments. The midwives and support group leader were supportive and modifications were made according to their suggestions. Women in the pilot study were enthusiastic about "Feeding cues at birth", and the chart of "Feeding cues after the first few hours". An additional chart modelled on the Infant Feeding Assessment Tool (Matthews 1988) was disregarded after the women in the pilot study found it to be too complicated (see Appendix 9).

#### **5.5.4 Running the session**

It is suggested that when the group is in progress the facilitator should facilitate not control the group, keeping in the background and letting the conversation run (Bloor et al. 2002). Group silences have a variety of possible causes and the facilitator can reiterate that a range of views are welcome to defuse tension (Bloor et al. 2002). It may be useful if the discussion seems to be drawing to a premature end to encourage debate about any contradictory points (Kitzinger 2006).

#### **5.6 Rationale for Individual Interview**

Semi-structured interviews will be used to explore experiences and allow the respondents to give their opinions and allow the researcher to gain more depth of information than a self-administered questionnaire.

The data collected from an interview are a result of the interaction between the researcher and participant where the participant gives an account of their thoughts, feelings, actions and experiences that have happened or may happen in the future. The researcher works with the participant to build the participant's version of reality and then has to analyse how that version came about. Interview data can be regarded as either a resource which would be what the participant felt was reality or as a topic which is built jointly between the researcher and the participant (Seale 2004).

##### **5.6.1 Types of interview**

Interviews can range from structured, where the questions are asked in a standard format, semi-structured where open questions give rise to divergence enabling the following up of different points, and in-depth interviews where one or two issues are explored in detail (Britten 2006). Most qualitative interviews however are semi-structured or in-depth and need to be adaptable and flexible (Taylor 2005). The aim in qualitative research is to examine the participant's own form of meaning or to understand the question from the person's perspective and to avoid imposing the researcher's framework of understanding and assumptions on the data (Britten 2006; Taylor 2005).

### **5.6.2 Conduct of an interview**

An interview is a collaborative process where with the interviewer's help the participant accesses aspects of his/her knowledge (Britten 2006). Interviewers should try to be responsive and sympathetic to the participant's use of vocabulary and conception of the issue, trying to uncover ideas and tease out detail of what is said (Britten 2006). There needs to be openness to unexpected ways the ideas may be framed and that this is a report of behaviour and not the actual behaviour (Taylor 2005).

### **5.6.3 Attributes of an interviewer**

The personal attributes of the researcher may affect the interview and how this may influence the participant needs to be considered (Britten 2006). A relationship of trust and respect is aimed for where the participant feels acceptance and sensitivity on the part of the researcher who needs to be able to reflect on their personal influence on the conduct of the interview (Taylor 2005). The role and perceived status of the interviewer can influence the responses of participants. Taylor (2005) gives examples of more deferential responses from participants to a researcher perceived as of a higher status but if they felt the researcher had a more neutral status, then a more critical stance to the topic was evident. The researcher needs to hone their skill at interviewing and reflect on their own performance. The conduct of the interviews should be considered as to how directive are the questions posed, are leading questions used and are the cues from the participant's responses noted and acted on. By using these strategies, knowledge of the research process and the topic are developed (Taylor 2005).

### **5.6.4 Types of question**

Questions should be aim to be open, neutral, sensitive and clear to the participant and there should be six types of question (Pope & Mays 2006; Patton 2002; Taylor 2005). Starting with easy to answer questions and gradually increasing the level of difficulty, the six types of questions are; behaviour, opinion, feelings, knowledge, sensory and background issues. The researcher aims to be sensitive and responsive to the person being interviewed (Pope & Mays 2006) (see Appendix 10).

### **5.6.5 Summary**

Exploring and planning the data collection methods and materials utilised within the focus groups and interviews was a constructive way forward and was a helpful foundation for planning the actual data collection.

## **5.7 Methods**

Qualitative methods were used in this study to explore the expectations, knowledge and experiences of women and midwives with regard to breastfeeding initiation. The data collection was undertaken during 2010.

### **5.7.1 Ethics**

The study received internal ethical approval of the School of Nursing, Midwifery and Health of the University of Stirling in December 2009 and from the West of Scotland Research Ethics service (the NHS ethics committee), in January 2010. Following NHS ethics approval, there was liaison with the local Research Liaison officer who contacted the lead midwives in the health board area involved. Information about the study was sent to the lead midwives who in turn provided the information to local staff and approval of the Research & Development department was obtained in March 2010. Information and consent materials for women and midwives were explained at recruitment and again immediately before the focus groups and interviews.

### **5.7.2 Pilot Study**

A pilot focus group with six postnatal women (all professional occupations) from a voluntary breastfeeding support group near the University was carried out to test the focus group schedule for the women. The volunteer co-ordinator of the group agreed to introduce me to the women. The women were recruited after an initial visit by me to the support group to explain the purpose of the focus group. On the day they were very willing to participate. I introduced my supervisor and the information and consent materials and the conduct of the group was explained. All the women were articulate but some spoke very quickly and lots of babies were crying which made hearing clearly what they said difficult.

There were a number of helpful points that emerged from running the focus group. There was work needed on the clarity of the questions and I needed to find a sequence that would encourage more group participation and not such a lengthy

explanation of their own experiences to date. More focus on their experiences at birth of skin to skin and baby behaviour would be more helpful. The interview guide was then amended and invaluable experience was gained by running the group.

### 5.7.3 Setting

The National Health Service (NHS) in Scotland provides healthcare throughout Scotland and has 14 regional organisations that are involved in its administration. There are also Special Health Boards and National and Support Organisations to support the work of the NHS (National Health Service Scotland 2012). In Scotland in 2011 there were 58,590 live births registered with National Records Scotland which equates to a live birth rate of 11.1 per 1000 population (General Register Office for Scotland 2012).

The study took place in 2010 in Greater Glasgow and Clyde Health Board area in Scotland where there were 14,043 live births in the year ending March 2010 (ISD Scotland 2013). In 2009/10 42.7% of babies were breastfed (including mixed breast and formula fed) and 31.7% exclusively fed at the first health visitor check at around 10 days after birth in this health board area (ISD Scotland 2013).

The Director of Public Health Report (2007-8) highlights the changes in the population of the area. While the indigenous population had fallen, there was a rise in the migration of asylum seekers estimated to be 11,000 in 2008. There was an estimate that also by June 2008 there could be a further 6,700 economic migrants in the area (The Director of Public Health 2008). In the subsequent report in 2009-11 it was reported that one quarter of babies born in 2008 were from Pakistani, other White and African families and a range of different ancestry groups. It was estimated that there could have been families from 70 nationalities living in the city area. Single parent household make up a third of all homes in the city area which emphasises the diversity of the population of the families of babies and children in the area. Poverty and lifestyle risk factors can influence the health and well-being of babies and children and can be made worse by poor socio-economic circumstances and family difficulties (The Director of Public Health 2011).

The Maternity Units in the health board area where the study took place had attained full Baby Friendly accreditation status (current at data collection 2010), where the care of women met the best practice standards, for breastfeeding. This required that midwives were educated to a standard that met the UNICEF UK Baby Friendly Initiative standards (UNICEF UK Baby Friendly 2013a).

The model of care in the maternity clinics, (linked to the maternity units) where women were recruited, was midwife led. The midwife was the lead professional for low risk women and was responsible for antenatal care, with support from wider maternity care services when required (Service Descriptor 6) (The Maternity Services Action Group: The Scottish Government 2011). Home births were available to women on request and two midwives dedicated to home births took referrals for home births in the health board area.

I attended an information sharing meeting with lead midwives before the ethics application was made. A short presentation was given about the proposed study and discussion was invited on the midwives views about the suitability of the proposal. A fruitful discussion ensued with regard to their interest in the area of study. The midwives made suggestions about recruiting at the maternity clinics in the west and south (see population in section 5.7.4.1 below) and about venues for focus groups with women. Suggestions were also made with regard to including home birth midwives as well as community and hospital based midwives.

Meetings were arranged with the midwife team leaders in the relevant west and south clinics. The midwives were very helpful and made suggestions about how best to recruit the women and suggested venues that might be available, which would be familiar to the women, in order to conduct the focus groups.

## **5.7.4 Sample**

### **5.7.4.1 Population**

Women were recruited from two contrasting maternity care clinics in the health board area in order to achieve a spread of socio-economic and cultural experiences. One area had pockets with a very low ranking in the Scottish Index of Multiple Deprivation (SIMD). The SIMD provides a ranking of data zones in Scotland where one is the most deprived and 6505 is the least deprived based on a combination of relevant

data (The Scottish Government National Statistics 2012). Women were recruited from more than one data zone area where examples of the overall ranking in 2012 were 361, 427 and 639. These women attended a maternity clinic in the south of the health board area. In contrast, the other area chosen for recruitment was a maternity clinic in the west of the health board area where examples of data zone ranking were 2,190, 2,402 and 6,480 of the total 6,505 in the total list of data zones (The Scottish Government Neighbourhood Statistics 2012b).

#### **5.7.4.2 Women**

Purposive sampling was used to recruit the women from the two maternity clinics who were at least 28 weeks gestation when initially approached and women who had babies who were less than 6 months old. To ensure all relevant aspects were covered, a mixture of homogenous samples, who might give similar perspectives to many 'Scottish' women and a heterogeneous grouping of women new to Scotland whose views might vary from the cultural 'norm' were recruited (Ritchie & Lewis 2003).

#### **5.7.4.3 Inclusion and exclusion criteria**

Both pregnant (antenatal) and postnatal women were included in the study.

Women were eligible if they were:

- Primigravida
- Able to read and/or understand English
- Living within the study area and be over 16 years of age.
- Women who were at least 28 weeks gestation when recruited and were over 16 years of age
- Postnatal women who had initiated breastfeeding in the previous 6 months, who had an uncomplicated birth and who were discharged from hospital with their baby. It was planned to recruit both women who were continuing to breastfeed and those who had stopped.

Antenatal and postnatal women were recruited to 5 separate focus groups (see Table 19).

**Table 19 Sampling Matrix**

<b>Group</b>	<b>Category</b>	<b>Type of participants</b>
Group 1	Women from support group	Postnatal women
Group 2	Women from antenatal clinics	Antenatal women
Group 3	Ethnic minority women from antenatal clinics	Antenatal women
Group 4	Ethnic minority woman from antenatal clinics now postnatal	Post natal woman
Group 5	Women from antenatal clinics now postnatal	Postnatal women

#### **5.7.4.4 Recruitment**

Women were recruited by the researcher from antenatal clinics and a support group. In the antenatal clinic the midwives screened women in the reception area of the clinic for eligibility. The women were offered information about the study by the researcher, and if verbal consent was obtained, the study was explained and the women offered a participation pack. Some women declined the information and they were thanked and the conversation ended. If the women accepted the pack (containing an information sheet and a consent form; see Appendices 11 and 12), a reply slip collecting contact details was completed in the clinic and returned to the researcher. This allowed the researcher to ring the women to arrange a date and time for the focus group discussion and to give the women the opportunity to ask questions about the research.

Postnatal women were either recruited as before at their antenatal clinic then phoned later when their baby was a few weeks old or recruited during attendance at a breastfeeding support group. Postnatal women who had initiated breastfeeding in the previous 6 months, and who were discharged from hospital with their baby were included. Women who were continuing to breastfeed and those who had stopped were recruited. At the support group a woman who had an older child and this current baby elected to attend the focus group and this was agreed as it was considered she could potentially provide valuable information. The researcher was introduced initially by the professional supporting the group.



Attempts were made to recruit teenagers via parenthood education classes. The parenthood education midwife introduced the research. If verbal consent to explain the research further was obtained, the researcher offered information about the study. Although reply slips were completed and returned and phone and text contact was achieved none attended on the day of the planned focus group.

A similar situation arose when attempting to recruit postnatal women from ethnic minority groups. The women had accepted the information pack during an antenatal visit and were contacted a few weeks after the date their baby was due. Seven women had completed the reply slips and phone and text contact was subsequently made but only one woman attended with her baby son and she agreed to be interviewed.

Recruiting had variable levels of success with all antenatal women. Recruiting was quite challenging with regard to postnatal women with a range of 1:4 to 1:7 of those contacted managing to attend, perhaps understandably. With a new baby women's priority was less likely to be research. When recruiting postnatal women by phone it was considered that if the women said that they and the baby were well and willing to attend the focus group then, although initially the criteria was planned for women who had uncomplicated births, the type of delivery they had would be accommodated in the results. Pragmatic decisions were made therefore to include a woman with previous breastfeeding experience and due to pressure of time not to repeat attempts to recruit teenagers or postnatal ethnic minority groups.

#### ***5.7.4.5 Telephone scripts***

Telephone scripts were prepared in order to personalise the invitations and follow up the personal contact already made with the women in the clinics and support group. These pre-worded telephone scripts were used and adapted from suggestions about telephone contact (Krueger & Casey 2009). This was drafted prior to each recruiting episode to ensure sensitive contact and consistency of information. The general structure was drafted and used as an outline for the conversation. This started with an introduction of the researcher and reminder of when and where we had contact. This was followed by an enquiry as to the woman's (and if postnatal, the baby's) health and verbal consent to proceed was then obtained. Information about the focus

group was then explained. Questions were invited about the arrangements before the end of the call.

## **5.8 Procedure for the focus groups**

Following recruitment, five focus groups were arranged by phoning the women and agreeing a date and time that was suitable. Most focus groups were planned with more women accepting and agreeing to attend than actually arrived. In one group only one woman attended and she consented to take part in an individual interview. One focus group was held alongside a breastfeeding support group which was extremely noisy and plans were made not to repeat that type of arrangement. All the rest were held in quiet comfortable rooms with cold drinks available and toilet facilities within community NHS clinic areas.

### **5.8.1 Data collection**

I introduced my supervisor as the co-facilitator and explained the information and consent materials as well as the conduct of the group. The participants completed the consent and demographic information forms and were invited to ask questions before commencing the focus group (see Table 20).

Considering the focus groups were being facilitated by me, a postgraduate student, it was helpful to have my supervisor present to ensure smooth running of the sessions and to help with any unforeseen circumstances. At the beginning it was explained that different views were welcome and then during the session it was checked that there was some agreement with a stated point of view if the conversation did not make that clear. Divergent views were also sought. It was also stressed that there were no correct answers and a range of views were welcome. Giving out socio-demographic forms (Appendix 13) as people were arriving helped to reduce awkwardness at the start. Going over the information sheet, obtaining signed consent forms and introductions at the beginning helped to set the scene. Audio recording of the session allowed me to facilitate the group rather than be engrossed in note taking.

Most time was spent on the key questions. The participants were asked to give their view on what was most important to them. Then I summarised the main discussion

and asked for confirmation of its veracity, then after a reminder of the purpose of the research asked if anything has been missed from the discussion (Krueger & Casey 2009). In this study the questions were based on the six types of question and covered the topics of skin to skin contact, baby behaviour at birth, problem solving and hand expressing. These questions were informed by the literature and knowledge of the expected sequence of events after the birth.

In the key question section the women were asked to rearrange (in a sequence) and comment on photographs showing the sequence of instinctive behaviour at birth. The women were asked to match words to pictures on the leaflet “Feeding cues at birth”, that I devised. This leaflet has both photographs and explanatory text of skin to skin contact between mother and baby and instinctive behaviour. In addition, there was a brief explanation that babies can be sleepy and not able to display instinctive behaviour at birth, and therefore may be unable to attach (see Appendix 9). This strategy was used to find out if the women knew how babies could behave at birth as they initiate breastfeeding. Photographs are examples of indirect vicarious experience as opposed to the direct vicarious experience of actually seeing the mother and baby pair initiating breastfeeding. The women were also shown and asked to comment on the chart of “Feeding cues after the first few hours” which was designed to make women aware of the sleep states of babies and the baby’s corresponding ability to breastfeed in the first days after birth (Long 2006) in (see Appendix 9).

**Table 20 Dates and numbers of ante/postnatal women attending**

<b>Date</b>	<b>AN/PN</b>	<b>Number attending</b>
20 April	PN	3
4 May	AN	4
8 June	AN	6
29 June	PN	1
27 July	PN	4
		Total 18 women

### 5.8.2 Debriefing

Having two people facilitating made it easier to be sensitive to participants needs for further explanation or to leave the group (researcher plus supervisor). One participant in an antenatal group stayed behind for a short time to expand a few points of interest. At the end of each group the participants generally started chatting between themselves and prepared to leave. An honorarium of a £10.00 store voucher was given to each woman in lieu of travel expenses.

## 5.9 Midwives

### 5.9.1 Sample

Recruitment took place in the same health board area as the women. I made appointments with the lead midwives in the West and South areas with regard to recruiting community and home birth midwives and with the hospital based lead midwife with regard to recruiting in hospital. These meetings started a process of personal contact with staff to raise awareness of the study. Again purposive sampling was used to identify midwives who practised in a range of midwifery settings.

Midwives were given study information packs about the study. Community midwives were recruited from the same clinic that was visited to recruit women; in effect the midwives were involved in the care of some of the women in the focus groups. It was agreed that the interviews would be completed during convenient periods during the midwives' shifts which may have had a positive impact on recruitment.

Midwives were also invited to approach the researcher for an information pack. The packs contained an information sheet; a consent form and a reply slip (see Appendices 14 and 15). The reply slip containing contact details was completed and returned by the midwives and a date and time arranged for the interview.

### 5.9.2 Inclusion criteria

Midwives representative from all areas of practise were included. Eighteen midwives were planned to be sampled to ensure that they represented the range of experience and areas of practice (these variables may affect knowledge and confidence in helping women to breastfeed Cantrill et al. 2003). Table 21 below shows how the sample was planned.

**Table 21 Planned recruitment of midwives**

<b>Group</b>	<b>Category and No</b>	<b>Category and No</b>	<b>Category and No</b>
	Community	Labour ward	Postnatal ward
1-5 years' experience	3	3	3
6-15+ years' experience	3	3	3

### 5.9.3 Procedure for semi-structured interviews

Semi-structured interviews were conducted with 18 midwives. The planned number representing the areas of practice was achieved but samples of midwives with different lengths of experience were unavailable as fewer newly qualified midwives were practising in the study area.

The interviews in this part of the study were semi-structured and were adapted according to the midwife's practice setting. The interviews aimed to explore midwives expectations, knowledge and experiences of breastfeeding initiation. The midwives were interviewed adjacent to their work area in a quiet private room. One midwife was interrupted to return to practice as the ward had new admissions. Before each interview, I introduced myself and explained the information and consent materials as well as the conduct of the interview. The participants completed the consent and demographic information forms (see Appendices 15 and 16) and were invited to ask questions before commencing the interview.

Each interview was different, as the content was influenced by the participant's responses and explanation of their experience, attitudes and beliefs. I found this challenging as some midwives were very frank about their views and their reported behaviour. One midwife explained that she got angry when the baby would not attach to the breast at birth, which was an unexpected admission from a professional midwife. Most of the midwives were aware only of my status as a researcher. I was aware of neither deference nor enhanced criticism during the interviews but did reflect later (see comments in section 5.11.2).

The structure and format of the questions were modified to best capture information from midwives practising in each of the clinical areas involved. An honorarium of a £10.00 store voucher was given to each midwife as a thank you gesture.

## 5.10 Analysis

In this thesis within the paradigm of interpretivism a hybrid process of inductive and deductive thematic analysis will integrate data-driven codes with theory driven codes (Crabtree & Miller 1992 cited in Fereday & Muir-Cochrane 2006) based on Social Cognitive Theory (Bandura 1986).

All focus groups and interviews were audio-taped and transcribed by the author. Confidentiality was ensured by using pseudonyms for participants on all documents. The computer package NVivo 8 was utilized to inductively code the transcript data. The transcripts were coded initially according to concepts drawn from the Focus group and interview guide then as recurring words and concepts emerged from the data, new inductive codes were assigned. The coding was then analysed to create tree structures/themes (Richards 2009) (see Appendices 17 and 18). A process of thematic analysis was used (Pope & Mays 2006).

### 5.10.1 Inductive coding

Inductive coding was first carried out by searching for patterns and associations in the data (Ritchie & Lewis 2003). This involved topic coding, where the topics being discussed were coded in the same category and the meanings in the context were considered and a process of interpretation and reflection followed to allow new ideas to emerge (Richards 2009).

#### 5.10.1.1 Women – key themes

From the inductive coding of women's data five overarching analytical themes emerged, most with several subthemes: Antenatal expectations, Knowledge and experience, Difficulty in initiation, Support and Important to learn. These themes described a process that was consistent with an antenatal woman's position with regard to anticipating breastfeeding her baby but then being tentatively introduced to possible difficulties with the start of breastfeeding. This process continued with postnatal women's experiences of the reality of the difficulties they experienced at the start of breastfeeding their babies. The conclusion of the process of learning to feed their babies included their views of how they were supported, reflections on their experience and what they felt had been important to learn. The first draft of the findings was then written up using this inductive logic.

### **5.10.1.2 Midwives – key themes**

From the inductive coding of midwives data eight overarching themes emerged some with several subthemes: Skin to skin contact, Baby behaviour at birth, Midwives' expectation of giving help, Attachment, Hand expressing, Personal experience, Midwives' frustration, and Midwives' solutions. These themes reflected midwives' views and experiences when they were involved in helping women with the process of initiation of breastfeeding. This was dependent on the site where the care was provided. The midwives' views in relation to aspects of the questions about the use of skin to skin contact for example, which were relevant in the labour ward, were different to those in the postnatal ward, in relation to expectations, knowledge and experiences of breastfeeding initiation. A distinction seemed to be less clear in the views of community midwives who may at times be involved in labour ward and home births. The first draft of the findings was then written up using this inductive logic.

### **5.10.2 Deductive analysis**

The findings were then subjected to deductive analysis using a template of codes (see Appendix 19) developed a priori based on the theoretical concepts of Social Cognitive Theory (SCT) (Bandura 1986). This hybrid approach was adapted from an outline described by Crabtree and Miller (1992) where a codebook aids the management of data (Crabtree & Miller 1992). Fereday and Muir-Cochrane (2006) described creating a template as in Crabtree and Miller based on their research questions and a theoretical concept of social phenomenology, which was then applied to their study (Fereday & Muir-Cochrane 2006). Fereday and Muir-Cochrane (2006) then proceeded to use the codes to analyse their data using the computer programme N-Vivo with the a priori codes.

In this current study an adaptation of the examples in Fereday and Muir-Cochrane (2006) for devising the codes was adapted for SCT and the resulting template of codes was applied to the results of the inductive coding that had previously emerged from the N-Vivo process. Deductive analysis was applied during line by line analysis of the women's and midwives' results to interpret and understand how the inductive themes were embedded in SCT (see Tables 23 and 25).

## **5.11 Summary and reflection**

### **5.11.1 Focus groups with women**

After each focus group a point was made to reflect on the events and processes that were followed in order to consider any bias inherent in my conduct (Pope & Mays 2006).

The women who attended the focus groups were all very willing to participate. One postnatal focus group was recruited from an existing support group but it was not known if the participants knew each other. The two antenatal and two postnatal focus groups were recruited solely from antenatal clinic visits.

Audio recording was consented to in each group but was at times tricky to use effectively. In some rooms the background noise distracted me but did not appear to affect the participant's contributions. The question guide, photos and trigger materials were helpful to encourage discussion and elicit the women's knowledge of instinctive behaviour. At times the concepts I presented were unfamiliar to women and appeared a bit complex. The women however generally found the materials helpful and were keen to impart their personal experiences in the light of the contexts presented via the range of materials. They were interested in having information about instinctive behaviour and sleepy babies.

### **5.11.2 Interviews with midwives**

There were a few issues with regard to interviewing midwives. The question arose in my mind about how the midwives would perceive me as a researcher. There were some midwives I had known many years before when I worked in the health board area and I wondered if this would affect recruitment. This did not appear to present any problems and one midwife who knew me volunteered to be interviewed.



## Chapter 6 Study results: Mothers

### 6.1 Introduction

The aim of the sixth chapter is to inductively analyse the women's results then to use Social Cognitive Theory deductively to explore and help explain the expectations, knowledge and experiences of women with regard to breastfeeding initiation.

#### Objectives

1. To explore the expectations and knowledge of antenatal women of breastfeeding initiation.
2. To explore the expectations and knowledge and experiences of breastfeeding initiation in postnatal women.
3. To apply Social Cognitive Theory deductively to the results of inductive coding
4. To determine if the materials used to facilitate discussion in focus groups were found useful in understanding initiation.

The methods and setting of this study have been described in Chapter 5. Eighteen women were recruited (ten antenatal women and eight postnatal women). The women were generally older, 12 participants over 31 years, against average age of Scottish childbearing population 29.6 in 2010, (General Register Office for Scotland). They were more educated than the child bearing population, 11 participants with higher degrees seven with first degrees, against 46.05 percent of 25-34 year olds had tertiary education in 2012 (OECD Factbook 2013: Economic, Environmental and Social Statistics<sup>©</sup> OECD 2012). They represented a range of ethnic groups (see Table 22). The antenatal women were all primigravidae. One of the postnatal women had one previous baby that she had breastfed but the rest were primigravidae. At the time of the focus groups five of the postnatal women were still exclusively breastfeeding, two were partially breastfeeding and one was bottle feeding.

**Table 22 Women's Demographic Information**

Focus group no.	Age group,	Ethnic group,	Gestation at delivery,	Highest educational qualification,	Language,	Leaving hospital together,	Marital status,	Occupational group,	Pregnancy in weeks,	Still breastfeeding
Transcript of PN woman Focus Group 1	"26-30"	"German"	"more than 37 weeks"	"Higher degree"	"other"	"yes"	"Married"	"Education" Lecturer	Not Applicable	"Partial breastfeeding"
Transcript of PN woman Focus Group 1	"36-40"	"American"	"more than 37 weeks"	"Higher degree"	"English"	"yes"	"Married"	"Education" Lecturer	Not Applicable	"Exclusive breastfeeding"
Transcript of PN woman Focus Group 1	"26-30"	"White British Scottish"	"more than 37 weeks"	"First degree"	"English"	"yes"	"Married"	"Professional" Optometrist	Not Applicable	"Exclusive breastfeeding"
Transcript of AN woman Focus Group 2	"26-30"	"White British Scottish"	Not Applicable	"First degree"	"English"	Not Applicable	"Married"	"Professional" Civil servant	"32-36"	Not Applicable
Transcript of AN woman Focus Group 2	"31-35"	"White British Scottish"	Not Applicable	"Higher degree"	"English"	Not Applicable	"Married"	"Education" Teacher	"36-40"	Not Applicable
Transcript of AN woman Focus Group 2	"26-30"	"White British Scottish"	Not Applicable	"Higher degree"	"English"	Not Applicable	"Married"	"Manual" Carer	"36-40"	Not Applicable

Focus group no.	Age group,	Ethnic group,	Gestation at delivery,	Highest educational qualification,	Language,	Leaving hospital together,	Marital status,	Occupational group,	Pregnancy in weeks,	Still breastfeeding
Transcript of AN woman Focus Group 2	"31-35"	"Mixed"	Not Applicable	"Higher degree"	"English"	Not Applicable	"Live with partner"	"Professional" Scientist	"36-40"	Not Applicable
Transcript of AN woman Focus Group 3	"36-40"	"White Spanish"	Not Applicable	"First degree"	"English"	Not Applicable	"Live with partner"	"other" Unemployed	"36-40"	Not Applicable
Transcript of AN woman Focus Group 3	"31-35"	"White Polish"	Not Applicable	"Higher degree"	"Polish"	Not Applicable	"Live with partner"	"Education" Student	"32-36"	Not Applicable
Transcript of AN woman Focus Group 3	"26-30"	"Pakistani"	Not Applicable	"First degree"	"English"	Not Applicable	"Married"	"Manual" Sales advisor	"36-40"	Not Applicable
Transcript of AN woman Focus Group 3	"31-35"	"Chinese"	Not Applicable	"Higher degree"	"Mandarin"	Not Applicable	"Married"	"Professional"	"36-40"	Not Applicable
Transcript of AN woman Focus Group 3	"31-35"	"Dutch"	Not Applicable	"First degree"	"English"	Not Applicable	"Married"	"Professional" Social worker	"32-36"	Not Applicable
Transcript of AN woman Focus Group 3	"31-35"	"German"	Not Applicable	"Higher degree"	"English"	Not Applicable	"Married"	"Professional" Transport planner	"36-40"	Not Applicable

Focus group no.	Age group,	Ethnic group,	Gestation at delivery,	Highest educational qualification,	Language,	Leaving hospital together,	Marital status,	Occupational group,	Pregnancy in weeks,	Still breastfeeding
Transcript of PN woman Focus Group 4	"31-35"	"White Lithuanian"	"more than 37 weeks"	"First degree"	"English"	"yes"	"Single"	"Manual" Shop manager	Not Applicable	"Exclusive breastfeeding"
Transcript of PN woman Focus Group 5	"31-35"	"White British Scottish"	"more than 37 weeks"	"Higher degree"	"English"	"yes"	"Married"	"Education" Teacher	Not Applicable	"Exclusive breastfeeding"
Transcript of PN woman Focus Group 5	"26-30"	"White British Scottish"	"more than 37 weeks"	"Higher degree"	"English"	"yes"	"Married"	"Professional" Solicitor	Not Applicable	"Exclusive breastfeeding"
Transcript of PN woman Focus Group 5	"31-35"	"White British Scottish"	"more than 37 weeks"	"First degree"	"English"	"yes"	"Live with partner"	"Professional" Occupational therapist	Not Applicable	"Partial breastfeeding"
Transcript of PN woman Focus Group 5	"31-35"	"White British Scottish"	"more than 37 weeks"	"Higher degree"	"English"	"yes"	"Live with partner"	"Education" Teacher	Not Applicable	"Formula feeding"

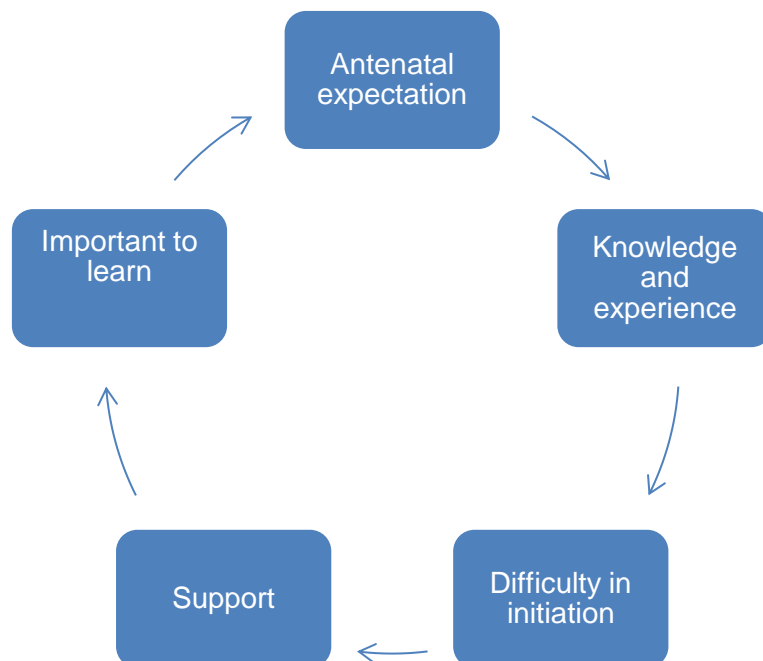
## 6.2 Findings

Five overarching analytical themes emerged from inductive coding of the women's results and are presented in order of experiences from pregnancy to some weeks after the birth (most with several subthemes):

- Antenatal expectations had two subthemes which related to influences on women's decisions and confidence about starting to breastfeed.
- Knowledge and experience had two subthemes: Knowledge of breastfeeding and Knowledge and experience of skin to skin contact.
- Difficulty in initiation was the largest theme with three subthemes: Antenatal anticipation of difficulties, postnatal experiences, and a major one concerned with Hand expressing.
- Support was one theme that reflected on what help women had expected and then experienced.
- Important to learn had two subthemes: Reflections on experience and Persistence.

Themes and subthemes in order of experiences are illustrated in Figure 7.

**Figure 7 Women's views of breastfeeding initiation: emergence of themes**



Social Cognitive Theory (SCT) was then used deductively to interpret and understand the themes in an effort to conceptualise key areas of the women's

experiences. The themes and subthemes identified from the data were interpreted within the framework of SCT. The relationship of themes and subthemes to SCT is illustrated in Table 23.

**Table 23 The Relationship of Themes and Subthemes to Social Cognitive Theory**

Theme	Subtheme	Relationship of themes and subthemes to SCT
<b>6.3 Antenatal expectation</b> Included the influences on women's decision to breastfeed and their confidence about starting.	6.3.1 Influences on decision to breastfeed described who and what was most influential in women's decisions to breastfeed.	Outcome expectancies, Vicarious experience, Motivation, Verbal persuasion
	6.3.2 Confidence about initiating breastfeeding described how confident the women thought they were about starting to breastfeed.	Perceived self-efficacy, Motivation, Self-regulation, Vicarious experience, Verbal persuasion
<b>6.4 Knowledge and experience</b> related to what women had learned about breastfeeding, skin to skin contact at birth and postnatal women's actual experience.	6.4.1 Knowledge of breastfeeding explained what women knew about the benefits of breastfeeding.	Self-regulation, Self-efficacy
	6.4.2 Knowledge and experience of skin to skin contact revealed what antenatal women knew about skin contact and the instinctive nature of baby behaviour. The experiences of postnatal women were described.	Outcome expectation, Motivation, Psychological state, Vicarious experience, Enactive attainment
<b>6.5 Difficulty in initiation</b> described antenatal women's reaction to anticipating potential problems and how to deal with them, and the postnatal women's reaction to their actual experience of problems.	6.5.1 Antenatal anticipation of difficulties explored women's reactions to the introduction of potential problems.	Outcome expectation, Motivation.
	6.5.2 Postnatal experiences revealed the women's actual experiences of problems	Level of self-efficacy, Self-regulation, Reflection, Psychological State, Lack of Enactive Attainment, Goals, Lowered self-efficacy, Environmental factors
	6.5.3 Hand expressing revealed how antenatal women reacted to the concept and described postnatal women's subsequent experiences.	Motivation, Level of SE, Vicarious experience Physical/psychological state, Effort and persistence, Verbal persuasion, Lack of enactive attainment
<b>6.6 Support</b> revealed what help women had expected and the reality that they experienced	6.6.1 Postnatal women's expectations of help described the varying levels of help women experienced	Level of self-efficacy, Persistence, Verbal persuasion
<b>6.7 Important to learn</b> was a reflection of women's experiences and what had been learned.	6.7.1 Reflections on experience which described women's lack of awareness about the nature of the difficulties that have subsequently become apparent when starting to breastfeed.	Reflection, Self-regulation, Level of self-efficacy, Psychological state

Theme	Subtheme	Relationship of themes and sub-themes to SCT
	6.7.2 Persistence became part of the solution to dealing with the difficulties women faced.	High self-efficacy, Verbal persuasion, Enactive attainment

This chapter will present the themes and subthemes alongside their related SCT concepts. The main points will be illustrated with the use of relevant quotes. Occasionally quotes will be incorporated in the text and this will be indicated by quotation marks and/or italics. At the end of main quotes the code FG1-5 is given, this indicates the focus group the quote comes from along with parity and whether the woman is antenatal or postnatal. All women's names have been changed to protect their anonymity.

### 6.3 Antenatal expectation

#### 6.3.1 Influences on decision to breastfeed

The influence of family, partners and friends was evident in encouraging all groups of women in their intention to breastfeed. This was perhaps more evident in the women from cultures other than Scottish. The influence of familiarity with breastfeeding and encouragement was more evident than the influence of health education. These were the most important influences for the women and have been covered extensively in the published literature (see Chapter 4).

Knowing that their mother had breastfed them was an important influence on women. The women in one antenatal focus group were from a variety of cultural backgrounds including Spanish, Polish, Dutch, German, and Scottish/Pakistani who were very much influenced by the familiarity of breastfeeding in their own culture and all planned to breastfeed.

*"I mean I think for myself coming from an Asian culture as well it's very, very important that we do try and breastfeed our children."* (Fatima, first baby Scottish/Pakistani, Antenatal woman, FG 3)

Anticipating the relationship with the baby as being rewarding was also a reason for women's motivation.

The health benefits of breastfeeding are promoted as a reason to breastfeed by UNICEF UK and this and other aspects of breastfeeding are promoted in the antenatal clinics the women attended and were important influences on some women.

*“It was just the health benefits I wanted to try and breastfeed.”* (Lizzi , first baby Postnatal woman FG 5)

See also section 3.7 Outcome expectancies, Vicarious experience, Motivation, Verbal persuasion.

### **6.3.2 Confidence about initiating breastfeeding**

Most of the antenatal women expressed uncertainty about learning how to breastfeed. Women thought being prepared by learning about positions to feed the baby would help and even the women who were culturally familiar with breastfeeding wanted help, for example, by getting checked by staff to see if they were breastfeeding correctly. This may have related to their inexperience but could also reflect current family support being absent, especially in more recent migrants. These women seemed to be not very confident but they were self-directed in that they considered how they could best be helped by others. They were planning to recruit the help they thought would be necessary in order to succeed, but were also motivated by their own internal standards in that they assumed they would breastfeed.

Postnatal women reflected that they had been thinking more about actually giving birth rather than breastfeeding. The thoughts of labour took precedence over thoughts of anticipating how to start breastfeeding the baby.

*“I didn’t think about that, it was about giving birth.”*

*“That’s exactly what I was just about to say that (giving birth) was my biggest anxiety.”* (Angi and Ally, first time mothers, Postnatal women FG 5)

Watching someone who has coped and persevered, especially someone who they can identify with, can help increase a person’s self-efficacy. Of the women who had seen someone breastfeeding before in a social setting, the influences were mixed. Some thought breastfeeding would be easy, as their friends made it look easy. A



woman who had stopped breastfeeding reflected that she had not expected the difficulties she actually had. Others had thought that it could be difficult because they had seen friends experiencing difficulty and only a rare person they knew had persevered.

It may help to be encouraged to do something, as the person may then make more effort. Encouragement is more likely to help people believe they can achieve a skill if it is realistic and it is possible to succeed). Postnatal women had sought reassurance about breastfeeding during their antenatal care and were told there were lots of help lines, help in hospital and help from the midwives back at home “*I think the midwives here (antenatal clinic) were really good*”.

See section 3.7 Perceived self-efficacy, Motivation, Self-regulation, Vicarious experience, Verbal persuasion.

## **6.4 Knowledge and experience of breastfeeding**

### **6.4.1 Knowledge of breastfeeding**

The women had done quite a lot of reading and researching on the internet about breastfeeding before the birth. They seemed to be quite self-directed and found out most of the information themselves. Some said they hadn't had much discussion about breastfeeding with midwives, but despite this they seemed to know about the health benefits. All but one had missed the breastfeeding workshop as they either didn't know about it or thought they were too far on in pregnancy to attend.

*“I'd looked into it (breastfeeding) myself a lot and I'd looked into it on the internet quite a lot looking at it and spoke to people who had and hadn't breastfed and eh I hadn't spoke much to the midwives either and missed the kind of breastfeeding session thing.”* (Angi, first baby, Postnatal woman FG 5)

See section 3.7 Self-regulation, self-efficacy.

### **6.4.2 Knowledge and experience of skin to skin contact**

In relation to skin to skin contact the antenatal women knew about skin to skin contact with their baby at birth and generally indicated that it meant having the baby

in skin contact with them at birth. The women had thought quite carefully about having skin to skin contact and most had anticipated doing this after their baby was born, describing what they thought happened as; “having it, popping it, on either onto actually your breast or your chest, em, as soon as, almost as soon as it comes out”. This was something they planned to do. Some mentioned that skin to skin has physical benefits for regulating the heartbeat and calming the baby. The women talked about bonding being helped by skin to skin contact and how important this was to the developing mother-baby relationship.

One woman felt skin to skin contact would probably be a positive experience but seemed quite guarded as she seemed apprehensive of the labour and what might happen if she had to have a caesarean, *“it’s generally a good thing, although I suppose I don’t know what would happen if you had a caesarean or something”*. The woman was anxious about giving birth and did not have effective strategies about skin contact if she needed an operative delivery. The woman had an expectation that she could have a negative physical outcome of labour that would affect her ability to start breastfeeding.

Observation of another mother and baby pair starting to breastfeed while having skin to skin contact (baby naked with his/her back covered) would be unlikely unless the women had attended a birth. In order to expand the discussion in relation to breastfeeding and skin to skin, a series of colour photographs showing babies skin to skin and the sequence of babies’ pre-feeding/instinctive behaviour at birth were shown to the women (see Appendix 9). Photographs are examples of symbolic modelling as a source of vicarious experience. The photographs were used to find out if the women knew how babies could behave at birth and start to breastfeed and how a mother may respond to her baby’s behaviour (see Chapter 5 for details). Only one ante natal woman seemed to have heard about instinctive behaviours at birth (this was from attending NCT antenatal classes). She demonstrated insight of pre-feeding/instinctive behaviour and attachment to the breast as a result of seeing the photos.

*“Also I suppose it kind of fits in with some other stuff that’s in the antenatal classes about how the baby kind of knows like what you are saying it kind of*

*knows what to do and it does its thing em I can't remember what you call it but it kind of makes its own way to the breast when it, for that first feed."*

(Annabelle, first baby Antenatal woman, FG 2)

Overall the antenatal women had a positive attitude to seeing the sequence of instinctive behaviour in the photos. They indicated it was "so natural" and stated they hadn't "realised how instinctive it was". Several suggested the pictures were "helpful", and "it's outside your everyday experience on the whole". The women identified with the photos (vicarious experience) which gave them insight into the process of instinctive and successful attachment behaviour.

When the topic of skin to skin was raised with the postnatal women a few women said they were surprised that their babies took the initiative to attach to the breast and start feeding during the period of skin contact. "She just pretty much knew what to do, ah, very quickly", where the baby attached instinctively.

Women that were successful in having the babies attach to the breast at the first attempt attributed the success to the baby's instinctive ability.

*"I had a really good start with her but I think that was down to her rather than anything else cause she was born munching the first thing you saw was (licking movements demonstrated) ... and the moment she was lying on my breast she just (started sucking)." (Una, first baby Postnatal woman FG 1)*

One woman recollected that her baby was moving around but was not interested in feeding despite the midwife trying to attach the baby.

*"I was holding him there and he was definitely between girns and kind of cries he was smacking his lips and kind of moving his head towards where my nipple would be and stuff he wasn't interested in actually taking anything from it but that's what he was looking for it and ... the midwife that was who delivered him just kind of manhandled me and tried to get him come on." (Angi, first baby Postnatal woman FG 5).*

See section 3.7 Outcome expectation, Motivation, Psychological state, Vicarious experience, Enactive attainment.

## 6.5 Difficulty in initiation

Women said they had knowledge of the health benefits of breastfeeding. Antenatal women were knowledgeable about skin to skin contact and anticipated having this after the baby was born. A few postnatal women had experienced the baby attaching instinctively when they had skin contact but more than half of the women did not have this experience and their babies did not attach after the birth. Pre-feeding/instinctive behaviours, (which comprises of a sequence of movements made by the baby immediately prior to initiating breastfeeding) are explained in chapter 2. This section will recount the antenatal women's reactions to anticipating potential problems and the postnatal women's reactions to their experiences of problems where the baby did not attach at birth.

### 6.5.1 Antenatal anticipation of difficulties

Women recalled friends who “were made to feel a little bit guilty about it”, when they gave up breastfeeding. Some women were philosophical about their plans if breastfeeding didn't work.

*“I'll know that I've done my best, em, I'm not going to beat myself up about it I'm just going to get on with it (planned to bottle feed if breastfeeding unsuccessful).”* (Katy, first baby antenatal woman FG 2)

Perception of social outcome expectations of disapproval, from, for example, healthcare professionals such as midwives or health visitors (Luszczynska & Schwarzer 2005), could explain some of the antenatal women's anticipation that they could be made to feel guilty if they faced difficulties starting to breastfeed.

The problem was posed by me that the baby could present as sleepy at birth. Some antenatal women responded that they would either be philosophical or relieved that the baby seemed content and they could get a good night's sleep. Other women expressed a more concerned attitude and would be upset if the baby was sleepy and did not want to feed and worried that there might be something wrong with the baby.

*“I think I would always have that feeling that like a bit kind of I dunno if panicky is the right word but just obviously they can’t tell you why.”* (Therese, first baby, Antenatal woman, FG 2)

Being informed about alternatives or strategies, *“when it doesn’t work ... that’s not been addressed”*, was important to some women in order to be prepared for problems and to know how to deal with them. But the women had not been informed what strategies could be used if attempts to breastfeed were difficult at the beginning. They could not have anticipated what they might plan to do, so they started to devise strategies in the group, such as having help lines. People who feel highly efficacious will think of how they will achieve success in a task and how to go about it but people who have a low estimate of their self-efficacy will think of all the reasons for their efforts to go wrong (Bandura 1989).

Matching text to the chart “Feeding cues after the first few hours” was considered thoughtfully by the antenatal women. The women were interested in learning at what stage of sleep their baby would be able to be fed.

This is perhaps a difficult area for antenatal women to be commenting on as although they had heard that there could be problems they may not have heard about specific difficulties from friends who tried to initiate breastfeeding at birth. The women in the focus groups had been presented with a problem of which they had no previous knowledge. Their ability to react to this was reflected in the range of levels of self-efficacy and motivation in their answers, where some were pragmatic and others worried.

See section 3.7 Outcome expectation, motivation.

### **6.5.2 Postnatal experiences**

More than half of the postnatal women experienced problems with breastfeeding at birth and had varied experiences of skin contact. One woman described that although the baby was *“smacking his lips and kind of moving his head towards where the nipple would be”* the baby did not attach. The midwife tried to attach the baby but he did not actually feed for about a day after he was born.

Women's dialogue of their difficulties of starting to breastfeed was emotional and had an undercurrent of sadness and regret. They described feelings of "*failure*" and "*embarrassment*" or being "*cheated*" when their babies did not attach. It was evident that clinical procedures, such as forceps delivery and caesarean section, contributed to preventing the women from enjoying the first moments with their babies. One woman was even more negative than others and sounded quite sad and guilty when she was recounting her experiences, she and others talked about the effect of drugs on themselves and the baby.

*"I was in theatre and had a forceps where he was dragged out ... I look at that one (photo of instinctive behaviour) and wish my baby had done that when he was born but he was just too sleepy and just not interested in it, even when they put him on my chest he wasn't rooting he wasn't doing anything; admittedly I'd had some morphine."* (Kay, first baby, Postnatal woman FG 1)

Women reflected weeks later, during the focus groups, on the experiences they had immediately after the birth.

When someone is stressed it can make coping more difficult. A state of high arousal, such as experiencing fear, can induce anticipation of additional stressful events and can raise anxiety levels even higher. When someone feels tired or in pain they are more likely to feel a sense of inefficacy (Bandura 1986).

Most women who had instrumental or operative deliveries did not have skin contact and some sounded quite shocked about their experiences and upset when they did not have skin contact.

*"I'm probably the wrong person to ask as I didn't get as much skin-to-skin contact because my baby got taken AWAY (woman's emphasis lengthening the word) while I was getting stitched up so and afterwards the midwives had wrapped him all up in a towel"* (Kay, first baby, Postnatal woman FG 1)

This woman was a distressing example of someone whose baby had been delivered by forceps and been separated from her ("*taken AWAY*" her emphasis in a very sad

tone), presumably to be resuscitated. She described her “*bit of a nightmare time*”. This woman found dealing with her pain and circumstances around the delivery difficult where she did not have skin contact with her baby or the opportunity to start breastfeeding.

Most of the postnatal women had their babies placed on their chest with the babies’ heads above the breast. A number of studies have described positions the baby was placed on the mother’s chest with the nipples at the baby’s eye level (Widstrom et al. 2011), prone between the breasts (Carfoot, Williamson, & Dickson 2005) , skin to skin belly to belly (Walters et al. 2007), skin to skin on the mother’s abdomen (Righard & Alade 1990).

When the baby did not attach at birth the postnatal women had a variety of reactions. Angi explained that although she knew a bit about instinctive behaviour she was so “*overwhelmed with everything*” at the birth that she wouldn’t have remembered how the baby was supposed to behave, but he didn’t attach at birth.

*“You’re not with your family you’re in a strange place I think there’s a lot of things (that are confusing straight after the baby is born).”* (Angi, first baby Postnatal woman FG 5)

Postnatal women said they did not know what to do about breastfeeding after the birth when they were in the labour ward or theatre. The midwife had taken over and tried to attach the baby to the breast.

*“You feel as if you should know what to do, I felt a bit of a failure when he wouldn’t go on straight away I felt really really embarrassed.”* (Lizzie, Postnatal woman FG 5)

There was no mention of instinctive behaviour of the baby when the women described how the midwives attempted to help them attach their babies to the breast after the birth. Having midwives touching their breasts was a surprise to the women and they used emotive words such as “*manhandled*” and “*grabbing*” to describe the way the midwives held the breast and moved the baby into position to attach to the

breast. When a person is highly emotionally aroused, as women are immediately after giving birth, unwelcome experiences as described can affect their anxiety levels. Women described their distress when the midwife attempted to get the baby to feed. This quote illustrates the anger some women felt about how they were cared for.

*“He wasn’t interested in feeding not interested at all, em, but she did kind of try so it wasn’t the nicest experience I wasn’t expecting it, to start she got hold of my breast and my nipple and tried to position the nipple into his mouth and I was just like ‘can you get off the breast, please’ you know it just felt uncomfortable ... there wasn’t any kind of preamble there wasn’t any sort of preparation for her touching my body she just got hold of my breast and tried to shove it into his mouth ... I was a bit kind of zonked anyway and but I knew that I didn’t like it and my partner was sitting there going, you know so it was all a bit weird. There’d just been a change of shift as well she just kind of walked in so I didn’t know her she hadn’t delivered him and so it was just a bit strange.” (Lizzie, first baby, Postnatal woman FG 5)*

This was not a mastery experience, of having the baby attach and feed, and according to SE not being successful can lower efficacy expectations.

Angi admitted that after the midwife tried to attach the baby and he didn’t attach she felt very worried that her attempt to breastfeed was going wrong, *“I felt is this the start of him, the start of me, not being able to breastfeed”* and she didn’t know whether to blame the baby or herself and she then questioned her ability to be able to breastfeed. The goals a person has set for themselves can change if the task does not go as planned and are more easily affected if the person doubts their ability (Bandura 1989).

The women’s high levels of emotional arousal and these experiences could contribute to reduction in their expectation of success in attempts to attach their babies and when in doubt about their ability, be more likely to give up. A feeling of dependency was evident.



*“I felt I was really dependent on somebody else I should feel know what to do but I didn’t know what to do and just the emotions running around.”* (Ally, first baby Postnatal woman FG 5)

When failure happens at the beginning of an experience, the result is a lowering of self-efficacy (Bandura 1986).

Where a person feels a rapport with people around them, feeling autonomous and being able to have control of one’s own actions, are among influences on thoughts and behaviour that can be affected by their carers behaviour (Luszczynska & Schwarzer 2005).

Although the women said they didn’t know what to do after the delivery, to have the midwife attempt to attach the baby for them resulted for some women in a sudden feeling of dependence. This unexpected loss of autonomy happened at a time straight after giving birth when women were also very emotionally vulnerable. From the data it appeared that during and after their experiences in the labour ward or theatre, the women expected the midwife to be the one who attached the baby to the breast, *“I just buzzed every single time I tried to feed her they were so busy”* illustrating a state of dependency.

However some women in the focus groups criticised the midwife’s ability to attach the baby to the breast. This later cognitive appraisal by the women, where they suggested lack of skill on the part of the midwives, demonstrated that these women had high levels of efficacy expectation of themselves and these particular women were now discounting the value of the midwives interventions.

*“They couldn’t do it either they were just like that, ‘nup’.”* (Gaby, first baby Postnatal woman FG 5)

A person reflects about what they have done and considers their own thoughts and perhaps changes their thinking about something when they develop more understanding (Bandura 1986).

See section 3.7 Level of self-efficacy, Self-regulation, Reflection, Psychological State, Lack of Enactive Attainment, Goals, Lowered self-efficacy, Environmental factors.

### 6.5.3 Hand expressing

Antenatal women were introduced to the concept of hand expressing in the focus groups by me and this was followed by vigorous discussion. The strategy of hand expressing was introduced by the midwives to postnatal women either in labour ward or shortly after arrival in the postnatal ward. This intervention comprised a major unexpected part of women's experiences in the postnatal ward and was discussed extensively in the focus groups as a major component of initiation of breastfeeding. The practice in the local maternity units was that when the baby didn't attach to the breast for 6 hours after the birth, the staff encouraged women to hand express their breastmilk, (NHS Greater Glasgow and Clyde 2011). This reflected UNICEF/Baby Friendly guidelines for sleepy babies and expressed breast milk (EBM) was given via a cup or syringe 8-12 times in 24 hours until the baby wakened and was able to attach and feed from the breast (UNICEFUK Baby Friendly 2012b).

None of the antenatal women seemed to have heard about hand expressing and cup or syringe feeding the baby with EBM if s/he was sleepy and unable to feed at birth. This seemed to shock and upset women as they hadn't heard of this strategy before. The women in the multinational group replied in quick succession.

*Patti: "would be surprised and worried."*

*Angela: "not liking the cup, never seen something like that before."*

*Fatima: "would try not to take analgesia." (another agreed) (Antenatal women, first babies FG 3)*

Another woman was particularly exercised by having to think about how to deal with the situation of her baby not feeding and having to hand express. She compared this to her thoughts about preparing for the birth itself. The woman was frustrated about having a birth plan and she was uncomfortable about also being asked to think about having a feeding plan.

Some women carried the thought on to feeling that as they didn't know how labour might affect them and they didn't know how they would feel themselves, then if the baby didn't feed, they would want to be able to change to bottle feeding.

*"Yes there's no right or wrong it's just a natural process you do the best you can ... I think some people would just be happy with just and quite happy with what will be will be, can't do anything about it you know."* (Agnes, first baby, Antenatal woman, FG 2)

According to Bandura the thought of problems can lead to exaggeration of the anticipated level of difficulty if people doubt their own abilities (Bandura 1986). A person's expectation of being able to be successful in an activity affects whether they will even attempt the behaviour or avoid something they perceive as beyond their ability to cope (Bandura 1986). People who have a lower sense of self-efficacy tend to pay more attention to failure (Bandura 1989).

Some women however agreed they would want information about hand expressing before the birth in order to be prepared for the possibility of their baby not feeding. The discussion was developed in one group where there was interest in learning more and having the benefit of being able to anticipate what they may be asked to do and have some insight into their future intended behaviour.

*"It's better knowing I suppose that if the midwife says you could hand express and feed it this way if you knew before that she might say that in this situation and these are some of the things that might help then you might not at the moment at the precise moment say oh I'm not sure about that I don't know cause but if you'd had time to anticipate that kind of mull it over before."* (Annabel, first baby, Antenatal woman, FG 2)

Thinking about what they need to do can motivate people even when there are adverse circumstances (Bandura 1989). People plan for something they consider to be worthwhile (Bandura 1997).

Others were not so sure about perhaps their commitment and felt that the information that women wanted could be different for each.

*“I think you probably have to tailor it to the individual ... it’s not one size fits all.”* (Agnes, first baby, Antenatal woman, FG 2)

It varied in how often and how long the postnatal women needed to express their breasts in order to obtain EBM. It could be that the baby had EBM only once by cup or syringe but giving the baby EBM by syringe could induce anxiety.

*“The midwife gave him it (EBM via syringe) ‘cause I went out and said ‘cause there was air in it and I was frightened of it in his mouth and that kind of thing.”* (Angi, Postnatal woman FG 5)

Expressing was found to be stressful and difficult as the amounts obtained were very small and some women found expressing very painful.

*“She did try to get me to express but nothing was coming out.”* (Kay, first baby Postnatal woman FG 1)

*“I just found it really really painful.”* (Gaby, first baby Postnatal woman FG 5)

Watching others not managing to express was off-putting to some women who were anxious about being able to express.

*“There was a couple of girls in the beds opposite from me who were having real problems.”* (Ally, Postnatal woman FG 5)

According to SE vicarious experience of watching others, failing to achieve something, can reduce feelings of self-efficacy (Bandura 1977).

Lizzie explained that her baby had to go to the neonatal nursery for three hours after the birth as he was a bit unwell. When he came back he still didn’t attach to the breast so she was advised to hand express. Lizzie found that the midwives were *“rushed off their feet”*. She felt they were upset that she was asking for help and that there was a lack of consistency in the advice the midwives gave. Lizzie felt she had to persevere with hand expressing along with the other three women in the room who were also upset *“I just got on with it and expressed”*. Lizzie was encouraged to persevere with hand expressing by the midwives and made this effort after their

verbal persuasion. The other women in the room were also hand expressing and may have provided role models with whom she could identify.

*“There were 4 women in the room all doing the same thing and you know there was loads of tears.”* (Lizzie, first baby, Postnatal woman, FG 5)

The women’s psychological state can affect how well they coped but Lizzie managed to persist and express and give the baby EBM and according to SE achievement lowers anxiety. Anxiety and guilt seemed to overwhelm some women, where expressing was difficult and the baby was refusing to attach to the breast.

*“Actually what you do if he won’t feed” ... I felt then felt really guilty and I shouldn’t have had the morphine.”* (Kay, first baby Postnatal woman FG 1)

Eventually one woman felt the midwives were becoming frustrated and was resigned that the baby wouldn’t be able to be breastfed.

*“And then I had several ones and they were, midwives were getting fractious as well it wasn’t just her and me they were getting impatient with her and they were putting her to it and it’s almost like it’s just not going to happen for you.”* (Gaby, first baby Postnatal woman FG 5)

The more self-efficacy a person feels the longer they will persist especially if they expect eventual success (Bandura 1977)but adverse thoughts and feelings can reduce the likelihood of success (Bandura 1986).

See also 3.7 Motivation, Level of SE, Vicarious experience, Physical/psychological state, Effort and persistence, Verbal persuasion, Lack of enactive attainment.

## **6.6 Support: Postnatal women’s expectation of help**

One of the women explained that she didn’t know what help to expect as she had heard some negative stories but she felt she had had help after all. For her the reality was better than the expectation.

*“I had a terrible expectation but I did (get help) and I think that’s even helped me now that I didn’t expect much because I did get help in hospital and support so.”* (Angi, first baby, Postnatal woman FG 5)

Others felt they’d had the help they had expected but the ward was so busy and some midwives were short tempered or seemed not interested.

*“Em, the help I got was probably what I expected but I didn’t expect the ward to be so much mayhem going on and just em and it got to the point, I didn’t even ask the nurses cause I, really they were nice but then there was one that was just you could tell it was just she just didn’t, she couldn’t be (bothered) doing it to be honest.”* (Gaby, first baby, Postnatal woman FG 5)

Some women hadn’t thought about what help they might need because they didn’t think it would be so difficult at the start and they were not prepared and some felt alone with their problems.

*“I didn’t realise it would be quite so difficult, as it was, em just the whole experience of getting breastfeeding started.”* (Lizzie, first baby Postnatal woman FG 5)

Women thought the midwives were not consistent with their help and support possibly because they were so busy.

*“Every shift that came on they’d tell you to do it a different way ... well try and feed or express a different way.”* (Lizzie, first baby Postnatal woman FG 5)

A woman described her first 24 hours as difficult as she was trying to get the baby to attach which took ages and the midwives were busy so she asked another mother for help and that seemed to boost her confidence. For Ally it was the support of her husband that helped her to get breastfeeding started the day after her baby was born.

*“It was really having his support I think was almost the turning point for me in my own mind.”* (Ally, first baby Postnatal woman FG 5)

These women were influenced by people they found credible who verbally encouraged them to make more effort to continue and try to breastfeed.

See section 3.7 Level of self-efficacy, Persistence, Verbal persuasion.

## 6.7 Important to learn

This theme looked back with the postnatal women on their experiences and what in retrospect would have been important for them to learn about.

### 6.7.1 Reflections on experience

The women were asked if they wanted to learn more about the very start of breastfeeding what aspect would be most important. One woman was quite definite that she did not consider that the baby would not start to breastfeed after the birth; she thought it would be herself that had the problem. This woman was judging how capable she had felt herself to be and she was not convinced she would have been able to cope.

*“It never occurred to me that your baby might not want to feed, do you know I was already aware that there might be a problem with feeding I might not be able to feed him, it never occurred to me that at the very very beginning he just might not want to.”* (Angi, Postnatal woman FG 5)

A woman explained how she had felt guilty about taking analgesia in labour despite needing to have an instrumental delivery. She felt the delivery and the drugs were the reason her baby wouldn't feed at birth and she was having such difficulty in starting to breastfeed. Her baby was becoming unwell because of lack of nutrition and needed to be fed.

*“I felt guilty actually ... he was too low down to do a caesarean so that's how they ended up taking me to theatre and wheeching him out em so it could have been that he was just knackered and that as well but it just made me keep thinking if I hadn't had the drugs then maybe he would have been feeding.”* (Kay, first baby Postnatal woman FG 1)

Another member of the same group then explained that she'd had a similar experience with her first baby who was born in the US.

These women described how their babies were initially unable to attach and breastfeed and they reflected how they had anticipated that failure to breastfeed would be due to a lack of their own ability. Now they were able to acknowledge that due to the circumstances at birth, that sometimes it is the baby and the baby's ability that makes breastfeeding work.

According to Bandura, human beings are able to be reflective and think through their experiences and consider their own thoughts about these experiences. This can help people to learn about themselves and to change how they think about things (Bandura 1986).

Gaby now felt guilty and sad about having given up breastfeeding and she felt because she had asked for a bottle and the midwife tried to explain the benefits of breastfeeding that the midwife was trying to make her feel guilty.

*"Guilt well for me personally I just about cry every single night because I'm not breastfeeding and I just think it's society me personally I've now got a major chip on my shoulder ... and it's awful I'm made I think I'm made feel a bit guilty."* (Gaby, first baby, Postnatal woman FG 5)

Conversely, another woman felt the opposite that she should feel guilty because she has managed to breastfeed where someone else has not.

*"There's only one thing I would say and I know this is almost the flip side of what you guys have been saying but sometimes ... Em, sometimes I feel a wee bit apologetic about breastfeeding as well ... there is definitely an emphasis on breastfeeding so if somebody is bottle feeding then you almost feel a bit apologetic that it's worked for you or something like that."* (Ally, Postnatal woman FG 5)

These women were reflecting from the opposite sides of experience.

See section 3.7 Reflection, Self-regulation, Level of self-efficacy, Psychological state.



### 6.7.2 Persistence

Women talked about being persistent as a route to success in initiating breastfeeding. Izzi felt that starting feeding was difficult because for her she found breastfeeding painful to begin with, but by persisting that was overcome and she carried on but she could see that was not the case for other women.

*“I was quite sure I will breastfeed, but for other ones I’m not sure I think that would be quite a breaking moment breaking time one week.”* (Izzi, (English is not her first language) first baby Postnatal woman FG 4)

Angi had a strong view that she didn’t want any difficulty with breastfeeding to affect her experience with her newborn baby and but she acknowledged that the baby wasn’t showing signs of distress which helped.

*“I was determined that a fail, an inability or a difficulty in breastfeeding was not going to spoil the first few days of my baby’s life and my experience with him ... But I was quite willing to listen to the midwives and keep trying for a while you know but then he wasn’t screaming to be fed and I think that might have been a different story then if that had been the case.”* (Angi ,first baby, Postnatal woman FG 5)

This woman was quite open to verbal persuasion by the midwives. According to SE it can be helpful to be encouraged to do something that the person is capable of doing as they may then make more effort and persist (Bandura 1986).

The women were shown and asked to comment on the photos of instinctive behaviour at birth in the leaflet “Feeding cues at birth”. This has both photographs and explanatory text of instinctive behaviour and an explanation that babies can be sleepy and not able to display instinctive behaviour at birth, thus are unable to attach. Some women had seen similar pictures but did not seem aware of the instinctive behaviour sequence until they saw the photos. They had been aware that babies can be sleepy after birth due to drugs during labour but had not connected that the baby wouldn’t feed.

*“I can’t say at birth that I was consciously aware of any of that.”* (Ally, first baby Postnatal woman FG 5)

This was behaviour that was recognised now by the women as a pre-feeding behaviour.

*“Now she’ll root around, when she’s lying on me she’ll snuffle around and she’ll move her way round till she almost finds the breast that was never something that was a consideration or what happened.”* (Ally, first baby Postnatal woman FG 5)

*“He’s probably doing that now.”* (Kay, first baby, Postnatal woman” FG 2)

The postnatal women thought the text and photos would be helpful.

*“It’s good to have a bit about sleepy babies because if all the emphasis is on what is supposed to happen and then if that is not what happens then that can be a bit upsetting as well.”*

*“I think seeing those still photos is actually helpful more helpful than the videos.”* (Tracy, second baby Postnatal woman FG 1)

Matching text to the chart “Feeding cues after the first few hours” (Appendix 9) was considered thoughtfully by the postnatal women. The women were still learning to assess when their babies were deeply asleep or in active or in-between sleep but some realised their babies will feed *like a reflex*. A few women had used charts when they went home and thought this one would have been helpful in hospital and at home.

*“It might have been helpful in hospital but also afterwards when the midwives come out – talking it through with the midwives maybe a couple of days later once you are back home would be useful.”* (Ally, first baby Postnatal woman FG 5)

A woman reflected on her knowledge which she felt was adequate but she acknowledged that she did not expect the baby would not attach. She attributed her success in initiating and continuing to breastfeed to her persistence and effort, *“I’ve spoken to a lot of people who have given up and we have all persisted and it has*

*paid off*". The views on the information about instinctive behaviour, "so would it (*Feeding cues leaflet*) have made any difference to us I don't know" could be explained by SE that this woman had experienced enactive attainment and her success would have raised her judgement of her capability to breastfeed and perhaps lessen her need now for further information.

Gaby who gave up breastfeeding in the first week felt she would persist with breastfeeding if she has another baby:

*"A whole combination, I gave up too early, my fault a wee bit as well I think I've given up too early I think I should have persevered, em, in hind-, you know the next time I'm having another one I'll definitely try a bit harder."*  
(Gaby, Postnatal woman FG 5)

See section 3.7 High SE, Verbal persuasion, Enactive attainment.

## 6.8 Summary

Social outcome expectations of approval of family and friends and health education messages helped motivate women to plan to breastfeed. Deciding to breastfeed their babies was a positive choice for the women, where these influences were similar to previously published evidence.

Women's knowledge of breastfeeding was gained as a result of mainly self-directed learning and some vicarious experience, although there was some input from midwives. Some of the antenatal women thought it looked easy but some raised doubts about their ability in anticipation of breastfeeding. Most had sufficient belief in themselves to be self-directed and planned to obtain enough assistance to achieve their goals.

From the data it was apparent that skin to skin contact with their baby was something antenatal women looked forward to and judged would be beneficial to both themselves and their baby. Antenatal women were very interested in the photos of instinctive behaviour. They gained insight of how their babies could behave and acknowledged that they had not seen someone breastfeed for the first time. Only

one woman raised the possibility of being unable to have skin contact because of difficulties in labour, indicating her negative physical outcome expectation of labour.

A few postnatal women were surprised to have the experience of their babies taking the initiative to instinctively attach to the breast during skin to skin contact at birth. This successful start to breastfeeding led the women to express pleasure that their breastfeeding had started well.

From the views that women expressed it appeared that they had varying levels of self-efficacy and differed in their reaction to hearing about potential problems. Some antenatal women anticipated that others would make them feel guilty if they had difficulty at the start and they had to give up breastfeeding (anticipating a negative social outcome). The postnatal women reflected that they had been thinking more about giving birth than starting to breastfeed. They thought breastfeeding looked easy but they knew of people who had difficulty. They had been reassured though that “lots” of help was available.

More than half of the postnatal women’s babies did not attach to the breast at birth. This lack of achievement, the environment and the circumstances around the birth of pain, separation from the baby, being affected by drugs (analgesia) and lack of skin contact contributed to high anxiety levels. Some women said they were overwhelmed and felt they had failed at the start of breastfeeding. This feeling of failure was compounded by the midwives attempts to attach the babies to the breast “hands on” being unsuccessful, and women being upset and angry by this unwelcome intervention. The subsequent expectation, that the midwives would attach the baby to the breast, led to a feeling of dependency. The environment around most women was affected by a lack of rapport with the midwives and a sense of lack of autonomy.

Being introduced to the concept of hand expressing was unsettling for antenatal women. They doubted their ability to cope and wanted to avoid something they viewed as unfamiliar and difficult. However some women indicated that they wanted to learn more in order to be able to anticipate how to cope.

The postnatal women became anxious when being encouraged to hand express when their babies were not feeding, and found it difficult to do successfully. Watching others not managing was difficult but being encouraged along with peers who were also having difficulty seemed to help women persevere. Feeling anxious and guilty along with lack of success with expressing and where the baby would not attach to the breast resulted in one woman giving up in the first few days.

The help women had, while it could be positive, was affected in the women's opinion by the midwives being so busy they lacked consistency in giving information. Women had not expected the difficulties they experienced and generally women found peers and partners more supportive than the midwives.

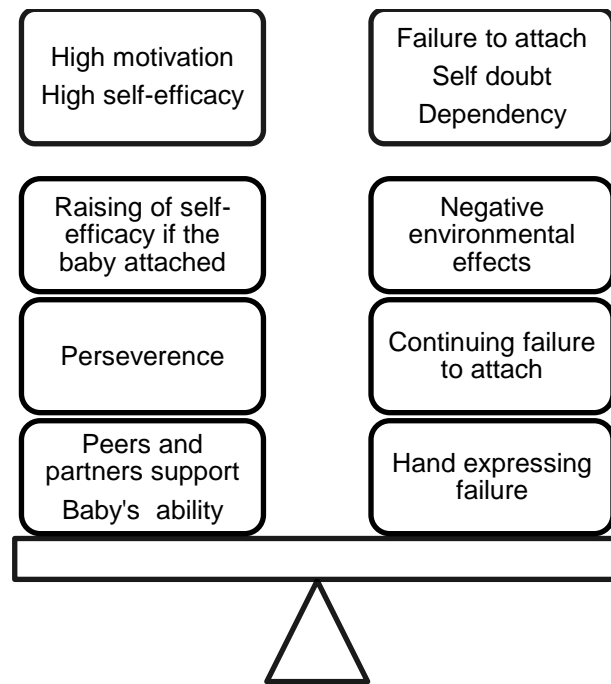
The women reflected that as well as their own ability being important, the skill of breastfeeding involved the baby's ability to feed. There was also a realisation that the circumstances of the delivery contributed to breastfeeding being difficult for both mother and baby.

Women who were determined to breastfeed were open to verbal persuasion and persisted. Successful initiation needed women to be persistent and for the babies to be able to start feeding. Women participating in the focus groups, who were eventually successful, spoke in ways that suggested that they had a raised self-efficacy about their ability to breastfeed. The woman who changed to bottle feeding regretted doing so and vowed to persist next time.

Antenatal women gained insight as to how the baby could behave at birth by viewing photographs of skin to skin contact between a mother and her baby enacting instinctive pre-feeding attachment behaviour. Most women expressed pleasure and an understanding of instinctive baby behaviour at birth.

The postnatal women thought the text and photos of the "Feeding Cues" leaflet was helpful but persistence had been the important aspect for them to succeed. The balance of influences on self-efficacy for women was fairly even and is illustrated in Figure 8.

Figure 8 Balance of influences on self-efficacy for women



## Chapter 7 Study results: Midwives

### 7.1 Introduction

The aim of the seventh chapter is to inductively analyse the midwives' results then to use Social Cognitive Theory to explore and help explain the expectations, knowledge and experiences of midwives with regard to breastfeeding initiation.

#### Objectives

1. To explore the expectations, knowledge and the experiences of midwives around breastfeeding initiation.
2. To apply Social Cognitive Theory deductively to the results of inductive coding.
3. To determine if the materials used to facilitate discussion in focus groups and interviews were found useful in understanding initiation.

A detailed discussion of methods is provided in chapter 5 section 5.6

Eighteen midwives participated in this study and their ages ranged from 20-25 to over 46 years. Four had less than six years' experience, and fourteen had 6-15 or over years' experience. Four practised on the community, six in labour ward, five in the postnatal ward, one was a mentor (who provided breastfeeding support and education to midwives) and two practised exclusively as home birth midwives in the health board area. The home birth midwives had their own caseload and called on midwives from the community to accompany them to births.

All the midwives had attended UNICEF breastfeeding education and 15 had personal experience of breastfeeding, three had not breastfed a baby themselves (no detail available). Two midwives divulged their personal difficulties with breastfeeding (see Table 24).

**Table 24 Demographics: Midwives**

Date of interview	Pseudonyms	Age range	Length of experience	Area of Practice	Breastfeeding Education received	Breastfed own baby
24-May-10	Lesley	36-40	6-15+	Community	yes	three
24-May-10	Morag	46+	6-15+	Community	yes	yes
27-May-10	Shona	41-45	6-15+	Community	yes	yes
28-May-10	Katrina	46+	6-15+	Home Birth	yes	yes
08-Jun-10	Eilidh	41-45	6-15+	Community	yes	no
10-Jun-10	Nicola	41-45	6-15+	LW	yes	yes
10-Jun-10	Lorna	46+	6-15+	Ward / other	yes	yes
10-Jun-10	Marie	46+	6-15+	Ward	yes	yes
15-Jun-10	Kirsty	46+	6-15+	LW	yes	yes
15-Jun-10	Pat	41-45	1-5 years	LW	yes	yes
17-Jun-10	Aileen	31-35	6-15+	LW/PN	yes	yes for 6 weeks
17-Jun-10	Heather	26-30	1-5 years	LW	yes	yes
17-Jun-10	Sheila	46+	6-15+	Ward	yes	yes
16-Jul-10	Trish	20-25	1-5 years	LW	yes	no
16-Jul-10	Norma	41-45	6-15+	Ward	yes	no
16-Jul-10	Isa	31-35	1-5 years	Ward	yes	yes
23-Jul-10	Wilma	36-40	6-15+	Mentor	yes	yes
27-Jul-10	Ailsa	41-45	6-15+	Home Birth	yes	yes for 8 weeks



## 7.2 Findings

As described in the methods chapter five, the outline for the questions in the semi-structured interviews was designed to mirror the sequence of events after the birth. That is the baby would be placed on the mother's body after the birth for skin contact followed by processes to facilitate the start of breastfeeding. The questions were adapted as necessary for the differing areas of practise for each midwife. Eight overarching analytical themes emerged from inductive coding of the midwives results (some with several subthemes). Themes are illustrated in Figure 9:

- "Skin to skin contact" had five subthemes and related to the initial phase where babies were placed in skin contact in labour ward with their mothers and breastfeeding was encouraged: Knowledge, Length of contact, Emotion and bonding, Effect on breastfeeding, and Uses in the postnatal ward.
- "Babies' behaviour at birth".
- "Midwives' expectation of giving help" with two subthemes: In labour ward and in the postnatal ward.
- "Attachment" which had three subthemes: Midwives' response to attachment in the labour ward, Midwives' response to non-attachment in labour ward, Mothers' response to non-attachment in the labour ward.

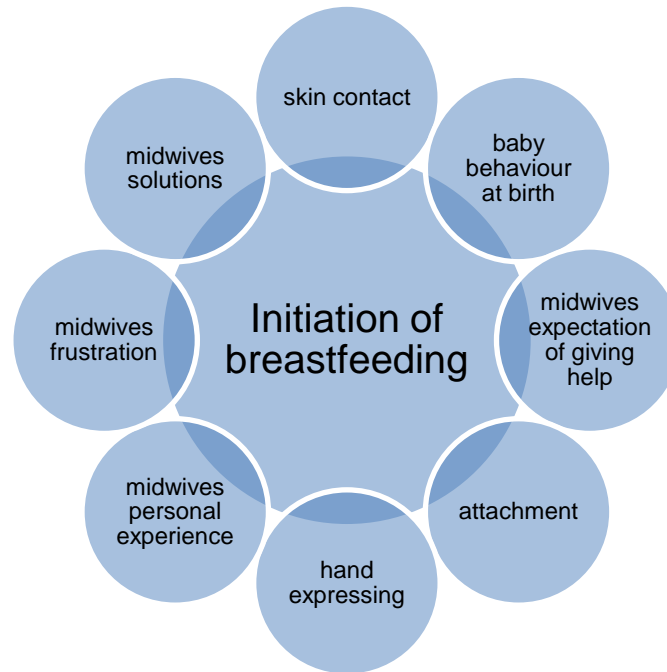
The main themes in the postnatal ward related to the fact that babies were not attaching and feeding:

- "Hand expressing"
- "Personal experience",
- "Midwives' frustration"

There was one brief reflective theme:

- "Midwives' solutions".

**Figure 9 Themes that emerged from inductive coding of midwives results**



Social Cognitive Theory (SCT) was then used deductively to interpret and understand the themes in an effort to conceptualise key areas of the midwives' experiences. The themes and subthemes were interpreted within the framework of SCT and an explanation was constructed for the midwives' experiences. The relationship of Themes and Subthemes to Social Cognitive Theory is illustrated in Table 25.

**Table 25 The Relationship of Themes and Subthemes to Social Cognitive Theory**

<b>Theme</b>	<b>Subthemes</b>	<b>Relationship of themes and subthemes to SCT theory</b>
<b>7.3 Skin to skin contact</b> , had five subthemes that concerned a range of aspects around the concept of skin contact	<i>7.3.1 'Knowledge'</i> revealed midwives knowledge, attitudes and customs with regard to facilitating skin contact.	Enactive attainment, Verbal encouragement.
	<i>7.3.2 'Length of contact'</i> described the limitations of time available and midwives' perceptions of mothers' lack of awareness about the optimum length of skin contact.	Social outcome expectations
	<i>7.3.3 'Emotion and bonding'</i> linked the action of having skin contact to the relationship between mother, father baby and connection to breastfeeding.	Enactive attainment, Lack of enactive attainment
	<i>7.3.4 'Effect on breastfeeding'</i> highlighted the lack of utilisation of instinctive attachment.	Vicarious experience, Outcome expectation, Enactive attainment, Motivation, Lack of vicarious experience of midwife, Goals, Verbal persuasion.
	<i>7.3.5 'Uses in the postnatal ward'</i> highlighted how the midwives regarded the utility of skin contact in the ward.	Enactive attainment, Motivation, Lack of enactive attainment and lowered SE for the midwife, Lack of reflection
<b>7.4 Baby behaviour at birth</b> , explained the baby's behaviour at birth.	Highlighted the range of possible behaviour at birth during skin contact and revealed the effects of analgesia on the mother and baby's inability to breastfeed.	Outcome expectation, Vicarious experience, Enactive and lack of enactive attainment for midwife and the mother
<b>7.5 Midwives expectation of giving help</b> , had two subthemes concerned with different settings.	<i>7.5.1 'In Labour ward'</i> revealed the type of help that was predominant and the reasoning for the midwives actions.	Lack of enactive attainment, Reflection, Outcome expectancy
	<i>7.5.2 'In the Postnatal ward'</i> revealed the physical help the midwives gave and the strategies they used to help the baby to be fed.	Outcome expectation, Lack of enactive attainment, Verbal persuasion, Lowered SE/Psychological state
<b>7.6 Attachment</b> , had three subthemes concerned with whether the baby starts to breastfeed or not.	<i>7.6.1 'Midwives response to attachment in the labour ward'</i> described midwives reactions and expectations with regard to attachment.	Enactive attainment, Verbal encouragement
	<i>7.6.2 'Midwives responses non attachment to the breast in labour ward'</i> revealed midwives' and mothers' emotions and actions to try to effect attachment.	Lack of enactive attainment, Lowered SE, Negative social outcome expectation, Psychological state, Lack of reflection, Verbal encouragement
	<i>7.6.3 'Mothers' response to non-attachment in labour ward'</i> revealed the feeling midwives ascribe to women when their babies do not attach at birth.	Lack of enactive attainment, Verbal encouragement, Psychological state
<b>7.7 Hand expressing</b> was concerned with various aspects of attempts to initiate	Explained the policy that midwives follow to initiate breastfeeding when the baby is unable to start feeding.	Motivation, Effort and persistence of mothers with higher SE, Psychological state, Lower SE, Verbal encouragement, Triadic

Theme	Subthemes	Relationship of themes and subthemes to SCT theory
breastfeeding		reciprocal causation, Enactive attainment.
<b>7.8 Personal experience</b> , concerned the midwives own experiences of breastfeeding.	Revealed the effects of the midwives personal experiences.	Lower self-efficacy, Psychological state, Reflection
<b>7.9 Midwives frustration</b> , was concerned with various aspects that related to the mothers and babies being unable to start breastfeeding easily	Revealed the complexity of views and attitudes midwives held with regard to their role in assisting women start breastfeeding.	Triadic reciprocal causation, Low SE, Lack of enactive attainment
<b>7.10 Midwives solutions</b> , was concerned with midwives suggestions for positive help for women.	Described positive strategies that could be put in place to help women.	Motivation, Level of SE, Outcome expectancy, Vicarious experience, Verbal encouragement.

This chapter will present the themes and subthemes alongside their related SCT themes. The main points will be illustrated with the use of relevant quotes. Occasionally quotes will be incorporated in the text and this will be indicated by quotation marks and/or italics. At the end of main quotes the name of the midwife is given. All midwives' names have been changed to protect their anonymity.

## 7.3 Skin to skin

### 7.3.1 Knowledge

Midwives talked freely about placing the baby in skin to skin contact with the mother. It was something most midwives seemed to be enthusiastic about, and was a pleasant part of their role in labour ward. This could be regarded as the midwives being successful in their achievement of being able to facilitate skin to skin between the mothers and babies. In the labour ward or at a home delivery, skin to skin contact between the mother and her baby was regarded as something that happened as routine at most deliveries. The physical benefits of skin to skin contact for the mothers and babies immediately after the birth were acknowledged. Most midwives mentioned regulation of temperature and one midwife explained the beneficial effect of maintaining normal temperature on blood sugar. Some midwives mentioned the

calming effect of skin contact. Only one midwife went on to include instinctive behaviour of the baby.

*“It means that as soon after the baby’s born as possible we put the baby eh on the mum’s chest with a blanket over the pair of them so that it is skin to skin contact between the mum and the baby and we leave the wee one there for as long as we possibly can. Em, ideas behind it, it’s helping to control the baby’s temperature it helps the baby calm down because they can hear the mum’s heartbeat em it’s starting that bonding process between mum and baby and it’s giving the baby the opportunity to try and initiate breastfeeding themselves.”* (Katrina, home birth midwife, previously a community midwife, had personal breastfeeding experience)

As described by SCT, being successful in an activity is having a mastery experience which raises self-efficacy (SE) (Bandura 1986).

The benefits of skin to skin contact to breastfeeding mentioned by most midwives included statements such as; *“that it creates an environment for breastfeeding”*, *“babies can smell the milk and start rooting”*, and *“the mother’s hormones are stimulated”*. Very few midwives mentioned the experience of instinctive behaviour that culminated in the baby self-attaching.

Skin contact between mother and baby was encouraged if the baby was well and not premature. At caesarean sections the baby was placed in skin to skin contact before the mother left the theatre. When the mother was ill, skin contact could be delayed and fathers could have the skin contact until the mother was able.

Midwives generally encouraged skin to skin contact with all mothers as beneficial. Some mothers preferred the baby to be dried or *“cleaned up”* before the baby was placed SSC, and one midwife described mothers’ preferences as *“mums don’t want dirty babies on them”*. The use of vocabulary associated with hygiene could be ascribed to the midwives’ or mothers’ attitudes.

*“Occasionally Asian ladies don’t particularly like skin-to-skin and they want the baby dried and wrapped up but you have to tell them, look it’s really important for initiating breastfeeding, bonding and for temperature control keeping the baby calm so quite happy. If they have been informed about skin-to-skin they are quite happy to have it done.”* (Eilidh, community midwife)

According to SE theory, verbal encouragement, when the person is encouraged to think they are capable of doing something, helps them make more effort (Bandura 1986).

### **7.3.2 Length (of skin contact at birth)**

The Baby Friendly Initiative guidance being followed at the time of the study was that mother and baby should be able to have skin contact for at least 30 minutes.

The time the baby was left skin to skin with the mother was explained in various ways, *“sometimes I mean they’ll have like skin to skin for an hour”* or *“the ideal that every baby will have at least half an hour”* and *“we leave the wee one there as long as we possibly can”*.

One example was that the baby had 45 minutes skin contact before weighing the baby and giving vitamin k.

*“I normally give skin-to-skin a good 45 minutes to an hour unless the mum asked for the baby to be taken away or to be dressed or anything and then I would normally weigh the baby then while I’m doing that and giving vitamin K I would give her (the mother) something to eat so that she would have some energy in her especially if its’ been a long labour and then I would put the baby back in for skin-to-skin and then help her with breastfeeding.”* (Trish, labour ward)

The labour ward was often too busy to delay transfer to the ward and the contact would be interrupted, unless the baby was actually feeding, to let the post birth care be carried out. In contrast some midwives said it didn’t matter how busy or quiet the labour ward was, *“they wanted folk out of labour suite and into the postnatal ward,*

*'clear the decks'.*" The baby got more skin contact if the mother did not need to be sutured but if she did need to be sutured then the emphasis was on the repair and not skin contact or breastfeeding. A perception was that midwives could be pressured to achieve a breastfeed before transferring the mother and baby to the postnatal ward. These were social expectations to encourage the baby to attach in a limited time, to avoid disapproval from colleagues. Some midwives could be frustrated with adhering to the policy of just half an hour after the birth for skin to skin. Allowing the mother to adjust in her own time would be much more beneficial to the mother and breastfeeding than, *"trying to shove a baby onto a breast"*. The desire to leave the baby and mother in skin to skin contact and not rush to carry out the postnatal routines often had to be defended; a midwife said *"she had huge arguments about it"*.

According to SCT failure affects confidence, and lowers SE particularly if something goes wrong in the first few attempts (Bandura 1977).

With regard to midwives' perception of women knowing what to do about skin contact and breastfeeding, the midwives said women were given information at parenthood classes, written information in the Health Education book and a breastfeeding DVD. However the information about how long the baby should be given skin contact was not emphasised and while the mothers *"are happy to have skin to skin"* and *"want the baby there right from birth"*, there was a tendency for her to, *"request they take the baby, wrap the baby and pass it round"*, (to family members in the room). This suggested that the mothers did not know about the UNICEF recommendations about length of contact. The baby was usually taken to the ward wrapped and carried by the mother or transported in a cot.

### **7.3.3 Emotion and bonding (in skin contact)**

The opportunity to bond with the baby during skin contact was seen by midwives as important for the mother, *"the baby gets dried and goes straight to the skin for the mother for bonding, psychologically, for the mother it's tremendous"*. Bonding had the same priority for midwives as the physical benefits breastfeeding. Fathers were involved either being with the mother when she had skin contact with the baby or he may also have skin contact with the baby.

All the midwives described what happened when the baby was placed in skin contact with her/his mother and included physical and psychological benefits. Most of the midwives were warm and enthusiastic in their responses and at times some could have been describing their personal experiences.

*“Bonding with the mother and the baby and a time for the mother to get to know the baby and just the focus is here (brings arms to an enclosing circle) ... you know that and gets time for the baby to you know smell the milk and you know that’s a nice place to be. The baby hears the heartbeat and you see the fathers coming in close as well when that’s happening you know there’s a kind of closeness going on and you know your baby settles down and it’s nice and calm, it’s just a nice ending of a labour and a birth.”* (Nicola, labour ward)

One midwife explained the relationship between the mother’s emotional state and the beneficial effects on physiology of lactation.

*“I think if a baby has initiated its first feed soon after birth it’s a good bonding process between the baby and the mum, the mum takes something positive from that ... it gives the mum confidence I think and I think emotional aspects of it all help to get, em, lactation process in place.”* (Morag, community)

This demonstrated the midwife’s knowledge of the mother and baby’s positive achievement and the benefit this has to the mother’s psychological state and therefore to her lactation.

According to SCT success has a positive contribution to self-efficacy in an activity and is more likely when the person is not anxious (Bandura 1989).

#### **7.3.4 The effect of skin to skin on breastfeeding**

The effect of skin to skin on breastfeeding was explained by a home birth midwife as an opportunity for instinctive behaviour, for the baby, “*to latch on themselves*” and she has had the experience of seeing babies latch instinctively. This midwife has learned that the earlier the baby latches the easier breastfeeding seems to be, and facilitating unhurried skin to skin helps.



Another midwife explained that sometimes the baby will root and instinctively latch without physical help from the staff. These were the only two examples where midwives stated that the baby was able to instinctively latch/attach while in skin to skin contact with the mother.

*“I have seen that (instinctive attachment) on occasion in labour ward where there’s skin to skin with mum and baby will start looking for it the breast on its own without us intervening and getting the mum to sit in this position or doing “hands on” or whatever it may be, em, and baby just finding it for itself.”*  
(Lesley, community).

Most midwives acknowledged that babies could be active and rooting and showing feeding cues but did not explain that babies were able to instinctively latch despite being aware of pre-feeding/instinctive behaviour.

*“Oh I think it benefits it, the baby’ll calm down and you know the baby’ll then realize where he is and what is going to happen and you know it’ll start rooting and smelling and licking and so I think it is just like before breastfeeding really and even if they’re a wee bit sleepy it’s still going to benefit.”* (Kirsty, labour ward)

A midwife who had never seen a baby instinctively latching explained that to encourage a baby to attach instinctively, the baby should be lying longitudinally along the mother’s body but she had not seen a baby attach naturally from that position or at all. In effect she had no vicarious experience of watching a baby instinctively attach.

*“I have never seen that happen but I don’t think we are leaving the woman long enough for that to happen ... I’ve heard it does happen but I’ve never seen it, never seen it.”* (Wilma, mentor)

This illustrates the range of knowledge and experience of the midwives. The first midwife had vicarious experience of watching instinctive behaviour, an outcome expectation that she could facilitate instinctive behaviour and she then experienced

enactive attainment through having the mothers skin to skin with their babies until they attached. The second midwife who mentioned attachment did not have an outcome expectation that this would happen so had not been motivated to facilitate instinctive behaviour although it happened without her obvious help. The latter two midwives did not mention instinctive attachment or did not have the vicarious experience of seeing this or the motivation to consider an outcome expectation of facilitating this behaviour. These two midwives may infer a representational generalisation of the majority of midwives behaviour in this hospital with regard to instinctive attachment (Lewis & Ritchie 2003).

Goals women set for themselves are similar to intention but the amount of perceived SE dictates what challenges women will attempt. Verbal encouragement can help people feel capable to make an effort (in this case to continue with skin contact). If the mother has decided she does not want to breastfeed then she will ask for her baby to be removed if s/he starts to root. Some women may lack knowledge or confidence and do not plan to breastfeed. Skin contact is beneficial for all babies, whether or not the woman plans to breastfeed, and was encouraged but midwives were sensitive to women's intentions.

*"If the baby starts rooting round then they want them moved 'cause they don't want to start 'that'." (Katrina, home birth midwife).*

See section 3.7 Vicarious experience, Outcome expectation, Enactive attainment, Motivation, Lack of vicarious experience of midwife, Goals, Verbal persuasion.

### **7.3.5 Uses of skin contact in the Postnatal ward**

Some midwives said that having skin contact could increase women's confidence. How worthwhile people think their actions would be influences motivation. This was illustrated by the midwives in their consideration of the perceived positive and negative aspects of skin to skin contact.

All the midwives in the ward said they encouraged skin to skin contact for two main reasons; if the baby has not yet breastfed, and to regulate the baby's temperature. On the whole there was less enthusiasm from the midwives about the use of skin contact in the postnatal ward. The perceived lack of privacy was one aspect of

concern, *“some women are really quite private ... even with breastfeeding mums you know they don't really want to be flashing themselves.”* There was also a concern about the mother falling asleep; *“we can't encourage bed-sharing and a lot of the mums if they lie down together for two minutes they fall asleep just because they are so tired”*. There was doubt about the benefit of skin contact by the midwives, *“sometimes it helps with the breastfeeding, I'm not a 100% convinced”*. Mothers were also thought to doubt the benefits of skin contact, *“maybe they don't quite see the importance of skin-to-skin”*.

According to Bandura, lack of success or lack of enactive attainment can result in lowering of SE but as well as lack of success for the midwife lack of reflection can inhibit or reduce understanding (Bandura 1986).

Skin to skin could be used as a calming strategy for the baby while attempting to attach the baby to the breast “hands on”. This example explains how using a physical strategy like “hands on” could be distressing for the baby and how much the midwife regarded attachment as the midwife's role.

*“I think probably it can be good, skin to skin, for settling a baby, just settling a baby down calming it down before you maybe try again at the breast because you see that quite a lot if you are putting a baby onto the breast they just become, they start to breast refuse, (my emphasis, cause and effect) so I think skin to skin is good for maybe like just calming that baby down even for 10, 15 minutes before you try again at the breast.”* (Norma, ward)

This demonstrated that when the midwife did not achieve her goal of physically helping the baby attach to the breast there was a lack of achievement for the midwife as well as the mother. There was no mention of instinctive behaviour here.

See section 3.7 Enactive attainment, Motivation, Lack of enactive attainment and lowered SE for the midwife, Lack of reflection.

## 7.4 Baby behaviour at birth

Pictures of instinctive behaviour (same photos as shown to mothers) were shown to midwives, to elicit their thoughts on how women would react to information about how breastfeeding could start. Despite the midwives familiarity with the way babies behave at birth (stopping short of instinctive attachment for most) there was a mixed reaction from midwives as to how they thought women would accept such information. This ranged from, *“when I was a young mum I would be thinking I hope I’m not showing off my boobs like that!”* and, *“I don’t think they would like to see this”* to *“they (photos) are beautiful I don’t see why anyone would be offended—showing the baby going onto the breast, perfect”*.

Midwives seemed surprised to see the sequence of photographs that culminated in instinctive attachment. They said women would be very surprised to see how a baby could behave at birth and find the breast and attach instinctively. One midwife correctly identified mammalian behaviour.

*“I think they are lovely pictures mmm I think they’d (the mothers) be very surprised by the fact that the baby was crawling up and going to actually find the nipple and find the breast because that’s, obviously, there’s a sequence of events there you know the baby’s smelling around and touching and it’s scratching at the breast like wee cats do, you know, wee animals.”* (Eilidh, community)

This was an attempt to assess how midwives would react to women having an increased level of knowledge and awareness of the possible instinctive behaviour of their baby that could culminate in attachment. The photographs were examples of symbolic modelling as a source of vicarious experience initially for the women. For most midwives there was an apparent lack of experience of facilitating instinctive attachment or they had not had the vicarious experience of seeing this behaviour in women they had delivered.

The way the baby behaves at birth when skin to skin was described similarly by most midwives. Nearly every midwife explained that the baby’s behaviour was dependent

on whether the mother has had narcotics in labour. If this was the case then the baby would be less alert, more inactive, and sleepy and show less interest in breastfeeding.

*“Some babies are really bright and alert and you can see that they are rooting and they are ready to feed and other babies maybe the mum’s had a long labour and she’s had quite a lot of opiates and the baby’s just not going to be interested for a long while and obviously skin to skin benefits these babies as well so it doesn’t matter if they don’t feed straight away.”* (Kirsty, labour ward)

The effect of narcotic analgesia on the baby’s behaviour could depend on how long it was given before the delivery.

*“It varies, some babies it doesn’t seem to and it depends when the mum’s had it, if the mum’s maybe had it within 2 hours of delivery the baby will be a bit more sleepy or if she has maybe had it maybe 10 minutes before delivery it’s not even affected the baby, they’re all different.”* (Kirsty, labour ward)

The effect of epidurals on the baby’s behaviour and breastfeeding was acknowledged. The effects of an epidural on the baby were less obvious to some midwives but others pointed out that there were opiates in the epidural. The type of delivery was considered alongside the method of pain relief as babies could be affected by having been delivered by forceps, vacuum extraction or caesarean section. This midwife compared babies who had been delivered spontaneously with no systemic analgesia or who had used the birthing pool as analgesia, to those affected by delivery or/and analgesia. The spontaneous un-medicated delivery resulted in a more active baby that had a successful start to breastfeeding.

*“The baby can be quite sleepy too, em, and the mum’s still quite sleepy so these babies don’t often initiate their feed as well as the mums who’ve had a straight forward labour even if it’s a good number of hours (duration of labour) and hasn’t had much in the way of analgesia then been in the pool or mobilising or whatever these wee babies seem to be raring to go when they are delivered, you know wanting to feed.”* (Morag, community)

The home birth midwives explained that although most methods of pain relief were available to women at home not many women chose systemic analgesia ie narcotics. Most women used entonox or hypnobirthing or no analgesia at all.

*“Maybe out of the 60 women that have birthed their baby in the last year at home there’s maybe half a dozen used diamorphine.” (Ailsa, home birth)*

A midwife summarised the effects of analgesia on breastfeeding for midwives and mothers. The midwife indicated that she took a professional responsibility to try to attach the baby to the breast for the mother, indicating that this behaviour was an accepted professional strategy.

*“Yeah, I would say you do notice a difference yeah, especially with narcotics, em, I mean I always tell women at classes you know that (narcotic analgesia) does affect the baby, midwives have all seen, the effects that can have on babies em that just totally knocks them off no matter when they have had the drug whether it be an hour before delivery or four hours before delivery it does have an effect on baby ... And em and these babies are horrendous, horrendous to breastfeed, em, as professionals for us to position and attach because they are just not interested and then mum gets deflated because baby’s not (attaching), too sleepy and then she canny get it on herself and yeh it’s just a vicious circle isn’t it?” (Lesley, community)*

The midwife lacked success in attachment when the women had a narcotic and was aware that the mothers were affected by the midwife’s apparent failure. The question could also be raised about how much of the mother’s upset about the baby not attaching could be attributed to the midwife’s attempts to use “hands on” to encourage the baby to attach.

Demonstrating the midwives’ awareness of positive achievement for the mothers, it was interesting to hear about women from other cultures. According to Trish, migrant women tended to labour very quickly with less analgesia and breastfeed easily.

*“They (migrant women) would come in and just, ‘I’m breastfeeding’ and put the baby on and go up to the ward and the baby’s fed and yeah, no I don’t know*

*why that is though, I just don't know if that's their culture that's the norm for them but for us the norm is probably artificial feeding.” (Trish, labour ward)*

The midwives' experiences ranged from caring for women giving birth at home who tended to use minimal analgesia, to women who required narcotic or epidural analgesia in hospital. The midwives views were varied in that timing of the administration of narcotics affected the babies' behaviour or that timing made no difference or babies were all affected if the mother had analgesia. One midwife (above) suggested if the mother was from another culture she would probably have had less or no analgesia and would spontaneously attempt to attach her own baby. There was a professional acceptance of the responsibility to attempt to attach the indigenous women's babies for the mother “hands on” regardless of the type of delivery or administration of analgesia.

See section 3.7 Outcome expectation, Vicarious experience, Enactive and lack of enactive attainment for midwife and the mother.

## **7.5 Midwives' expectation of giving help**

### **7.5.1 Midwives' expectation of giving help in labour ward**

For midwives, physical expectations of the effects of helping women to breastfeed may be positive or negative where their strategy of “hands on” could result in the midwives' success in facilitating the baby's attachment or failure to achieve attachment. Social outcome expectation may be approval by their peers and the mother with success but disapproval with failure. The midwife's self-evaluative outcome expectation could be feeling proud of the perception of her own success or disappointment if she failed to attach the baby for the mother. Most midwives' perceptions (except the few who talked about instinctive attachment) was that the mothers expected the midwife to use the physical “hands on” to help the baby attach to the breast.

*“I think they expect you to fix it for them (attach the baby to the breast), if it doesn't, if the baby doesn't attach spontaneously then I think they instead of thinking, right how can I hold my baby and how can I be in the best position to do this, they expect the midwife to do it for them ... unless they've done it*

*before and even then I think they don't have a lot of confidence.*" (Kirsty, labour ward)

Another view was that some women, whose babies attached without help, were described as "*really independent*", reflecting midwives' expectation of attachment as being the midwives' responsibility.

Following a caesarean section the woman's reduced mobility meant that more physical help with breastfeeding was needed. It was implicit in most cases in labour ward that midwives used "hands on" and this midwife said that if they didn't the baby wouldn't attach.

*"I know we should'nae really be doing 'hands on' but there are times (e.g. after a caesarean) that if we didn't they wouldn't go on the breast."* (Nicola, labour ward)

The midwives' discussions suggested it was very important for the baby to have fed in the labour ward, perhaps a social outcome expectancy, as the emphasis was on the midwife's attempts to achieve attachment of the baby to the breast. This example of repeated attempts perhaps reflected her self-evaluation of anticipating how she would feel if successful or alternatively if she failed.

*"Before we go upstairs (to the ward) I would try to get that initial feed ... If the baby doesn't attach right away ... just continue skin-to-skin ... and then just retry."* (Aileen, labour ward)

In contrast, the expectation that to help women attach their babies after birth midwives had to physically attach the babies "hands on" was strongly refuted by a breastfeeding mentor. She asserted that no midwife would use "hands on", "*we don't use our hands at all so it's very much hands off*". She seemed confident that midwives were happy not to physically manoeuvre the baby.

*"I think most of the people I've spoken to prefer it to the days when we used to be hands on when we used to help the mum, because that doesn't help the*



*mum if we're, so it it reduces confidence if she doesn't know how to do it. It's far easier to be hands off ... they (midwives) certainly wouldn't do it with anyone watching them.” (Wilma, mentor)*

The midwife explained the information that babies could attach spontaneously at birth was mentioned during in house educational updates for midwives but was discounted as being possible because, “*there's a time issue*”. It was expected that the women were transferred to the ward as quickly as possible and couldn't be given the time to let their babies instinctively attach in the labour ward.

This discrepancy in assertions about using “hands on” could be explained by the reflection of a midwife, that perhaps midwives interfered to attach the baby because there was pressure (social expectancy) to transfer the mother and baby to the ward, resulting in the baby being handled and almost forced to feed.

*“I think as professionals we very much feel a wee bit of pressure in the fact that right we need to get this baby on after say 30 minutes of of skin to skin just to see what it'll do ... And then no if it doesn't then you then get into this vicious (laughs) circle of right no that's an hour now and it still hasn't fed so let's just try even more. Whereas if we did just leave baby to find it on its own then it may be a bit more normal and natural for mum.” (Lesley, community)*

According to SCT, lack of success can lower SE especially in the first few attempts in an activity (Bandura 1977) and people can reflect on their behaviour and consider how to do things differently (Bandura 1986).

The midwives' outcome expectations therefore could be they would be regarded as having failed if the baby did not attach quickly and being expected by others, to carry out the action of “hands on” (perhaps covertly) to try to expedite attachment. This emphasized the start of, as the midwife said, the “*vicious circle*” of trying to get the baby to feed in the first hour after birth. The midwives take on this responsibility but then experience lack of success when the baby does not attach. When the midwife did not achieve her goal of physically helping the baby attach to the breast there was a lack of achievement for the midwife and implicitly acknowledged, for the mother.

This shows a dissonance between what the midwives thought the women expected, doing what they and their peers thought helped attachment, the sometimes covert behaviour of, “hands on” and the reflection of this midwife about how the natural behaviour of mother and baby may be more helpful.

Outcome expectation can refer to the anticipation of physical, social, and self-evaluative consequences of action (Luszczynska & Schwarzer 2005). Outcome expectancies are important in the initial plans or intention to do something but are less important once the behaviour or action is underway and can be applied to breastfeeding support (Luszczynska & Schwarzer 2005).

### 7.5.2 Midwives' expectation of giving help in the postnatal ward

The midwives reported that the balance between the mother having skin contact with her baby in the postnatal ward to encourage attachment and the midwife using “hands on” would favour the use of “hands on”. A sequence in the ward on the first day after the birth was described by midwives where the mothers expected their babies to feed but were unable to get the baby to attach, *“a lot of them (mothers) I don't think have a practical knowledge of how to get their baby to attach”*. Women may not have vicarious experience of seeing someone breastfeed and were unlikely to have seen initiation of breastfeeding before. There was then lack of success for women in the postnatal ward following on from the lack of success in the labour ward.

According to SCT women's short term outcome expectations (Luszczynska & Schwarzer 2005) of feeding the baby may not have included that there would be difficulty and where lack of success can lower SE especially in the first few attempts in an activity (Bandura 1977).

In contrast midwives reflected that the information available to women before their baby was born could be very much focused on the positive and not on the reality.

*“A lot of the things they are all told and a lot of the information they get is all very idealized and the perfect situation with the perfect baby who knows how*

*to feed and how to attach from that very first minute ... and the majority of babies have not a clue.” (Sheila, ward)*

When women discover the baby’s lack of ability to attach, this contradicts what they have been told to expect in the antenatal information and classes they may attend before the birth and where they are unaware of strategies to help them succeed. A midwife said, *you will put it to the breast but it still won’t attach*, assuming the midwife meant using “hands on” to encourage the baby to attach.

As described by Bandura (1977) repeated experience of lack of enactive attainment lowers SE especially in the first few attempts in an activity, in this case of both mother and midwife (Bandura 1977).

Midwives said that it was sometimes very difficult to avoid “hands on” help because many mothers needed help, but they had no time to sit with each one. Mothers therefore became upset when the baby would not attach. There was a dilemma of helping one woman, but while they did that, they were not able to help the other mums needing the same help. This example explains the dilemma as perceived from both the mother’s and midwife’s perspective.

*“In their first day and particularly on their first night, then it’s just horrendous and the visitors have all been in and they are all on such a high and then they crash quite often overnight because by then their tiredness hits them and this baby still won’t take a feed and it’s not at all as they imagined it ... ideally they should be able to do it themselves ideally we would have enough time to sit with every mum for as long as it took to get her baby to attach and frequently we don’t and it is very difficult sometimes to be completely ‘hands off’ with them the way we should be.” (Sheila, ward)*

According to SE, if the mother doubts her ability she may stop trying and give up and the midwife may feel the same about her own ability.

Midwives expressed frustration that the mothers seemed to expect a midwife's presence and physical help each time she attempted to feed her baby. The women

seemed unable to attempt to attach their own babies in the ward and appeared dependent on midwives' help.

*“Oh yes, uh huh, that's the that's the the what a lot of the girls here are feeling as well that the mums don't want to, it's their babies and they , they don't want to try and have a wee go themselves they're just expecting somebody, I'm not saying them all, but somebody there constantly at every feed putting this baby on and you're trying to teach the mums to do it themselves but sometimes they don't listen you know they just think well I'll buzz and you go in 'can I help you?' (Midwife) 'I need my baby's due to be fed' (Mother) 'well take your baby out of the cot strip it down put baby on' (Midwife) and you're like that cause you know it's not their fault if you've got another 8 or 9 patients that you are looking after and they are all the same but just to encourage them to do a wee bit more for themselves.” (Norma, ward)*

Midwives would very much have liked that there was more staff to help with breastfeeding as, *“the women sense it as well because they are maybe, buzz, I know youse are busy, I know you're busy”*, it was difficult to help each woman. The midwives in the wards seemed keen to express their frustration and apparent helplessness in a difficult situation.

This would appear to be a tipping point in midwives reactions to trying to cope with the complexity of trying to help multiple women at different stages of the learning and achievement process of initiating breastfeeding.

According to SE, a person's psychological state is affected by stress which can exaggerate feelings of being unable to cope (Bandura 1977).

The process may take some time while the mother tries to learn how to assess when her baby will be ready to breastfeed. For a mother who is unfamiliar with babies' feeding cues an aid to teaching may be helpful. The midwives were shown a chart describing sleep states, (the same chart adapted from Long 2006 that was shown to

the mothers; see Appendix 9) and asked for their views which on the whole were positive.

*“Yup, uh huh, because some of the girls will go like that ‘is he looking for a feed?’ and the baby is absolutely zonked and you are like that ‘no you’re not going to be able to feed that baby that baby’s sound’, so yeh yep mm yep that would definitely work. (Marie, ward)*

## **7.6 Attachment of the baby to the breast**

### **7.6.1 Midwives’ response to attachment in labour ward**

When the baby was able to attach shortly after the birth, almost without exception the midwives were enthusiastic and were relieved and delighted. The mother would want to feed again and was reassured that feeding had a better chance of going well. So here midwives recognised the benefit of the mothers experiencing success.

*“Oh over the moon it’s great ‘cause you know that if it’s rooting it’s attached it’s going to be a great wee feeder.” (Ailsa, community)*

Giving verbal encouragement and an explanation of what to expect over the next few hours could be given to the mother, if she indicated that she wanted to breastfeed. This was the only midwife who referred to this strategy and described her communication when the baby instinctively attached. It seemed a normal part of her practice to encourage instinctive attachment.

*“Probably quite glad (that the baby has attached) because it means I don’t have further work to do just to make sure it happens and it’s good to be able to encourage the mum of ‘look what you’ve done by yourself’ em ‘it’s you and your baby that’s done this you don’t actually need me to push it, it’s something that’s natural for you and your wee one and you know your baby can do it so if the baby doesn’t go on in the next 6,8 hours then you know they can do it it’s just a matter of patience’ so it’s good to be able to encourage the mum with that.” (Katrina, home birth)*

A number of midwives liked to check that when attachment was achieved, that the attachment was correct in order to avoid damage to the nipples.

*“Em, I like to just check that they are attached properly so that you are not going to cause problems further down the line.” (Kirsty, labour ward)*

It was considered a relief for both the mothers and the midwives that the baby fed. This could be described as enactive attainment for both mother and midwife when this happened.

*“It’s lovely for them it’s great good to know you can usually see the mum is so much happier you know ‘she’s on, baby’s on’ and you think oh that’s great it’s a good feeling you’ve encouraged you’ve been there and helped her and given her a hand and the baby’s gone onto the breast ... I think it’s so stressful, I think a lot of people get really ‘what if the baby doesn’t feed?’ and they express that to you ‘I’m worried that the baby’s not going to go on and feed’.” (Heather, labour ward)*

See section 3.7 Enactive attainment, Verbal encouragement.

#### **7.6.2 Midwives’ responses non attachment to the breast in labour ward**

The problem was that not all babies were ready to feed straight away in the labour ward and if the baby had not fed then the midwives expected problems in the next few days.

*“(Laughs), wonderful! ... (laughs), no I think it’s great if the baby goes on the breast em you know straight away like that and there’s absolutely no problems I mean it’s absolutely fantastic it just seems to be, it just doesn’t seem to happen as often as eh we would like shall we say downstairs (in the labour ward) they always seem to have problems in the first 24/48 hours anyway.” (Lorna, ward/other)*

This was an acknowledgement that lack of achievement and breastfeeding went wrong with unwelcome frequency. The most frequently expressed emotion felt by the midwives when the baby did not attach in labour ward was disappointment, “*mm I suppose in a way there’s always a little bit of disappointment*”. There was also a range of reactions from, “*it doesn’t bother me*”, or the pragmatic, “*you just look at the situation and think well that’s why that hasn’t happened and you accept it*”, to the

more emotional, “*well, I don’t really panic*”. When things go wrong at the start of learning a skill, then SE is lowered (Bandura 1977).

Midwives stated they helped mothers with attachment. By implication this would be using the physical strategy of “hands on” by the midwife.

*“If the baby doesn’t attach right away I’m quite happy to give a little bit of assistance to try and get the baby on, if not just continue skin-to-skin.”* (Aileen, labour ward)

Midwives may have an expectation of disapproval from colleagues if they do not enable attachment. An example was recounted by a midwife of the experience of frustration and anger that the baby would not attach.

*“Em, frustrated, an, sometimes angry if you’ve maybe spent a long time and it’s just not for attaching and we’ve all been there em, just try and get it to attach use different positions but sometimes it can be frustrating not just for the mum and not just for the baby but also for the midwife but then you just have to take a big deep breath and start all over again until hopefully it will or I just leave it and give it more skin to skin and think it’s not ready to attach at that precise minute.”* (Eilidh, community)

The midwife was evidently being honest in her appraisal of her reactions but did not indicate at that time that reflection on her experiences might have been helpful. According to SCT, verbal encouragement could be given but when the action was unsuccessful the midwife’s standing with the mother would be lowered and the woman’s self-efficacy lowered.

With a clear strategy used to encourage the baby to attach using “hands on”, the mother, midwife and the baby become upset when the baby is not keen to attach. Therefore upset and a lack of success and loss of confidence arises for both midwife and mother.

*“(Sighs) it can be challenging especially if you can see the mum getting uptight you can also see the baby getting uptight and then if we try to get the baby on*

*and it's still not going on she probably feels 'well if the midwife can't get it on then how am I supposed to do it?'" (Trish, labour ward)*

This encouraging can be counterproductive and some midwives recognise that "hands on" can result in the baby starting to breast refuse.

*"I don't think we will ever know what the reason for individual babies (to breast refuse) is but sometimes they've I think if we're getting, heavy handed isn't the right word but trying to force the babies to feed because either mum or midwife is getting agitated." (Katrina Community)*

According to SCT social outcome expectations may be anticipated to be negative (Luszczynska & Schwarzer 2005). When people consider they may not be competent their anxiety can be raised by anticipating the activity (Bandura 1989) but people are able to reflect and change their thinking when they develop more understanding (Bandura 1986).

### **7.6.3 Mothers' response to non-attachment in labour ward**

Midwives had differing views about what women felt if the baby didn't attach, that ranged from women being "very stressed", to one midwife's view that some women feel "quite relieved" as they didn't really want to breastfeed anyway.

An experienced midwife said that she explains to the women that babies have got to waken up (presumably from the effect of narcotics) and may not attach for 24 hours and the mother should watch for feeding cues from her baby when s/he starts to waken up. This was encouraging persistence and perhaps accepting the effect of narcotics on the baby as normal.

Midwives highlighted that women feel guilty as they think they are doing something wrong and this has a negative effect on their emotions.

*"I think it is important that women know and are reassured that it's not every baby that feeds within the first hour because women tend to feel guilty when they always say "what am I doing wrong?" (Pat, labour ward)*



The experience of not having the baby feed as the woman had expected could be very disappointing and this initial stage where breastfeeding seems to be going wrong could be upsetting. Midwives attributed feelings of failure to the mums if the baby didn't feed.

*“Their very first feed, it’s not happening the way it says in the books and they can just become really disappointed and feel as if they have failed at it.”*  
(Trish, labour ward)

According to SCT lack of enactive attainment, when something doesn't work well, may affect the goals the person sets for themselves especially if the person doubts their capability (Bandura 1989) and if a person is encouraged to think they can do something, they make more effort (Bandura 1986).

As described by SCT a person's psychological state affects how well they think they can do something (Bandura 1977).

## 7.7 Hand expressing

The topic of hand expressing was not usually covered in antenatal breastfeeding education classes. Also women may not have read about it in the written information given at antenatal clinics and would not anticipate having to do this.

*“I’d be surprised, if they’ve had no antenatal education that they would (know about it) and it’s, it’s not something that all women enjoy either, it’s quite full on because if that’s how they think breastfeeding is going to start I think that’s when a lot of women fall off.”* (Wilma, mentor)

According to SCT, people are motivated by thinking ahead and planning to do something that would be worthwhile (Bandura 1997).

If the baby had not latched/attached in the first 24 hours then the mother was encouraged to hand express colostrum every 3 hours and try the baby at the breast. Then have skin contact and repeat expressing 8-10 times in 24 hours. Midwives acknowledged this needed, “*just perseverance*” by the mothers.

A consensus among the midwives was that the proportions of women in the postnatal ward who needed to hand express specifically because the baby was sleepy and not able to breastfeed, could be 70-80%.

*“Mm, 70 to 80% a lot of these I mean today in the ward we had, em, well just there’s 21 patients and ... 14 are breastfeeding so out of those 14 a couple are parous women and they’ve been ok, we’ve got a couple day 3 day 4 and they’ve persevered and it seems to be turning the corner em a couple of other ones maybe about 6 or 7 are kind of first time breastfeeders and they are all at that stage where they are putting the baby to the breast every 3 hours and they are trying to hand express.”* (Norma, ward)

*“If we weren’t as busy and we allowed women time, they’ve got 2 midwives in a 24 bedded postnatal ward with 24 babies minimum ... You could have 8 women that you are looking after in a day all feeding 8 to 10 times a day how do you divide yourself you can’t.”* (Pat, labour ward)

Success is also more likely if the person is not anxious as the activity may increase the anxiety. If a woman doubts her abilities and has a lower self-efficacy this can lead to an exaggeration of the level of difficulty and she may not try or give up quickly. Women needed to work very hard to be able to express even small amounts at the beginning and midwives indicated the difficulties of supporting these women, *“they are quite hard work these women”*. This highlighted the emotional stress that both women and midwives undergo during this process. One midwife confided that the women wanted the midwives to hand express for them, as the women were embarrassed and unfamiliar with this process.

*“I think when you show a woman how to hand express they are totally freaked out, you know the fact that they have got to lift their breast touch it and massage it and express at the end of their nipple **they’re absolutely horrified!** (midwife’s emphasis). So they actually allow you to do it you know ... because they couldn’t possibly do ‘that’.”* (Ailsa, home birth)

The midwives' attitudes to hand expressing was at times illustrative of perhaps their own distaste, but it was difficult to separate what their feelings were from those of the women, as the language used may be reflective of that of women.

*"No, no I don't I think quite a lot of them they don't want (midwife's emphasis) to hand express either it's not something that they, when they thought about breastfeeding, they didn't think they'd have to milk themselves you know and it's not exactly the nicest prospect for them you know."* (Isa, ward)

This process, with regard to helping mothers to initiate breastfeeding, was the policy, *"but this is what we've got to do ... the protocols you've got to follow ... this can go on for days"*. This sounded like failure and lack of motivation on the part of the midwife.

Women's motivation varied and they had not expected breastfeeding to be so difficult, *"I never realized it was so hard, nobody told us it was so hard"*, (midwife recounting what women say) when women experienced breastfeeding going wrong and having a lack of success. When only a small amount of milk was able to be expressed and women compared the volumes bottle fed babies were consuming, their confidence could be lowered. Women would see this as failure.

However a woman with high self-efficacy will believe in herself and be capable of problem solving while in difficult situations and be determined to achieve her aim. Verbal encouragement by someone women find credible is more likely to be effective and will be helpful if the surrounding conditions help them achieve their aim. The midwives explained if the woman was really keen to breastfeed and she was reassured that her baby would be fine, she was doing no harm to her baby by hand expressing and syringe/cup feeding, she would persevere *"it's about confidence in knowing that your baby will be alright"*. If the strategy was explained and the woman was encouraged, she would carry on and persevere until her baby fed, *"it's their perseverance and determination that sees them over the hurdles"*.

It could take a few days of encouragement before mothers managed to help their babies to start feeding and midwives felt very positive when that happened. This mother and midwife had experienced eventual success.

*“After spending two days with someone whose baby’s not all that keen to feed and you are hand expressing and you come in and they are ‘she went on and fed today’ it’s lovely so you know that they will eventually feed you em.*  
(Heather, labour ward rotation)

After a few days expressing, mothers may obtain large volumes of expressed breastmilk but their babies may still not attach. It becomes very difficult for mothers to stay motivated, when the baby does not attach. The women express then cup feed their babies then have skin to skin contact. Eventually women lose confidence. Combined with this the mother wants to go home to familiar surroundings so the woman may request a bottle and plan to feed expressed breastmilk or formula.

According to SCT the environment, behaviour and personal factors affect peoples’ decisions in what they will attempt. If the environment is unfamiliar and the skill difficult, the person’s self-efficacy may fall when they perceive themselves to be failing (Bandura 1986).

It was important to encourage the mums to persevere, as they can regret giving up feeding for the rest of their lives.

*“After a few days or maybe a couple of weeks down the line, (women) look back on it and think, ‘I wish I had persevered a day or two longer cause it might have come right’ and then they torture themselves for the rest of their days.”* (Sheila, ward)

The more self-efficacy someone has the more effort they will make and the longer they will persist even if the task is not easy, especially if they expect eventual success (Bandura 1977). Others who doubt their abilities will give up more readily (Bandura 1986).

## 7.8 Personal experience

The emotional effort of supporting women could be very difficult for the midwives. They wanted to help women but some have had the same negative personal experience which made them all the more sympathetic to the woman's plight.

*"But I remember being there myself, you do, you are exhausted, you don't know what's hit you with your first child. You can read every book under the sun and you know when things do not go according to plan it's very, very difficult and I think we need to appreciate that."* (Pat, labour ward, rotation)

According to SCT when people have self-doubt about their abilities they are more readily affected by what they see as failure (Bandura 1989). Perception of failure can reduce self-efficacy and if the person doubts their ability they may give up (Bandura 1986). A person considers how anxious or physically hampered they are when they consider if they will manage to do something (Bandura 1977).

A midwife admitted frustration when the mother gave up despite the midwife's efforts, but she had insight as she was also a mum and could understand the effect tiredness could have on a woman's confidence.

*"Since I've become a mum I understand the effect tiredness can have on mums and the guilt factor that your baby's not feeding right".* (Shona, community)

Having had personal experience could be helpful, *"I can (now) give that mum the skills to show her how to get some kind of breastmilk"* (by hand expressing) acknowledging if the mum was very anxious she would find expressing very difficult. This midwife has reflected and learned that because she was confident she could impart confidence to women who were having difficulties.

Reflection can help a person to learn about themselves and change their thinking and behaviour (Bandura 1986).

## 7.9 Midwives' Frustration

The main source of frustration in the interviews with midwives was by far, that they were too busy and there was not enough staff or time to help with breastfeeding. Midwives experienced a very difficult environment.

*“If we weren't as busy and we allowed women time, they've got 2 midwives in a 24 bedded postnatal ward with 24 babies minimum that's when you don't have twins and you're telling me that those ladies are getting adequate attention, adequate assistance with their breastfeeding, I guarantee they are not, I've worked in the wards myself it's impossible. You could have 8 women that you are looking after in a day all feeding 8 to 10 times a day how do you divide yourself you can't.”* (Pat, labour ward rotation)

If the environment was not conducive to being able to do something satisfactorily and the skill was difficult, the midwives may have had a lower self-efficacy when they perceived themselves to be failing (Bandura 1986). In SCT, the environment, behaviour and personal factors affect peoples' decisions in what they will attempt (Bandura 1989).

When babies were not feeding women needed help every time they tried to feed their baby and it was insinuated that midwives were not enthusiastic when they heard women were breastfeeding, *“it's very time consuming it's one of the most time consuming things that we do”*. A midwife explained that the protocol about skin to skin and expressing had to be followed and she said quietly, *“and this can go on for days”*.

The perception from the midwives was that responsibility for success with breastfeeding seemed to be heavily weighted toward the midwives.

It seemed to be a source of frustration that women did not have antenatal preparation about learning to breastfeed. Some women admitted they had not availed themselves of the breastfeeding classes or done any reading. Midwives vented their frustration with the fact that mothers knew about the benefits but not about how to breastfeed. When faced with the baby not attaching, the women changed to bottle feeding quickly. Midwives thought more could be done to encourage women to learn

beforehand, *“oh, I think antenatally that’s where the focus needs to be”*, about how to breastfeed.

Midwives were frustrated that when women asked for help the baby was still wrapped and in the cot and the mother had not prepared herself for feeding either. Women were dependent on the midwives’ help.

*“I’ve seen them in the ward like the baby’s lying in the cot and the mum’s fully dressed in her bed and will say ‘can you help me with breastfeeding?’ although it’s our job to try and promote it and help as much as possible it’s not all our responsibility.”* (Kirsty, labour ward)

Women seemed to expect midwives to be militant about breastfeeding and so decide to breastfeed until they go home in order to escape censure, *“and so people say ‘you know I’m going to breastfeed until I get home’”*. A midwife thought there were maybe a few militant midwives but they were in the minority.

*“There’s maybe 1 or 2 militant (midwife) breastfeeders out there.”* (Isa, ward)

The opposite view was also held that perhaps that by assuming women want to breastfeed, maybe midwives were pressurising women into conforming to the midwives’ expectations and this midwife believed that women *“toe the party line”*.

*“So it may well be that a lot of women don’t actually want to breastfeed but they toe the party line they do what (is expected of them).”* (Morag, community)

Midwives felt upset when women they have been helping and spent a lot of time with, gave up. This perhaps indicated the midwives’ emotional vulnerability and feelings of failure.

*“Uh, it’s rotten you know when you know especially if you’ve broke your back trying, help somebody feed ... and they’ve changed and you feel as if you know what what could you have done more?”* (Isa, ward)

Midwives acknowledged that a high percentage of women started breastfeeding. Very quickly the figures go down before the women go home and then are even lower by six weeks. There was a great deal of sensitivity about this where midwives said they got blamed and yet they thought they had given as much support as possible.

*“They want to blame the midwives for saying they didn’t get enough help for that’s the letters of complaint that come in, they didn’t get enough help in the ward.”* (Kirsty, labour ward)

Failure lowers self-efficacy if the person thinks they lack skill in a common situation (Bandura 1977).

### 7.10 Solutions

Midwives who successfully fed their own babies were confident about helping women. One midwife developed her own confidence in feeding her babies with encouragement and being persistent and felt better able to encourage women now.

*“I thought it can be done, it can be done, but that was me being that bit maybe bloody-minded.”* (Shona, community)

People are motivated when they can anticipate both positive and negative aspects of their actions and plan what might be worthwhile and valued (Bandura 1997). The more success the person achieves, the stronger the feeling of efficacy and the more a person feels able to be persistent (Bandura 1986).

Midwives suggested that there was a role for parenthood classes to give women a realistic expectation of initiation of breastfeeding and that it does not always go smoothly, *“maybe say to them you know it might not, baby might not attach straight away it may take a few days for things to click”*. Explaining the possible problems, where women could anticipate behaviour that could be helpful could increase their motivation. The judgment a person makes of the consequences of their behaviour is their outcome expectation and their level of SE influences their motivation (Bandura 1989).



A solution to helping mothers whose babies were not attaching was considered. Midwives felt that it would be useful for the mothers to have had an explanation of what can happen from postnatal women who have had some experience of persevering through difficulty in initiating breastfeeding. In effect some vicarious experience and supportive help from their peers who had a raised self efficacy could help.

*“I think perhaps if mums antenatally spoke to a group of breastfeeding mums who had gone through the difficult days to make them realise exactly what the reality of it is so that when their baby behaves like that it doesn't hit them like a bolt from the blue but that if they persevere they will come out the other side because a lot of mums have no clue at all of how a baby actually behaves.”*  
(Sheila, ward)

When something goes wrong at the start someone with lower self-efficacy may give up but it may help if they have experience of someone like themselves persevering and succeeding (Bandura 1977).

A positive view from midwives was that verbal encouragement was helpful and that persistence will result in the baby feeding.

*“As I say just back to its normal, again putting nice cues like that, (showing the women ‘Feeding cues after the first few hours’) but like they're not written in stone just try and relax, trust yourself, in a day or so you will pick up all the cues just going back to this ‘you will do it, you will it's not a matter of if you will do it if you want to you will’ there's very few babies that don't.”* (Marie, ward)

A midwife suggested that boosting the mother's confidence is what it is all about and if women get enough positive information then it makes a difference to their confidence.

*“It's about staying calm and relaxed about it though, ‘don't worry this baby will feed’ but that is the hardest bit it's trying to engender that confidence in the mum and that ‘this wee droplet that you have managed to scoop on your*

*finger and put in baby's mouth' will make a difference if we do it often enough."*  
(Shona, community)

According to SCT people are motivated to find positive ways of doing things if their self-efficacy is high and the reverse is the case when the person doesn't think of themselves as efficacious (Bandura 1989). Giving verbal encouragement however is most effective if given by someone credible, the situation has potentially a positive outcome and conditions are in place to facilitate the person's efforts to succeed (Bandura 1977).

## **7. 11 Summary**

### **7.11.1 Labour ward**

The contribution of skin contact was acknowledged as important to the initiation of baby feeding, the mother's confidence and to the physiology of lactation. Midwives achieved a mastery experience by facilitating skin contact for most mothers and babies.

Only one midwife expected and facilitated instinctive attachment and encouraged and explained babies' instinctive behaviour further to her mothers. Another mentioned instinctive attachment as a possibility while others acknowledged the benefit of skin contact but omitted the mention of instinctive attachment. A midwife admitted never having witnessed instinctive attachment. Sometimes midwives needed to give mothers verbal encouragement to have skin contact in labour ward and skin contact could be limited when the mother did not want to breastfeed.

There was a range of views about photos depicting a baby displaying instinctive behaviour on his mother's chest. For most midwives there was an absence of outcome expectation to facilitate instinctive behaviour of the baby at birth and a view that mothers would be surprised to see babies behaving instinctively at birth. Women were however encouraged to have skin contact whether planning to breastfeed or not.

The length of time babies were left in skin contact was contradictory. Most midwives limited the time, reported by some but not all as at least 30 minutes, due to pressure of work in the labour ward. Generally mothers wanted skin contact but were unaware of the recommended length of contact. An argument was made however for allowing more time for women to enjoy having skin contact and to have less pressure on midwives to achieve a breastfeed before transferring the mother to the postnatal ward.

Midwives were knowledgeable about the physical benefits and also very enthusiastic about the positive emotional effects of successful skin contact on the mother and father's relationship with their baby. If the baby fed shortly after birth this enhanced bonding and the physiology of lactation.

Midwives responded to successful attachment in the labour ward with enthusiasm and relief and regarded attachment itself as their responsibility. Most midwives expected to physically attach babies to the breast in labour ward "hands on" as they perceived the mothers wanted them to do this and it was expected by their peers. It was also important to check that attachment was correct. One midwife argued though that she was sure "hands on" was not the method used and another reflected that "hands on" may be counterproductive. In contrast migrant mothers did not require the midwives' help to attach their babies.

Babies' behaviour and ability to attach at birth was affected by a number of factors, including the type of delivery and the methods of pain relief and was compared unfavourably to a natural delivery with little or no analgesia. The home birth midwives reported little use of narcotic analgesia at deliveries.

When the baby did not attach in labour ward, midwives were very disappointed, expected problems and recognised the mother's confidence was reduced. One midwife expressed that she could be angry.

Women's reactions to failure of their babies to attach in labour ward were assessed by midwives according to their perception of the mothers' motivation. Women could be encouraged to persist and be given an explanation of the effects of analgesia but

even with reassurance women were perceived to feel a failure from the very beginning if their baby did not feed.

### 7.11.2 Postnatal ward

While there were some positive comments about the success of skin contact in the postnatal ward, a number of barriers to encouraging this were mentioned. Amongst the reasons for lack of motivation to facilitate skin to skin in the ward was the midwives' lack of conviction about its benefits. This was apart from using skin contact as a calming strategy during unsuccessful "hands on" attempts to attach the baby to the breast when the baby starts to refuse the breast.

Midwives explained that women did not expect that the babies wouldn't feed in labour ward and/or at first in the ward. They assessed women as not knowing how to enable attachment, therefore justifying the midwives' use of "hands on". Neither had the women been given realistic expectations about the start of breastfeeding. However midwives also acknowledged that the babies would not attach. Repeated failure to enable attachment was upsetting for mothers.

There was no time to sit with each mum needing help but the women were then dependent on the midwives for help. This stressful situation affected women and midwives and both were upset.

Women did not expect to be asked to hand express their breastmilk when the baby was reluctant to feed after birth. Women could be encouraged and could become confident and persevere and eventually succeed when they understood they were not harming the baby. Some midwives thought it was important to encourage perseverance as giving up may result in lifelong regret. However the unfamiliar environment, personal factors and the baby's reluctance to feed, and a perception of failure, could reduce self-efficacy and women could give up trying to express and breastfeed.

Midwives' personal attitudes to hand expressing could be questioned and their motivation to help was doubtful when women needed a lot of support and were upset and reluctant to hand express.

Environmental factors, including being too busy, exacerbated the midwives' lack of ability to help women. The balance of responsibility was perceived to lie with the midwives and there was resentment toward the mothers who were regarded as having done little preparation. Women could also be perceived as pretending to want to breastfeed to escape the derision of the midwives or to feel pressured by the assumption that they would choose to breastfeed.

Midwives were sensitive to their own perceived failure when the women gave up despite their help and felt criticism directed at midwives was not justified. The help midwives offered could be affected by their own personal failure to breastfeed but when they had experienced success they could be motivated to encourage women.

It was suggested that it would be helpful for women to have antenatal education on potential difficulties and the encouragement of peer support. Some credible verbal encouragement from confident midwives could help. There was a range of views about photos depicting a baby displaying instinctive behaviour on his mother's chest. This reflected negative attitudes in relation to seeing photos of women shown with a naked chest, but some midwives had insight about the activity and purpose of the information contained in the photos.

The chart describing sleep states (chart adapted from Long 2006) received a positive evaluation.

### **7.11.3 Conclusions**

The data differed according to the care setting. The reasons the midwives gave for placing babies skin to skin with their mother after birth in the labour ward, focused on physiological and psychological benefits for the women and babies but not on the instinctive attachment behaviour of the babies. Although a few babies attached instinctively, pressure of time dictated that the midwives used the strategy of "hands on" in the attempt to attach the babies to the breast. In the postnatal ward the midwives said they used skin contact between mother and baby to calm the baby while "hands on" manoeuvres continued to be made by the midwife to attempt to

attach the baby to the breast. This was followed by hand expressing breastmilk when the baby did not attach (Table 26).

**Table 26 Similarities and differences in skin to skin and attachment themes**

	Labour ward	Postnatal ward
Knowledge and use of skin to skin	Knowledge of skin to skin in the labour ward was of the physical and psychological benefits and that women enjoy skin to skin.	In the ward midwives used skin to skin to calm the baby when attempting “hands on” to attach the baby and to help regulate the baby’s temperature. The midwives in the ward knew that lots of babies didn’t attach in the first few days and mothers needed help three hourly.
Experiences of attachment	Experiences in labour ward were that a few midwives had seen babies attach instinctively but babies usually attached with “hands on” help from the midwife and there was also a rush to transfer the mother and baby to the ward.	In the ward the midwives experience was that they had to teach hand expressing and help mothers with attachment every three hours.

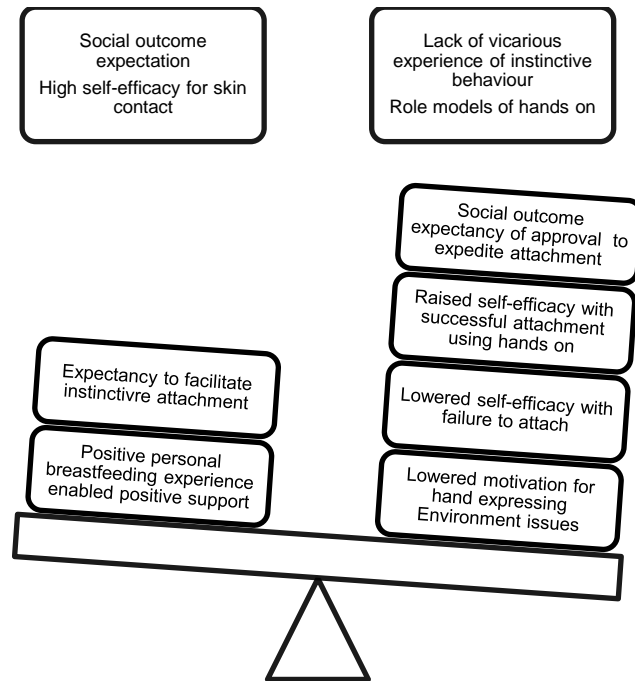
In the postnatal ward the amount of frustration in the attempts to initiate breastfeeding was more pronounced than in the labour ward as the midwives were helping women over a period of several days in the postnatal ward to try to initiate feeding. There had been limited time to give help with starting to breastfeed in the labour ward (Table 27).

**Table 27 Similarities and differences in the theme of Frustration**

Frustration in labour ward	Frustration in postnatal ward
Too busy to give appropriate care to all women. Women have not learned about breastfeeding.	Too busy Majority of babies did not attach in the first few days. Women <ul style="list-style-type: none"> <li>• Had not learned about breastfeeding</li> <li>• Needed help every three hours to attach baby</li> <li>• Needed to be taught hand expressing</li> <li>• Gave up after lots of midwives’ help</li> </ul> Midwives being blamed for drop in breastfeeding statistics

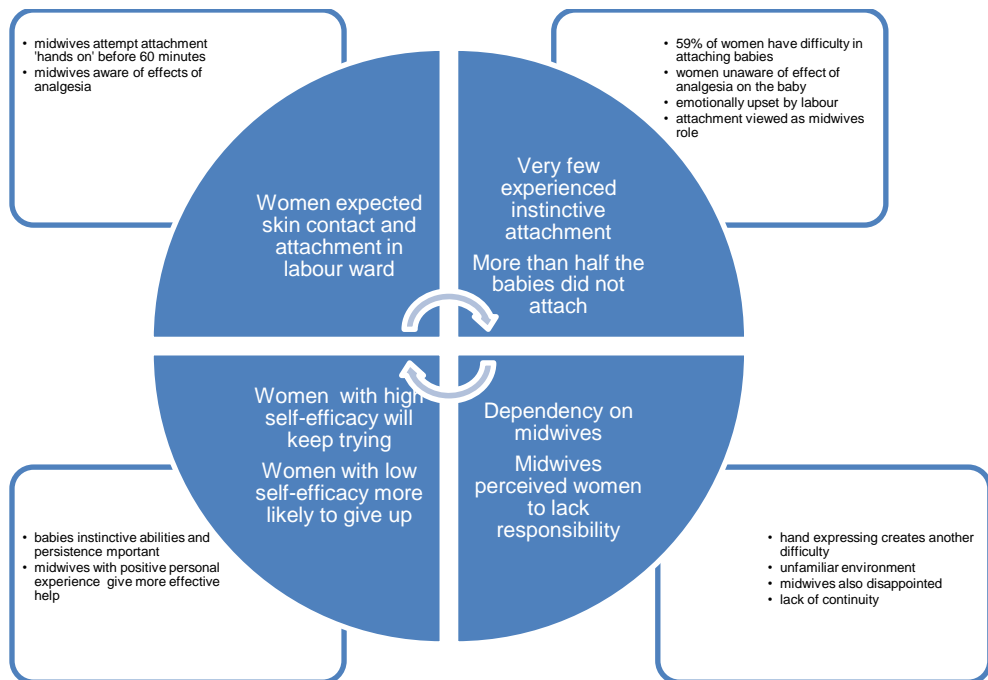
The balance of influences on self-efficacy for midwives unevenly tipped toward lowering motivation to be able to facilitate breastfeeding and is illustrated in Figure 10.

**Figure 10 Balance of influences on self-efficacy for midwives**



The cycle of events is illustrated in Figure 11.

**Figure 11 Cycle of events**





## Chapter 8 Discussion

### 8.1 Introduction

The aim of chapter eight is to bring all the results together and discuss the findings in the light of the study objectives, which were:

1. To explore the expectations and knowledge of antenatal women of breastfeeding initiation.
2. To explore the expectations, knowledge and experiences of breastfeeding initiation in postnatal women and midwives.
3. To determine if the materials used to facilitate discussion in focus groups and interviews were useful for understanding initiation.
4. To evaluate the use of Social Cognitive Theory as a theoretical tool

The discussion is informed by the qualitative synthesis (Chapter 4) carried out to investigate what has been previously known about women and midwives' expectations, knowledge and experiences of breastfeeding initiation. This discussion chapter also highlights the relevance of theory to the understanding of the processes involved during the initiation of breastfeeding with regard to women and midwives. The theoretical interpretation – of women's and midwives' experiences – provides insight into the way they both anticipate and react to circumstances around the initiation of breastfeeding. The data support social cognitive theory that behaviour interacts with emotions, perceived abilities and the environment, and influences how well women manage to initiate breastfeeding and how well midwives try to help women breastfeed.

For the study, qualitative methods were used to explore the phenomena surrounding the first breastfeed after birth and subsequent experiences of both mothers and midwives as both baby and mother learn how to breastfeed. As discussed in Chapter 1, the term initiation of breastfeeding was defined as: "*A process that starts at birth and continues until successful latching at the breast is learned by mother and baby, which may take 48 hours or more to achieve,*" and was the central focus of data

collection and analysis. Understanding of the early part of this crucial period for mothers and midwives is the subject of the research.

The findings from the qualitative study are compared to the results of the qualitative synthesis and other literature to identify the similarities and differences.

## **8.2 Key findings for antenatal women and mothers**

In summary, all the antenatal women interviewed were keen to breastfeed and although some were apprehensive of their own ability most did not anticipate any major difficulties. The few mothers, who experienced instinctive attachment after the birth, were surprised, pleased and happy about their babies' abilities to start breastfeeding but none of the postnatal women had been aware that this was a recognised instinctive process.

The majority of babies did not attach at birth and a view commonly expressed by the mothers was that they felt embarrassed, upset and a sense of failure when the midwives attempted to attach their babies for them using the "hands on" method as reported by (Fletcher & Harris 2000; Ingram, Johnson, & Greenwood 2002).

Compounding this experience, most women were then taught to hand express breastmilk, which was also regarded as stressful and difficult. Most women persisted and were able eventually to initiate breastfeeding. Like the antenatal women interviewed, the new mothers had not anticipated that the babies' instinctive abilities were important for initiating breastfeeding after birth but recognised this after the focus group discussions.

## **8.3 Key findings for midwives**

Although most midwives had a positive attitude to skin to skin contact between mother and baby after birth, only one said she expected to provide the opportunity for instinctive attachment of the baby to the breast. The midwives expected that babies would either be active and ready to attach or sleepy and reluctant to attach. The data suggested that most midwives had no experience of instinctive attachment.

Attachment was regarded by the midwives as their responsibility and they attempted using "hands on", with varying levels of success. The data suggested that this affected the midwives' level of self-efficacy both positively and negatively. When

babies were reluctant to attach, the midwives then taught mothers to hand express their breast milk.

Midwives who had experienced personal breastfeeding success appeared to be more confident about supporting women. When they were very busy, midwives spoke of their frustration, which could be directed at the women. The midwives understood that women did not have prior knowledge about the difficulties of trying to feed sleepy babies. Trying to encourage women in the face of what could appear to women as a double failure of baby not attaching and struggling to hand express was perceived by the midwives to be really difficult, along with the social expectations and circumstances in the postnatal hospital environment.

#### 8.4 Comparison of Mothers' and Midwives' Findings

To my knowledge, and following a thorough search of the literature, this is the only study that has interviewed both women and midwives specifically about initiation of breastfeeding. The synthesis (Chapter 4) focused on the initiation of breastfeeding but found that most previous studies did not have initiation of breastfeeding as their primary aim; in contrast, initiation was central to this qualitative study. This has allowed for deeper insights into this critical period and enabled a comparison and triangulation between the data obtained from mothers and midwives.

In this section, the findings in relation to expectations, knowledge and experience will be highlighted and similarities and differences discussed in the light of the findings of the synthesis and other relevant research. Table 28 summarises the similarities and differences which will be discussed in more depth in subsequent sections.

**Table 28 Comparison of women's and midwives' expectations, knowledge and experiences**

Similarities		Differences
<b>Expectations</b>		
Women anticipated having skin to skin contact with their babies as pleasurable	Midwives expected to facilitate and were warm and enthusiastic about skin contact at birth	
Women did not expect a specific length of time		Midwives usually expected to limit the time given

<b>Similarities</b>		<b>Differences</b>
for skin contact		for skin contact
Most women expected to start breastfeeding easily		Midwives expected to take responsibility for attachment 'hands on' and were focused on ensuring they latched the baby on before transfer out of the labour ward
Few women anticipated feeding difficulties		Midwives expected problems if the baby did not attach
<b>Knowledge</b>		
Women did not know about instinctive behaviour	Midwives did not mention instinctive behaviour	
Women were unaware of the effect analgesia could have on babies' feeding ability		Midwives were aware of the effect of analgesia on the babies
<b>Experiences</b>		
A few of the postnatal women experienced instinctive attachment	Few of the midwives had experience of facilitating instinctive attachment	
More than half the women experienced difficulty with attachment and were upset about 'hands on'	Midwives experienced disappointment if they failed to attach the baby using 'hands on'	
Women experienced feeling dependent on midwives		Midwives attributed women with having a lack of responsibility and/or skills
Women were in an unfamiliar and unsupportive environment	Being too busy stressed the midwives	
Women were upset about hand expressing	Midwives were unenthusiastic about hand expressing	A few midwives were more confident and willing to give help with expressing

#### 8.4.1 Expectations of the women and midwives

Antenatal women were keen to breastfeed and some thought it looked easy but others were apprehensive about starting to breastfeed and had an expectation of guilt if they failed. Most women were fairly confident of managing with help promised

from the midwives. They looked forward to the prospect of skin to skin contact with their babies at birth but were not aware of the expected length of the experience or that instinctive baby behaviour was possible. Women can expect starting to breastfeed to be “*easy and wonderful and natural*” and expect it to be automatic (Mozingo et al. 2000). There is robust evidence for the benefits of skin to skin contact for breastfeeding (Moore et al. 2008). Four in five women recalled having information antenatally about the health benefits of breastfeeding, most commonly from midwives and were more likely to initiate breastfeeding (Health and Social Care Information Centre 2012). However this is the first piece of research to explore women’s antenatal expectations in relation to skin to skin contact and instinctive behaviour with their babies at birth.

Midwives expected to facilitate skin contact and were pleased they could do this but most omitted mention of instinctive attachment. One explanation for the midwives’ views was that at the time of this study, the BFI guidelines recommended that midwives should help mothers initiate breastfeeding within a half hour of birth (World Health Organization 1998). According to the midwives, the BFI guidance being followed at the time of the study had been modified and that mother and baby should be able to have skin contact for at least 30 minutes. There was not usually an expectation of continuing skin contact until the baby fed instinctively.

Misinterpretation of policy has been noted in other studies e.g. in Weddig et al. (2011) the policy was “*skin to skin contact at birth and until the first breastfeed occurs, infant self-attachment at the first and subsequent feedings*” but even there midwives aimed for attachment to happen within 20 minutes of the birth. This would give only a very brief opportunity for the baby to achieve attachment and echoes the pressure felt by midwives in other studies to achieve attachment within 30 minutes (West & Topping 2000; Reddin, Pincombe, & Darbyshire 2007).

Confusion may arise from BFI guidelines (World Health Organization 1998) to put the baby to the breast in the first 30 minutes, rather than emphasising skin contact and observing baby for pre-feeding cues (Cooke, Cantrill, & Creedy 2009). Midwives’ social expectations (i.e. to avoid disapproval from colleagues) to encourage the baby to attach in a limited time could create stress and upset for some midwives. The lack of priority for a longer period of skin contact supports previous

findings that when the labour ward was busy there was less time for skin contact (West & Topping 2000; Reddin, Pincombe, & Darbyshire 2007; Weddig, Baker, & Auld 2011) and there could be a general assumption that women had to be transferred out of the labour ward area quickly at all times (Furber & Thomson 2007). One study reported significant success in implementing practice change in skin-to-skin care using a 5-day immersion model (Brimdyr et al. 2012). This comprised of education in optimal skin to skin practices according to Baby Friendly recommendations along with what appeared to be a form of vicarious experience and verbal encouragement for the staff of the study hospital. In my study, most midwives described an expectation to give “hands on” help with attachment in the labour ward, which differs from Reddin et al. (2007) where midwives seemed to lack interest or empathy with women’s efforts and left attempts to attach the baby to students. In my study, attachment was considered by most of the midwives as their responsibility and the majority of midwives expected to physically attach the baby to the breast using “hands on”, supporting suggestions in other research that midwives tended to think that the mother was not skilled enough (Henderson, Pincombe, & Stamp 2000).

Midwives in my study reported being pleased and relieved when babies attached in labour ward, and also saw this as encouraging for the women. This is enactive attainment for the midwives where success raised their self-efficacy (Bandura 1977) and supports findings of satisfaction when being successful in attaching the baby (Henderson, Pincombe, & Stamp 2000). My data suggested that failure to attach the baby lowered the midwife’s self-efficacy and she would anticipate problems, supporting other research (West & Topping 2000; Henderson, Pincombe, & Stamp 2000).

#### **8.4.2 Knowledge of the women and midwives**

Midwives were very positive and knowledgeable about most physical and psychological benefits of skin contact in labour ward. They also knew an active alert baby was advantageous to starting breastfeeding soon after birth, as suggested in previous research that an alert baby, not affected by the birth or drugs, would be more likely to attach soon after birth (Vogel & Mitchell 1998; Henderson, Pincombe, & Stamp 2000; West & Topping 2000; Matthews 1989; Righard & Alade 1990; Nissen et al. 1995; Nissen et al. 1997; Crowell, Hill, & Humenick 1994; Rajan 1994;

Beilin et al. 2005; Volmanen, Valanne, & Alahuhta 2004; Dewey et al. 2003; Rowe-Murray & Fisher 2002; Zanardo et al. 2010). In contrast, women in my study did not know this, which meant they were unprepared for any delay and/or difficulties in the start of breastfeeding.

Not knowing what to do when there was difficulty attaching the baby and being unexpectedly physically handled in my study, gave rise in women to feelings of failure, embarrassment and lack of enactive attainment resulting in lower self-efficacy and feelings of rejection when the baby wouldn't feed supporting previous findings (Mozingo et al. 2000).

Some midwives in my study used skin contact in the postnatal ward to calm babies when they were attempting "hands on" to achieve attachment, as babies became distressed and started to refuse to attach. In a study investigating midwives' knowledge and practice, midwives reported using "hands on" to attach babies but some failed to realise that mothers do not find hands-on helpful and that it can disrupt the neonate's ability to suck effectively (Cooke, Cantrill, & Creedy 2009). It was recognised by some midwives in my study that "hands on" could result in the baby starting to breast refuse supporting previous findings that babies who had been "*rammed onto the breast*" subsequently started to be upset and refuse to attach (Vogel & Mitchell 1998).

#### **8.4.3 Experiences of women and midwives**

This section will discuss women and midwives' experiences of instinctive attachment, difficulty in attachment, effects of labour and analgesia, "hands on" attachment, hand expressing, and effects on self-efficacy.

##### ***Instinctive attachment***

Very few postnatal women in the study experienced successful instinctive attachment of the baby to the breast shortly after the birth. Those who had experienced instinctive attachment viewed this very positively and had a sense of achievement, attributing attachment to the baby's ability. The importance of instinctive attachment in giving pleasure to women and closeness to their baby supports previous findings where also a sense of achievement has been reported even after a difficult delivery (Ryan, Todres, & Alexander 2011; McGrath & Phillips 2009). This is enactive

attainment where success raises self-efficacy (Bandura 1977). The mother's perception of breastfeeding progress and achieving feeding as planned (outcome expectations), can predict maternal breastfeeding self-efficacy in the first week (Dennis 2006; Blyth et al. 2002) However in my study most midwives lacked experience of instinctive attachment and few encouraged mothers to achieve instinctive attachment or to continue using their own and their baby's initiative to feed.

### *Difficulty in attachment*

More than half of the postnatal women in my study experienced difficulty with their babies attaching at birth, which reflects the findings in the most recent national Infant Feeding Survey ,(Health and Social Care Information Centre 2012) and other research (Wambach & Cohen 2009; Entwistle et al. 2010; Ryan et al. 2011; Dykes et al. 2003; Tucker et al. 2011; Mozingo et al. 2000; Kelleher 2006; McGrath & Philips 2009 ; Avery et al. 2009; Thomson & Dykes 2011; Hoddinott & Pill 1999a).

### *Effects of labour and analgesia*

Additionally narcotic analgesia or an epidural and the events around the birth could affect the mother who is expected to attach a very sleepy baby to the breast, increasing her experience of difficulty. Narcotics can cause the mother to be less able to respond to the infant, especially if the drug is given shortly before the birth (Rajan 1994). The postnatal women realised on reflection that their baby's reluctance to feed (not showing instinctive behaviour) at birth was not due to their personal lack of ability. It was not something they had expected and it was only later that a few women associated this with having had analgesia in labour.

Some women in the study spoke quite negatively about their birth experiences, regardless of whether this was an uncomplicated vaginal birth, an instrumental delivery or an operative caesarean section. It has been shown that being emotionally upset can affect lactation (Dennis 1999) and that the physical effects of birth can be unexpectedly upsetting (Kelleher 2006).

### *'Hands on' attachment*

In my study midwives expressed disappointment, and sometimes anger, when they failed to enable the baby to attach "hands on"; suggesting the theoretical position of experiencing a lack of self-efficacy with the perception of their own lack of skill



(Bandura 1977). Some midwives in my study also reported feeling very frustrated which supports findings where midwives felt helpless and frustrated when trying to find time to enable and achieve attachment (Henderson, Pincombe, & Stamp 2000).

### *Hand expressing*

Midwives followed the local policy to enable breastfeeding and most of the postnatal women were encouraged to hand express small amounts of expressed breast milk. In a review of methods of milk expression it was concluded that hand expressing may be the most suitable method to initiate the milk supply when the baby is unable to feed in the first few days (Becker et al. 2011). Women however did not expect or know about hand expressing and trying to hand express increased their anxiety and tended to make them doubt their abilities further. Watching other women overcoming difficulty and eventually being successful themselves raised self-efficacy. While it is acknowledged that breastmilk is the optimum nutrition for all babies at birth (WHO 1997; de Rooy & Hawden 2002) it is unclear the value that is placed on this resource by women and midwives. Guidance on the method of hand expressing breastmilk for ill babies or for a short period in the immediate postnatal period for a healthy but sleepy baby is available from UNICEF (2013) and has been adopted by local breastfeeding policies including in the area of this study. Morse & Bottorff (1988) found breast expressing by hand had different meanings for women. One group found hand expressing embarrassing and awkward and the other group had a relaxed attitude towards expressing. The former group could not express easily but the latter group did express easily and the expressed milk increased their confidence in breastfeeding (Morse & Bottorff 1988). Most midwives in my study discussed hand expressing in unenthusiastic terms and understood that women found this very difficult. This was an unwelcome task, which could affect midwives' motivation as they anticipated their efforts to teach hand expressing may not be considered of value by the mothers. A few midwives were more confident about encouraging persistence in the women's efforts to hand express when the baby was sleepy.

### *Effects on self-efficacy*

Women in the study praised the midwives and were reluctant to criticise them and some midwives did encourage persistence. This encouragement may be less likely to lead to success as the conditions for success, in this case consistent unhurried support, were not in place. Women however felt dependent on the midwives and not

in control. This supported the theoretical position that feeling autonomous and being in control of one's own actions are among influences on thoughts and behaviour that can be affected by the environment (Luszczynska & Schwarzer 2005). The environment of labour and postnatal wards was not conducive to women learning to breastfeed, midwives were busy, some were perceived to be uninterested, and there was a lack of continuity of care and inconsistency in the information, as indicated in previous findings (Dykes et al. 2003; Vogel & Mitchell 1998). When lack of support was a feature women felt alone with their difficulties (Dykes et al. 2003). Doubt about midwives' motivation or lack of empathy has been reported (Wambach & Cohen 2009). Midwives however have expressed satisfaction when able to give continuity of care where the ward was not busy (Dykes 2005) and in my study midwives were upset when women they had been helping gave up.

In contrast some midwives attributed lack of responsibility and lack of effort to the women but perceived that there were too many women needing help. This is supported in Henderson et al. (2000) where women were not confident enough to persist and pressure and distress in the midwives resulted from the lack of time to be able to give help to struggling women (Furber & Thomson 2007).

In my study the women reflected that the midwives' "hands on" technique to achieve attachment was not actually helpful. The women had persisted by themselves and succeeded and were now more confident. This supports previous findings that women who are successful in repeatedly managing to breastfeed in the first week develop an increase in their perceived ability to breastfeed (Creedy et al. 2003). Midwives' personal experience was important in explaining their attitudes. Midwives who had struggled with feeding their own babies, then experienced personal success, had more understanding and appeared more empathetic and confident in helping women. This supported the findings in West & Topping (2000) where midwives who had personal or professional success could be more pragmatic about following policy and in my study judged themselves more capable of imparting confidence to women having difficulties.

#### **8.4.4 Materials used to elicit and enhance knowledge**

This section relates to the objective to address usefulness of materials in understanding initiation. This study is the first to use such images to stimulate

discussion specifically around initiation. When shown the same photos (of instinctive behaviour) as the antenatal women, most postnatal women reflected they hadn't known about instinctive behaviour at birth and recognised that their babies now currently behave instinctively at the start of a feed. Matching text to the chart "Feeding cues after the first few hours" was considered more carefully by the postnatal women and they thought this one would have been helpful in hospital and also at home.

In contrast, the reaction of midwives to being shown the photos of instinctive baby behaviour at birth ranged from negative appraisals to more positive reactions but mostly stopping short of mentioning instinctive attachment. This was a finding in previous research where the scores on an assessment of the neonate's instinctive feeding behaviour at birth highlighted gaps in midwives' knowledge on a number of factors (Cantrill, Creedy, & Cooke 2004). For example more than half of their participants did not know that separating the mother and baby 15-20 minutes after birth is an important factor in negatively affecting the neonate's ability to attach correctly and the least frequent best practice was "*encourage the women to allow the baby to self attach with minimal assistance*" (Cantrill, Creedy, & Cooke 2004). The chart "Feeding cues after the first few hours" was thought to be potentially useful in the postnatal ward and could it be adopted in AN classes to enable women to prepare for initiation and consider the potential challenges in the first few hours.

### **8.5 Using social cognitive theory and the relevance of context**

The data were analysed deductively using social cognitive theory to interpret the expectations, knowledge and experiences of *both* women and midwives. I chose SCT because there have been a considerable number of studies showing an association with self-efficacy and breastfeeding. However in previous studies using SCT/SE and quantitative methods, the focus has been primarily only on the women to predict breastfeeding self-efficacy (Dennis 2006), enhance self-efficacy (Kingston, Dennis, & Sword 2007), and examine the effect of self-efficacy on initiation and duration (Blyth et al. 2002; Mossman et al. 2008; Wilhelm et al. 2008; Blyth, Creedy, & Dennis 2004; Chezem, Friesen, & Boettcher 2003; Bailey, Clark, & Shepherd 2008; O'Brien, Buikstra, & Hegney 2008; Kronborg & Vaeth 2004). In an example of qualitative research Entwistle et al. (2010) used SE and qualitative methods to

explore women's experiences in relation to support for breastfeeding in the postnatal period. My study was the first to apply SCT to the initiation of BF from the perspective of both women and midwives.

It was possible to use SCT to compare the women and midwives' expectation knowledge and experiences of breastfeeding initiation as it was relevant to both. Bandura (1997) suggested that self-efficacy should refer to a specific behaviour and although the theory has been developed to consider self-efficacy as generalized confidence, it is viewed mainly as relating to situation specific behaviour (Luszczynska & Schwarzer 2005). The behaviours during the specific period when women were attempting to initiate breastfeeding and midwives were attempting to help meant that SCT was particularly useful and applicable to both sets of participants. An interpretation using the two core constructs of SCT of perceived self-efficacy and outcome expectations, and the range of concepts involved in the theory, contributes to the understanding of both mothers' and midwives' experiences. However, knowledge of the structure and processes (context) involved in the care of women at this time was also necessary to illustrate the environment and setting relevant to the data that were collected and analysed using SCT. The associated relevance of the international policy of the BFI guidance was an integral aspect of the background to the study.

It has been proposed that people act within a concept of "Triadic Reciprocal Causation" where behaviour, internal personal factors and the environment interact (Bandura 1986). The self-efficacy construct suggests that women with a strong sense of self-efficacy believe they have the ability to carry out an action, in this case initiation of breastfeeding. My data support the theoretical position that most of the women in my study had a strong sense of self-efficacy to be able think ahead and consider they were capable of achieving their goal of breastfeeding and had a sense of determination to do so. People on the other hand who have a lower sense of self belief will pay more attention to barriers to achievement (Luszczynska & Schwarzer 2005) and in my study some women were worried that they would feel guilty if they failed, supporting the theory and indicating a lower level of perceived self-efficacy.

People consider how anxious or physically hampered they are when assessing their ability to do something and tiredness and pain can influence feelings of efficacy. Success is more likely if they are not anxious as the activity such as breastfeeding may increase their anxiety. Additionally the physical and self-evaluative outcome expectancy of the hand expressing strategy could only be considered as the situation arose, as the postnatal women had no previous knowledge of this. An apparent failure to obtain expressed breastmilk in this specific situation could easily affect self-efficacy. If a risk is perceived then people will tend to avoid the potential cause and women were anxious that they could harm their babies by syringe feeding or by their inability to obtain milk. Faced with the previous failure to attach and if the woman was anxious and considered she may not be competent this may be a sufficient barrier to attempting to hand express. Also not feeling autonomous and being able to have control of one's own actions are among influences on thoughts and behaviour that can be affected by the unfamiliar hospital environment (Luszczynska & Schwarzer 2005).

A woman with high self-efficacy would be determined to achieve her goals and resolve problems. The data suggested that most of the women managed to persevere and hand express but were upset and anxious while this was happening until the baby attached. Developing perseverance helps raise self-efficacy (Bandura 1989). Lowered self-efficacy due to the perception of failure could increase the risk of giving up (Bandura 1986).

Reflection can enable people to consider their thoughts about experiences and enables learning and to change their thoughts (Bandura 1986). In this study women reflected on their experiences of initiating breastfeeding and found their peers and partners had been helpful along with their own perseverance to succeed. They also reflected they had learned that the baby's readiness and ability to feed was important. The one woman who gave up regretted not persevering.

Midwives' behaviour can be similarly explained within the context of SCT. This study found that midwives had a positive social outcome expectancy of facilitating skin contact between the mother and baby after the birth and a strong sense of self-efficacy about achieving this. However few midwives anticipated encouraging

instinctive behaviour of the baby during skin contact at birth. This may have been a result of lack of vicarious experience of witnessing a mother and baby held skin to skin and instinctively attaching. The midwives were more likely to have witnessed other midwives attempting to attach babies to the breast “hands on” where modelled behaviour encourages performance.

Enactive attainment for the midwives was achieved when babies attached (usually “hands on”) in labour ward where success raised their self-efficacy but when the midwife failed to attach the baby this would lower her self-efficacy. The environment could affect their behaviour depending on their relationships with other staff and how autonomous they regarded themselves in the situation. People may consider that they lack competency so avoid situations which may happen when midwives are stressed and feel unable to cope. This supports findings where midwives were said “*to have lost their patience with supporting breastfeeding*” (Reddin, Pincombe, & Darbyshire 2007 pp75) and midwives being moved from area to area at short notice (Dykes 2005).

In contrast, the data supported the theoretical position that midwives who had personal experience of success were more likely to be able to give positive support to women.

### **8.5.1 Comparison of women’s and midwives’ results in relation to SCT**

Women were motivated and confident during the antenatal period and anticipated having skin contact with their babies. They did not know about instinctive behaviour and expected their babies to start breastfeeding in the natural way they had witnessed previously. However they were willing to learn about instinctive behaviour and hand expressing to enable them to succeed in breastfeeding. Generally they were highly confident, had high levels of self-efficacy. Meanwhile midwives expected to facilitate skin to skin and were very confident about women having skin contact with their babies but few expected to also facilitate instinctive attachment. Midwives with personal positive breastfeeding experience were generally able to give more positive support, because they had higher breastfeeding self-efficacy.

The postnatal women did not have the advantage of having prior awareness of instinctive behaviour or hand expressing. Those women, whose babies did not attach

instinctively, struggled with the reality of having experienced the physical and psychological effects of labour then having the midwives' unwelcome "hands on" interventions to expedite breastfeeding initiation. This immediately affected their perception of self-efficacy. The data suggested that most midwives intervened to attach the babies, with the method familiar to them (but not to the women) of "hands on", and were expected to transfer the women as quickly as possible to the postnatal ward. Midwives were seemingly unaware of the deleterious effect this "hands on" intervention had on the women's confidence. Their own self-efficacy though would be raised if the baby attached with their help either with or without physical assistance. There was a seemingly implicit acceptance by midwives that the drugs women had in labour as well as the type of labour and delivery affected the baby's behaviour. These effects compounded by the expectation of having to expedite transfer to the postnatal ward again reduced the midwives' autonomy and ability to adapt their behaviour to be woman centred and adjust care according to individual women's needs. Midwives continued with attempts to attach the babies then when this failed taught women about hand expressing.

However although the women experienced distress during their efforts to start breastfeeding, most women were able to persevere and with support managed to initiate breastfeeding. Five were still breastfeeding exclusively, two were partially breastfeeding and one had given up when the focus group took place. The balance of influences on aspects affecting the women's self-efficacy was very evenly matched (see Figure 8) between advantages and disadvantages in the specific situation of starting to breastfeed but most managed to initiate and continue feeding. This reflected the advantages the women in the study had of starting with an optimistic confident attitude supporting higher self-efficacy and duration of breastfeeding (Dennis 2006; Blyth et al. 2002; Mossman et al. 2008; Wilhelm et al. 2008; Blyth, Creedy, & Dennis 2004; Bailey, Clark, & Shepherd 2008; O'Brien, Buikstra, & Hegney 2008; Kronborg & Vaeth 2004) and having the benefit of a higher socio-economic and educational background (Dennis 2006; Kronborg & Vaeth 2004). They were better equipped overcome the difficulties and to be able to persevere and had family and/ or social support to carry out their plans (Dennis 2006; Kingston, Dennis, & Sword 2007; Mossman et al. 2008). They reflected on their ability to persevere and their new found knowledge that the baby's eventual ability to start feeding was also

important to their success. Women with less advantage in their socio-economic and educational background may have found the balance of disadvantage and reduced confidence, in this specific situation, would be greater than their initial motivation to breastfeed (Entwistle et al. 2010).

The environment, where women were upset and midwives' colleagues may have differing attitudes and experiences, having to follow policy, could result in midwives experiencing a lack of autonomy affecting their motivation. Stress levels were higher and perception of efficacy was lowered when dealing with high numbers of women depending on their help.

### **8.6 Utility of Social Cognitive Theory and the importance of context**

There are a considerable number of studies showing an association between self-efficacy and breastfeeding duration/exclusivity. The additional explanatory aspects of Social Cognitive Theory enhanced the understanding of the issues around initiation of breastfeeding. Social Cognitive Theory (SCT) was used deductively to interpret and understand the themes in an effort to conceptualise key areas of the women's experiences. The women's and midwives' experiences were explained through social cognitive theory. This explains that behaviour interacts with emotions, perceived abilities and the environment as in triadic reciprocal causation and affects peoples' decisions (Bandura 1986). These influences help explain how well women manage to initiate breastfeeding and midwives try to help women breastfeed.

The use of SCT gave a rich explanation of women's and midwives' experiences during breastfeeding initiation and a deeper understanding of the influences on behaviour than describing the behaviour alone. This contributed to the understanding of breastfeeding initiation but the physiology of breastfeeding, the structure of care and the associated policies were also integral to the exploration of this topic. The findings from this study have explained in some measure the behaviour and internal personal factors related to women and midwives. However the environmental variables are less well explained in Bandura's theory.

The environment or context in which behaviour is situated is recognised to be very influential on the outcome and people who believe in themselves and their ability



usually have a sense of control of their environment (Luszczynska & Schwarzer 2005). The environment around the women was outwith their control as they were the recipients of care in the vulnerable situation of giving birth. The data supported the theoretical position that their circumstances and unfamiliar surroundings affected women's ability to be autonomous, develop a rapport with the midwives or be able to start to develop their skill in breastfeeding.

Environmental approaches to changing health behaviour consider that changes in the social environment can lead to change at an individual level which in turn, if supported, can change the environment. When designing an intervention the environmental causes and influences on behaviour need to be considered and involve the participants in agreement of the way forward (McLeroy et al. 1988). It is suggested that if the environment does not support peoples' psychological needs then SCT predicts that peoples' motivation can be reduced. Dzewaltowski, et al. (2002) suggest within SCT four environmental factors could contribute to supporting behaviour; feelings of being comfortable in a place, perception of being able to control one's environment, being able to develop a skill in the environment and considering the behaviour is normal in the particular environment (Dzewaltowski, Estabrooks & Johnston 2002). The variables that were related to the environment found in this study affected both women and midwives.

With continuity and consistency of support women can be encouraged to succeed but in an unfamiliar environment attempting a difficult skill women lose confidence. When midwives were too busy it became very difficult for them to achieve success in helping women to breastfeed. Midwives practise within a structure of care that lacks the positive strategies to facilitate initiation and creates for both women and midwives an environment that results in a lack of self-efficacy and motivation.

The latest evidence and rationale for UNICEF UK Baby Friendly Initiative (Entwistle 2013) has new standards that support breastfeeding. Standard 2 relates to the importance of this period after birth to initiate a close relationship between mother and baby and the start of breastfeeding. This section includes suggestions on improving the environment to facilitate this process (Entwistle 2013) including encouraging feelings of being comfortable in a place and perception of being able to control one's environment. A more natural environment is advocated for low-risk

women where women can feel calm and in control and evidence suggests that in a midwife-led service, women are more likely to initiate breastfeeding (Entwistle 2013).

### **8.7 Utility of the Systematic Literature Review**

The systematic literature review on breastfeeding initiation included 21 studies, 13 involved only women, six involved only midwives, one included both women and midwives and one included women and various healthcare workers (i.e. lactation consultants, midwives and community child health nurses). The studies' aims were wider than the definition of initiation in this thesis and the relevance of the content to initiation was captured in statements devised for this thesis. The papers were interrogated for their findings in relation to women's and midwives' expectations, knowledge and experience of initiation.

In the synthesis (done before the analysis of the data) there were clear differences in the experiences of women when breastfeeding was going well as compared to when it was going wrong at the start. The features that were most evident when breastfeeding was going well were; the woman was familiar with breastfeeding, the baby attached shortly after birth and /or women were determined to learn to breastfeed. My study supports these findings. When breastfeeding was going well the midwives were knowledgeable, experienced, and confident and had time to give women-centred care. Only one midwife in my study was found to fit all these criteria. It could be suggested that most midwives did not meet the criteria nor had the time to give women centred care. In the synthesis although a few midwives recognised the importance of the baby attaching soon after birth there was little acknowledgement of the effect of labour analgesia on the baby's abilities or that babies could attach instinctively. Although the effect of analgesia was acknowledged by midwives in my study the mothers were not aware this could affect breastfeeding. In common with my study, the papers in the synthesis indicated that midwives used "hands on" or verbal encouragement and considered attachment as their achievement.

In the synthesis and in my study when breastfeeding was going wrong the features that were most evident for women were; the baby would not attach, the women had not expected this, women were worried about their babies' health, the midwives handled the women's breasts, communication with the midwives was unsatisfactory

and women could change to bottle feeding as a result of their difficulties. Women were negatively psychologically affected by their own physical discomfort and inappropriate care where the relationship and communication with the midwives was lacking and did not encourage persistence in their efforts.

In contrast the most evident features in the synthesis in relation to midwives were; a reluctance to help women, an expectation to physically attach the babies (although some midwives acknowledged this could lead to the baby refusing the breast), an expectation of a quick transfer to the ward, and a lack of motivation and knowledge. In turn this resulted in midwives appearing detached from women's needs and displaying undermining behaviour. Midwives were overwhelmed by the workload and the solution of formula feeding was regarded as normal. Although most of these points were also found in my study many midwives were willing to help and those with positive experience were more able to be helpful.

The role of the synthesis in refining the research questions was invaluable as it provided a broad range of information to consider that needed investigation in relation to initiation of breastfeeding. The studies in the synthesis mostly related to experiences of women after their babies were born but did not include antenatal women's awareness of the strategy of skin to skin contact and its role in instinctive behaviour or initiation of breastfeeding. In the synthesis the baby's behaviour at birth was recounted for postnatal women who had a positive experience of initiation and also for those who were experiencing problems. Since skin contact and instinctive behaviour of the baby at birth are related in a continuum, this area was to be a particular focus of investigation in my study. The type of support the women received when there was success and conversely during problems in initiation with for example hand expressing and was regarded as important to investigate and was not included in the synthesis.

Midwifery topics not explored in the synthesis were identified for inclusion in my study and helped to refine further research questions. These included the midwives' knowledge or lack of knowledge helped or hindered women's achievements particularly around skin to skin contact and the events around the very first breastfeed; the on-going attempts to start breastfeeding when the baby was reluctant

to feed and the strategies employed, such as hand expressing, to assist women at this time. The context of the care provided needed to be explored particularly in relation to strategies employed to address problems arising in the labour ward, the postnatal ward or community when the baby is not feeding. Midwives' views and experiences in the particular context were thought relevant. It would have been difficult to proceed with a focused examination of the period of initiation without completing the exercise involved in this systematic review of the literature and the inductive and deductive aspects of the analysis.

Entwistle et al.'s study (2010) confirmed the idea that analysis of a qualitative study based on self-efficacy theory might provide a valuable insight into women and midwives' experiences around the specific event of initiation of breastfeeding. The exploration of self-efficacy however led to broadening of this concept and incorporating developments in SCT in the synthesis. In turn this required further exploration of the environmental aspects involved in SCT.

The themes and subthemes linked closely to Social Cognitive Theory and provided a theoretical basis to explain women's and midwives' expectations knowledge and experiences of breastfeeding. This was very useful and was considered as a foundation to develop this strategy in my qualitative study.

## **8.8 Strengths/ limitations of the methods used in this study**

### **8.8.1 Strengths**

The main aim of this thesis was to explore the expectations knowledge and experiences of women and midwives with regard to initiation of breastfeeding. The position of "*Subtle Realism*" where an attempt is made to represent the reality of that concept of realism rather than "the truth" was taken in this thesis (Mays & Pope 2000; Snape & Spencer 2003). In order to satisfy scientific rigour of assessing qualitative research, criteria alternative to the quantitative criteria of validity and reliability has been developed such as credibility, transferability, dependability, and confirmability (Lincoln & Guba 1985). Mays & Pope (2000) outline as their criteria to assess quality; triangulation, respondent validation, clear exposition of methods of data collection and analysis, reflexivity, attention to negative cases and fair dealing. Walsh & Downe (2006) developed their own summary framework using an iterative

approach and the results include a focus on context. There are common aspects to these methods that the following sections attempt to address.

There are a number of strengths that apply to the thesis as a whole. First, it is the only piece of research to apply Social Cognitive Theory to research (both secondary as in the literature review and primary as in the qualitative study) in relation to initiation of breastfeeding; it is also the first to compare the findings (from both primary and secondary research) for women and midwives.

Second, it is also the first study to use novel images/tool of instinctive behaviour and sleep states to stimulate discussion in the focus groups and interviews.

Third, credibility of the research was enhanced by the undertaking of both a thorough international systematic literature review and a qualitative study. This enabled the qualitative study to be undertaken using a strong and robust evidence base. It also enabled me to understand and be informed by not only the research undertaken in a local area, but also the whole body of knowledge that had been undertaken internationally. The triangulation of sources of information from the review and the women and midwives in the qualitative study made the results more comprehensive and gives a fuller picture of the situation (Pope & Mays 2006; Ritchie & Lewis 2003). The exploration of women's and midwives' data separately in the review and this study highlighted that to my knowledge this is the first study to examine the specific period of initiation from the perspectives of both women and midwives to enable a meaningful comparison and first to describe what happens if initiation is delayed (hand expressing) from their perspective.

Both of the separate pieces of research (the systematic review and the qualitative study) also had their own strengths, as described below.

The systematic review aimed to describe, analyse and decide what the research evidence was saying and aimed to understand the person-centred experiences of initiation from the perspectives of women and midwives. The inclusion criteria were based on the phenomena of interest: initiation of breastfeeding and in the context of qualitative research, a search of key electronic databases was undertaken. The inclusion and exclusion criteria were rigorously applied jointly by me and my

supervisor. The included PRISMA diagram makes the decisions we made transparent (Ring et al. 2010). Quality appraisal was useful in helping to facilitate a depth of understanding of the studies. The method chosen to synthesise the qualitative studies was thematic synthesis described by Thomas & Harden (2008). This methodology allowed transparency by providing structured summaries of each study and allowed for evaluation of the context of the summaries in relation to the findings. To reach a higher level of interpretation and abstraction of the inductive themes, Social Cognitive Theory was applied to generate additional concepts and understanding and is the first time to my knowledge this has been used in this way (see sections 8.4 and 8.7). The systematic literature review focused on the specific area defined as initiation in this study and provided information that helped identify areas that had not been previously investigated. The analytic process was detailed in 4.2.5. In terms of credibility, transferability, dependability and confirmability, these processes highlight the trustworthiness of the data.

The Qualitative study allowed an understanding to be gained of the meanings women and midwives attached to their experiences of initiation of breastfeeding in the context of the environment during the period just after birth. Quantitative methods in contrast measure aspects the researcher considers important and the relevant specific results of this study could be utilized in a future intervention.

Social Cognitive Theory in the deductive analysis of both the qualitative review and qualitative study focused on the interpreted meanings that women and midwives experienced from a theoretical viewpoint. The advantage of this theory is that it focuses on situation specific behaviour. It helped to explain what was happening during the process of attempting to initiate breastfeeding. This included the outcome expectancies that were the motivation for the woman's goal to breastfeed but which reduced in importance when the behaviour was being carried out. The level of self-efficacy was more important in converting the goal into persistence and action. Enactive attainment was the most important aspect of SCT that indicated success for both women and midwives. Social Cognitive Theory gave a rich explanation of women's and midwives' experiences during breastfeeding initiation and a deeper understanding of the influences on behaviour than describing the behaviour alone. Within the paradigm of interpretivism the hybrid process of inductive thematic analysis of data-driven codes were integrated with deductive theory driven codes

based on Social Cognitive Theory. A template of codes based on SCT was devised and used in the deductive analysis. This process worked well where the inductive thematic analysis was complemented by the deductive and explanatory advantages of SCT.

There was a wide range of types of midwifery practice and experience captured in the data collection. The experience represented by the midwives was mainly those with more years in practice and from all types of care from midwifery led to those assisting with care of women with complex needs. Recruiting midwives was straight forward as the midwives were keen to attend. The venues were adjacent to the practice areas and midwives were freed to participate with only one midwife interrupted to return to the clinical area.

At all stages in the conduct of the qualitative study and analysis of the data my supervisors interrogated the processes as assurance of credibility, transferability, dependability and confirmability. The study findings provide rich detail of the commentaries of this group of women and midwives and the environment in which they were gathered to allow transferability to be assessed. This inferential generalisation can then be supported or refuted by further research (Ritchie & Lewis 2003).

### **8.8.2 Limitations**

There were a number of limitations of both the systematic review and the qualitative study. The overall limitations of the thesis include: the limitations of qualitative research; my role as a researcher; the use of SCT; engagement in the field.

#### *Limitations of primary and secondary qualitative research.*

It is argued that there are limitations to qualitative research such as a lack of objectivity as it is a more subjective exercise than numerical or statistical measurements. Rather than the breadth of quantitative research which can be generalised to the whole population, qualitative research focuses on depth of understanding of a specific phenomenon or experience in a particular context (Thomas & Magilvy 2011).

Snape & Spencer (2003) argue that there is not a standard way of conducting qualitative research. Methodology and methods of data collection, although characteristic of qualitative research, have considerable variation in use. Considering the traditions of qualitative research, a pragmatic decision was made to encompass “interpretivism”. I did not then choose a particular school or tradition on which to base the thesis as the similarities and differences between theoretical stances may not always be clear. This may have been a weakness in the research as following a more prescriptive course may have given the research a more recognisable structure.

The use of reflexivity acknowledges that a researcher brings their own perspective to the study and that prior knowledge and experience can influence the data. In my case I was a midwife teacher interested in breastfeeding and had successful personal experience of breastfeeding my children. As part of my role of teaching breastfeeding to student midwives, I frequently encountered women who had great difficulty trying to initiate breastfeeding. This led me to question the guidance that midwives could access on helping women to start breastfeeding and the predicament I found women in the ward who were trying to initiate breastfeeding. To develop my understanding I had searched the literature at that time but while there was extensive literature on intention to breastfeed and duration of breastfeeding, there was very little about the specific time just after the birth. I had various thoughts about women’s and midwives’ difficulties which included the effects of analgesia on the baby and lack of personal experience of breastfeeding of both women and midwives. I thought the time just after birth should be investigated as this was a particular problem that upset both women and midwives. I had attended breastfeeding education courses and was active in local promotion activities and started to be interested in conducting my own research into the problem.

It was difficult to know where to start and various attempts to clarify my direction were made which included Chapter 2 which was an exploration of the background of breastfeeding and an attempt to contextualise the experience. Chapter 3 then explored the choice of theoretical model of health related behaviour or behaviour change, confirming my leaning to self-efficacy but widening my thoughts toward using the more complete aspects of social cognitive theory. There were a number of



breastfeeding papers that used self-efficacy theory in a variety of ways to research different aspects of breastfeeding and I found the association of this theory to the process of breastfeeding illuminating. Social cognitive theory seemed to be able to explain the background to experiences in a comprehensive but non-judgemental way. This focus may have precluded a more thorough exploration of other theories that could have been utilised and offer further scope for understanding the complexity of breastfeeding behaviour.

My research proposal was completed with the information thought appropriate and went forward for ethical approval which was granted internally and with the NHS area that was chosen to conduct the study. This was an exciting but apprehensive time where I was aware of my novice status as a researcher as opposed to my more confident self as a midwife teacher.

In relation to credibility of the thesis, engagement in the field, spending time in the local clinical setting as a midwife teacher where the problems in initiation were evident, this real clinical problem motivated the research. The local setting had achieved a level of commitment to achieving the Baby Friendly award (see section 1.2.5.1). However following discussions with my supervisors around my previous role and the risk to bias in data collection especially from midwives who may in the past have been my students I decided to conduct my research in a different setting. This setting differed from my workplace in that it had achieved full Baby Friendly accreditation. The changed level of achievement could potentially have created misunderstanding in the joint construction of meanings between me and the midwives and their perceptions. For example I had been used to women carrying their babies from labour ward to the postnatal ward rather than as I discovered in the study area the babies being transported in a cot. I had not practiced recently in their unit and was perhaps less able to blend in to this different setting. In fact I had worked in that organisation some years previously and my familiarity, if dated, did lend some credibility to my efforts and appeared to enable the midwives to reveal their areas of doubt or challenges to their commitment.

Reflection was important, as a means to take a critical position towards the research, in order to make improvements. Notes were compiled after each data collection

event. I had been teaching student midwives and running tutorials and classes for quite some time and switching from teacher to researcher was actually quite difficult. It was apparent to me during an early focus group with antenatal women I felt such sympathy with their predicament of being unaware of the potential problems they might face that I was trying to teach them. I referred them to helpful written information and a peer support group and recognised that my personal views were getting in the way of objective and neutral data collection although difficult at the time, this helped me consider how to maintain “empathic neutrality” (Snape & Spencer 2003). I reflected on the position of “subtle realism” that I have knowledge of the subject area and that my views could influence the participants’ views and my understanding and description of their views. In order to minimise bias in further focus groups I considered carefully that the questions asked continued to be open and that the responses to their answers were neutral. The questions were modified after each group, some in the light of information from the findings from the midwives’ interviews which ran concurrently during most of the months involved in data collection.

During the midwives’ interviews I was aware that at times instead of probing questions I was asking leading questions and instead of asking the midwife to explain her point further I was really asking for her opinion. This was something I had to work very hard at to remember openness on my part. The participants gave cues that needed probing and this is a skill that needed practice. There were a few occasions when I felt perhaps the midwife’s response was to try to please me. Also some midwives got animated about the women’s lack of knowledge and their frustration about lack of time. Personal experience affected midwives’ responses where their difficulty could manifest in what appeared to be an aggressive view of the policies or a confident analysis of their positive development. I have gained an understanding of being empathic but to remain neutral in gathering views in order to be clear that the views are those of the participants.

Transcribing the recorded interviews and focus groups took much longer than anticipated. Hearing the women’s and midwives’ voices and transcribing their conversations helped me start to be immersed in their problems. I then started to learn how to use the data management system NVivo by inputting the data and

manipulating the transcribed data into codes and then themes. At times this was overwhelming as the amount of data seemed too huge to categorise. At this point it was suggested that a systematic qualitative review of the relevant literature could help to set the international context of my aim for the thesis and this was then commenced. In hindsight it would have been more useful to have completed this work nearer the start of my journey but as my work progressed and I developed more skill embarking on such a complex task became just a bit more feasible.

The transferability of my findings requires careful consideration of the unique clinical environment and the model of care within the research area. In fact two maternity hospitals had amalgamated a few months before my data collection commenced. The midwives were coming to terms with moving to another unit or having different staff joining their midwifery and medical teams but their adjustment to the new situation was not explored in my data. The care in place ensured the option of access to a midwife as the initial professional contact with relevant referral to national pathways and models of care.

The midwives' responses in the interviews were frank and without hesitation but there was perhaps more that could have been divulged with further probing. The midwives' practice with regard to care of women and babies is regulated by the Nursing and Midwifery Council and there was accreditation from Baby Friendly in their area of practice. I expected their conduct to be informed by the best practice standards enshrined in those organisations. In effect though, the environment was outwith the midwives' control, a lack of autonomy affected their motivation, stress levels were high and as a consequence their self-efficacy as a whole was lower than the women's. This newly amalgamated clinical environment would therefore need to be considered when judging the transferability of my findings.

Limitations of the qualitative synthesis: There are several limitations of undertaking any qualitative synthesis. Firstly Chapter 4 acknowledged that searching for relevant qualitative studies can be difficult as databases use different methods of indexing and the title of the paper may not indicate its focus. In my synthesis the titles in most of the papers in the search did not have the topic of my synthesis as their primary focus, requiring careful reading of text to identify relevant data (Ring et al. 2010). It is

possible that during this exercise some relevant studies may have been missed. The relevance of the selected studies was indicated in the tables relating to the characteristics of the reviewed studies (see Appendices 1 and 2). Secondly, the results of the synthesis were so powerful that at times my attention, at the start of the analysis of the qualitative study, was affected by the areas of the synthesis being supported by my study. The synthesis was completed after the data collection for the qualitative study and at the beginning of analysis. I had to make a careful effort to “bracket out” the findings from the synthesis as argued by Husserl (1931) in Holloway (2005). This was helped by the wider variety and more detailed material I had available in my study and in conducting the inductive part of the analysis, more immersion in its content.

Limitations of the qualitative study: The qualitative study had several limitations which need to be acknowledged. First, with respect to credibility the sample of women was carefully planned to be “symbolically representative” of the population in the study area but one of the study limitations relates to recruitment of women and mothers (Lewis & Ritchie 2003). The study failed to recruit any teenagers despite a range of efforts and a planned focus group which was ultimately not attended. The location of the focus group for teenagers was in a parenthood education venue quite distant from the teenagers’ homes and although the teenagers attended for parenthood education the distance to return for a focus group could have been off putting. Arranging interviews in a more local venue may have been more suitable but by the time the focus group had been arranged this was outwith the time frame available for this study. A similar situation arose when attempting to recruit postnatal women from ethnic minorities and recent migrants. Although seven women had completed the reply slips and phone and text contact had been made only one woman attended with her baby. On reflection, perhaps cultural issues may have prevented some women from venturing out so soon after giving birth as in a number of African and Asian countries the custom is not to leave the home for up to six weeks (Sheikh & Gatrad 2001). Perhaps telephone interviews would have been more suitable for the women in this situation.

Second, recruiting women in general was challenging. The areas where recruiting took place were chosen to enable a wide and diverse population of women in order

to reflect a range of views. However despite these efforts the final participants were older and more highly educated than the general childbearing population and therefore do not represent the wider childbearing population. However given the similarities of some of my findings, particularly to the section “when breastfeeding was going well” in Chapter 4 the synthesis, they are likely to be of some relevance to other women. Some of the findings when breastfeeding was going wrong in the synthesis (Chapter 4) were also supported by my study but other concepts have been introduced in my study for the first time and require further investigation. Given that the sample of women was restricted, further research with teens and ethnic minorities would enable more robust findings.

The results were obtained from one urban health board area and may not be considered generalisable to other areas or perhaps rural areas. However there are many aspects that supported findings in studies in the synthesis (see section 8.7) and may well be relevant to a wider population of women and midwives.

Third, with respect to transferability, the limitations of the sample of women therefore did not allow for understanding and joint construction of the meaning of the experiences to the society of women in the population as a whole. As a consequence the descriptions of patterns of cultural and social experiences of initiation of breastfeeding of a true cross section of women cannot be contextualised and therefore these results could be regarded as a “thin description” and of limited transferability (Lincoln & Guba 1985). However in the context of the events in the hospital along with rich description of the women’s and midwives’ experiences being compared in this study there may be relevance to the wider population.

Another strategy to assess credibility is “member checking” where the participants are asked to consider the researcher’s analyses and their reactions are incorporated into the findings. It can be argued that the participant’s version will be different from that of the combined results produced by the researcher (Mays & Pope 2000). “Member checking” was not carried out in the study but at the end of each focus group or interview a broad summary of the process was presented for confirmation of the veracity of the content.

Dependability of the results was addressed in Chapter 5 when an account of the processes and procedures was given. The analysis was innovative in relation to the inductive/deductive strategy and involving Social Cognitive theory in the deductive analysis. This was perhaps ambitious in that it required the inductive findings to be then re-analysed according to the a priori deductive codes. This was however scrutinised at each stage by my supervisors.

The confirmability of the research also depends on the researcher systematically attending to the context of knowledge and how it is constructed and the effect of the researcher on this process (Malterud 2001). This reflexivity is further explored in the next section.

### **8.9 Reflections on the project**

At the outset when planning this study my research experience was very limited and I had originally intended to design a complex intervention to help women initiate breastfeeding and the midwives supporting them. The intricacies of planning a complex intervention became apparent and it was evident that taking a positivist stance combined with an interpretive aspect in the evaluation would be very challenging. I recognised that there was a gap in the understanding of initiation and there was a real need to explore this issue in order to ensure that an intervention could be more comprehensively developed.

After exploring design options, I decided a qualitative design would afford me training and appreciation of a methodology that could contribute to a process evaluation of a future social intervention. I then explored the theoretical perspectives associated with qualitative research. A pragmatic approach to data collection and analysis was decided but a choice of theoretical model was considered which would be best suited to explain behaviour. After examining a number of theories of behaviour change models, the range of concepts involved in Social Cognitive Theory was considered most applicable to contribute to the understanding of both mothers' and midwives' experiences, both in anticipation of and during the initiation of breastfeeding.

I participated in a variety of training opportunities, for example running focus groups, qualitative interviews and computerised handling of qualitative data. Most training

though has been achieved by the support from my supervisors. The conduct of focus groups was more challenging than I had anticipated and I was very appreciative of my supervisor's presence.

This was a very complex but rewarding experience. The planning and execution of the study took longer and was more detailed than expected. The same was true for the analysis and organisation of the findings. The whole exercise would have been impossible without the contributions of my supervisors to my, at times, laborious efforts.

### **8.10 Recommendations for clinical practice**

To build on educational progress that has been made, additional effort could be made to educate both midwives and women in relation to specific strategies in order to enable initiation of breastfeeding. The environment where this takes place needs to be considered carefully to ensure that it enables midwives and women to develop reciprocal skills for initiation of breastfeeding.

It is clear from this research that women are unprepared for the reality of initiating breastfeeding and lack opportunities to see this through positive role models. The use of visual aids was well received in the context of this research and therefore offers a promising opportunity to introduce women to the reality of initiating breastfeeding while at the same time could be used postnatally as a prompt to help women recognise pre-feeding behaviour. This would give women and midwives vicarious experience of symbolic modelling through the photographs/cue card.

Specific recommendations are:

- An educational strategy to be put in place to help antenatal women have an outcome expectation of normal instinctive behaviour during skin to skin contact and awareness of the possible problems and solutions at birth when the baby is sleepy or unable to feed for any reason. This may be during antenatal clinics, since only two in five women attended antenatal classes (Health and Social Care Information Centre 2012).
- Heads of service should arrange changes in the environment to allow midwives more time to facilitate instinctive behaviour and that which is

conducive to implementing the Baby Friendly policies. Women should be involved in the discussion of proposed changes in practice. This is necessary in order to make the difference that is needed to significantly increase rates of initiation and duration of breast feeding.

- The current position where sleepy behaviour is considered normal in the hospital environment could be challenged. A more sensitive strategy to accommodate the time that is required for babies to recover from the effects of the labour, analgesia and birth adopted rather than “hands on”. The normal healthy behaviour should be recognised as instinctive behaviour and the mother and baby supported to encourage this for as long as it takes.
- Promotion of a more natural environment for low-risk women where in a midwife-led service women in hospital or at home are more likely to initiate breastfeeding.

### 8.11 Recommendations for research

- It would be desirable to explore further what women expect antenatally in relation to skin to skin contact and instinctive behaviour with their babies at birth.
- The use of photos of instinctive behaviour and the leaflet “Feeding cues at birth” as indirect vicarious experience and the information in the leaflet “Feeding cues after the first few hours” could be the focus of research with women and midwives. This may enable women to realise their outcome expectations of being successful (enactive attainment) with the aim of enabling a longer duration of breastfeeding.
- Research to highlight the barriers for midwives in the implementation of this strategy.
- Hand expressing could be the subject of research of women’s and midwives’ knowledge, skills and attitudes with regard to its use for sleepy but well babies.
- Social Cognitive Theory could be used as a framework to develop strategies and materials to enhance women’s confidence both antenatally and in the postnatal period. However, in order to consider an intervention in future, differing layers of influence should be considered. McLeroy (1988) describes the micro system as face to face interactions, the meso-system as



interrelations in different settings, exo-system as forces in the individuals' social system and macro system as influencing all due to culture and values (McLeroy et al. 1988). This approach is advocated to be important in support and education of women to start and continue breastfeeding for longer (McInnes et al. 2013). An intervention therefore would benefit from consideration of these issues.

- Qualitative research on the initiation of breastfeeding in the groups not able to be recruited – young mothers, more ethnic groups, women with disabilities or who have babies born with a disability. Since this study was one of the first to look specifically at the process of initiation, other qualitative studies are needed to confirm the findings in different hospitals/regions/countries.

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## Appendices

## Appendix 1: Characteristics of reviewed studies: Women's Expectations and Experiences

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(Hoddinott & Pill 1999) September  UK	To explore the infant feeding decision-making process of first-time mothers, using in-depth interviews to document their antenatal expectations and their actual experiences  Relevance to initiation: One of the paper's themes.	Qualitative  Interviews conducted using a topic guide.  21 white primigravid women of lower social class and low educational level were interviewed before antenatal booking. Women recruited initially were older and intended to breastfeed so further purposeful sampling was done to recruit teenage women who intended to bottle feed. 19 of these women were re-interviewed 6-10 weeks after the birth, 4 were still exclusively breastfeeding and 4 partially breastfeeding.	Preparation for Motherhood and infant feeding.  A perceived secrecy about the realities of the first few weeks after birth.  Unmet expectations — feeling a failure.  Support and help-seeking behaviour.  Coping with being a new parent by changing feeding behaviour.
(Thomson & Dykes 2010) UK	To provide a theoretical interpretation of the 'comprehensibility', 'manageability', and 'meaningfulness' of women's experiences of infant feeding.  Relevance to initiation: Topic that ran through the paper.	Qualitative  In – depth interviews  Semi structured interview schedule based on BFI audit and open ended questions.  Using Antonovsky's 'sense of coherence' theory to explain findings.  Purposive sample of 15 women, 12 primigravidae and	'Comprehensibility'  <i>Targeting the information.</i>  <i>The need for consistency.</i>  <i>Where is the choice?</i>  'Manageability'  <i>The birth experience.</i>  <i>'Manhandling' of women's breasts.</i>

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
		<p>3 multigravidae were recruited with a range of feeding experiences at between 4 weeks to 9 months postpartum.</p> <p>All had intended to breastfeed and at interview 9 were exclusively breastfeeding, 1 was mixed feeding and 4 were formula feeding. One woman was feeding expressed breastmilk via a bottle.</p>	<p><i>Personal support systems.</i></p> <p><i>The value of time and accessibility of support.</i></p> <p><i>Benefits and barriers to peer support.</i></p> <p><i>'Meaningfulness'</i></p> <p><i>Encouraging and not dissuading. Theoretical vs embodied knowledge.</i></p> <p><i>Media messages and public breastfeeding.</i></p> <p><i>Emotionality of infant feeding.</i></p>
<p>(Entwistle Kendall &amp; Mead 2010)</p> <p>UK</p>	<p>To present findings of qualitative interviews and to explore the experiences described by the women from low income groups within the explanatory framework of the self-efficacy theory (Bandura,1982)</p> <p>Relevance to initiation: One of the paper's themes.</p>	<p>Qualitative</p> <p>Part of a larger study concerned with breastfeeding outcomes for low-income women.</p> <p>In depth open ended interviews between 10 and 18 weeks post natal.</p> <p>Using Bandura's self efficacy theory to interpret themes.</p> <p>Purposive sample from 204 women in main study.</p> <p>7 women from low -income areas were interviewed between 10-18 weeks postnatal. Only 2 women were still breastfeeding at the time of the interview.</p> <p>3 primigravidae and 4 multigravidae.</p>	<p>Breastfeeding related to women's self confidence.</p> <p>The social environment.</p> <p>Knowledge of breastfeeding.</p> <p>The influence of maternity services on breastfeeding outcomes.</p> <p>Mastery, vicarious experience, verbal persuasion, emotional arousal.</p>

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(Ryan Todres & Alexander 2011)  UK	To reunify the embodied aspects of breastfeeding with the –socio-cultural-linguistic aspects to develop a material - discursive approach to the embodied and emotional dimensions of breastfeeding that incorporates sociolinguistic analysis with material being.  Relevance to initiation: Topic that ran through the paper.	Qualitative  Semi structured narrative constructing interviews video recorded.  49 women who were breastfeeding or had done so in the last 2 years. Women with a range of ages, educational qualifications, ethnicity and breastfeeding experiences etc were recruited to have maximum variation in the sample	The interembodied experience of breastfeeding.  A fundamental interdependence between the woman and her baby.  3 dimensions of this interembodied experience labelled:  Calling, Permission, Fulfillment.  Natural Science, Social Science and Existential Phenomenology
(Wambach & Cohen 2009)  USA	To examine urban adolescent mothers' breastfeeding experiences to fill this evidence gap by providing description from a contemporary American perspective.  Relevance to initiation: One of the paper's themes.	Qualitative descriptive design.  Focus groups and individual semi structured interviews. Questions re Kruger and Casey (2000), introductory, transition, key and ending questions.  23 teenage women who were currently breastfeeding or had breastfed in the last 6 months.  Ages 14 – 18 all except one were primiparae.  4 still exclusively breastfeeding, 9 giving breastmilk and formula and 10 had stopped at the time of the interview.	Prenatal Phase—Breastfeeding Decision Making.  Breastfeeding Initiation.  Positive Experiences After Hospital Discharge.  Problem Experiences After Hospital Discharge.  Support.  Continued Breastfeeding.  Weaning.  Timing of decision to breastfeed: all continuing had made decision to breastfeed early in pregnancy.

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(Dykes et al. 2003)  UK	To explore the experiences and support needs of adolescent mothers who commence breastfeeding.  Relevance to initiation: Topic that ran through the paper.	Qualitative  Focus groups  In- depth semi structured interviews  Focus groups  7 teen participants 6 were primigravidae and 1 was multiparous and had breastfed from 4 days to 5 months. Ages 16-19.  Interviews  13 teenage participants 12 primigravidae and 1 was multiparous.  8 stopped breastfeeding at 2 weeks, 1 at 3 weeks and 4 were still breastfeeding at 6 weeks. Ages 14 -19.	Focus groups to explore breastfeeding experiences:  Feeling Watched and Judged.  Lacking Confidence.  Tiredness.  Discomfort.  Sharing Accountability.  Interviews explored the support needs:  Emotional Support.  Esteem Support.  Instrumental Support.  Informational Support.  Network Support.
(Tucker Wilson & Samandari 2011)  USA	To investigate breastfeeding practices, barriers and facilitators among adolescent mothers ages 17 and younger.  Relevance to initiation: One of the paper's themes.	Quantitative  State level survey of women who deliver live born infants.  Qualitative  Semi structured interviews using the  Theory of Planned Behaviour.	Quantitative: 52% (196 of 389) initiated breastfeeding but at 1 month only a quarter continued to breastfeed and only 17% breastfed exclusively for 4 weeks.  Qualitative:  17 out of 22 participants initiated breastfeeding. 8 of 17 fed longer than 4 weeks but many also supplemented with formula or expressed breastmilk.  Barriers to breastfeeding:  Physical discomfort.  Difficulty latching on.

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
		<p>Quantitative: 11,567 mothers participating in 6 years of a state level survey of women who deliver live born infants.</p> <p>Qualitative: 22 Adolescent primigravid mothers 13-17 old. Purposive sampling to have maximum variation in urban/rural mix, ethnic group and variety of views and experiences</p>	<p>Concern about insufficient milk.</p> <p>Returning to school.</p> <p>Influences on initiation and continuation:</p> <p>Health care professionals.</p> <p>Family.</p> <p>Peers and partners.</p>
(Mozingo et al. 2000)  USA	<p>To investigate the lived experience of women who initiate breastfeeding but stop within the first 2 weeks.</p> <p>Relevance to initiation: Main topic of the paper.</p>	<p>Phenomenology</p> <p>Open-ended question to start then questions evolve.</p> <p>9 women who had initiated breastfeeding but stopped at 2 weeks.</p> <p>Graduates from high school to college, 7 primigravida, 2 had one child before one of whom had tried to breastfeed before.</p>	<p>Idealized Expectations.</p> <p>Clash with reality.</p> <p>Personal feelings of discomfort.</p> <p>Inadequate/ inappropriate assistance.</p> <p>Incremental disillusionment and cessation of breastfeeding.</p> <p>Relief versus guilt/shame/sense of failure.</p> <p>Lingering self doubts versus resolution.</p>
(Kelleher 2006)  USA	<p>Original study, women's experiences of postpartum care.</p> <p>This analysis</p> <p>Examines women's experiences associated with pain and discomfort associated with breastfeeding.</p> <p>Relevance to</p>	<p>Qualitative comparative sociological study on women's experiences of postnatal care.</p> <p>Semi- structured in- depth interviews.</p> <p>60 women approx 5 weeks postpartum.</p>	<p>Focus on women who discussed pain soreness and /or discomfort in relation to their breastfeeding experience.</p> <p>Themes</p> <p>No one tells you.</p> <p>Sore as hell.</p> <p>Scared of the pain.</p>



Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
	initiation: Topic that ran through the paper.	<p>30 women from Toronto and 30 from Boston from variety of socio-economic and ethnic backgrounds 62% were primigravida.</p> <p>This analysis was based on the subsets of women 52% or 87% who breastfed for any length of time after birth and focuses on 33 women who breastfed.</p> <p>Majority still breastfeeding and of these more than half exclusively.</p>	<p>Really intimidating.</p> <p>Packing it in or coping</p>
(Bradfield 1996)  NZ	<p>To hear women's accounts of their breastfeeding experiences following childbirth and to examine influences on those experiences.</p> <p>Relevance to initiation: Topic that ran through the paper.</p>	<p>Qualitative</p> <p>Semi – structured interviews when the baby was 6 weeks old or less. A second interview was done after the women read the transcript of the first interview. A final meeting was held as a group to discuss changes they wanted made to the draft report.</p> <p>A feminist methodology was used and feminist poststructuralist theory as a framework to study discourses related to women's experiences of breastfeeding.</p> <p>6 primiparous women who identified as having had some problems breastfeeding. This ranged from temporary sore</p>	<p>Knowledge of breastfeeding: Knowledge of mothers, sisters and friends.</p> <p>Knowledge of midwives, nurses, lactation consultants.</p> <p>Knowledge of the experts.</p> <p>Women's own knowledge.</p> <p>Women's knowledge in conflict with the staff.</p> <p>Power and control.</p>

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
		nipples to the baby not attaching.	
(Vogel & Mitchell 1998) NZ	<p>To gain an understanding of a) the influences perceived by mothers and health care workers to be important in determining the establishment of breastfeeding.</p> <p>b) experiences with and attitudes to the use of bottles and the alternative methods of feeding.</p> <p>Relevance to initiation: Main topic of the paper.</p>	<p>Qualitative</p> <p>Focus groups</p> <p>Saturation sampling.</p> <p>7 groups total of 45 participants.</p> <p>4 Groups of Mothers:</p> <p>Immediately postpartum in hospital, mothers with babies several months old, Pacific Island mothers and mothers involved in La Leche League.</p> <p>Most women had breastfed at least briefly, duration varied between 5 days and 2 years. Mothers had from 1 to 8 children.</p> <p>3 Groups of Health care workers: lactation consultants, midwives, community child health nurses.</p>	<p>Mothers:</p> <p>Antenatal preparation.</p> <p>Initial help.</p> <p>Post operative experiences.</p> <p>Attitudes to bottles.</p> <p>Hospital environment.</p> <p>Time of discharge.</p> <p>Alternative care.</p> <p>Early problems.</p> <p>Health care workers:</p> <p>Labour and delivery.</p> <p>Early feeds.</p> <p>Nursing care in hospitals.</p> <p>Methods of assistance.</p> <p>Time of discharge.</p> <p>Bottle feeding.</p> <p>Alternative feeding methods.</p> <p>Hospital environment.</p>

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(Hong Callister & Schwartz 2003)  USA	To gain insights into the perceptions of first-time mothers regarding nurses' support of breastfeeding.  Relevance to initiation: Topic that ran through the paper.	Phenomenology  An hour long interview which continued until information became repetitive and the data were fully explored.  20 married primiparous women who had initiated breastfeeding.  2 women had discontinued exclusive breastfeeding at time of interview 48 hours after the birth.  Education ranged from completion of high school to 1 <sup>st</sup> year of graduate school. Sample reflected demographics of the state.	Emotional Support by Nurses. Informational Support by Nurses. Tangible Support by Nurses. Non supportive Behaviours by Nurses.
(McGrath & Philips 2009)  AUS	To explore, from mothers' perspectives, the experiences and decision making associated with a subsequent birth following a Caesarean Section. This paper focuses on the mother's experiences of feeding their newborns following the birth.  Relevance to initiation: Main topic of the paper.	Iterative phenomenological qualitative research methodology using open-ended interviews.  Phenomenological reflection principles were followed.  20 women 6 weeks after the birth. All had a previous caesarean section and the current deliveries were 2 vaginal births, 2 attempted vaginal births, and 16 elective caesarean sections.	Group 1. Strong desire to breastfeed. Group 2. Decision not to breastfeed from the start. Group 3 Quickly turned to bottle feeding when faced with obstacles. Groups 2 and 3 Bottle feeding seen as easier and more convenient option. Factors associated with the experience of a CS that impact on breastfeeding.

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(Avery et al. 2009) USA	<p>To identify the processes contributing to breastfeeding decisions among Caucasian and African American women.</p> <p>Larger study commissioned by US Dept of Health of which the above aspect is reported here.</p> <p>Relevance to initiation: Main topic of the paper.</p>	<p>Qualitative</p> <p>Focus groups and semi structured interviews.</p> <p>The transcripts of the 24 groups were made available after the main study findings were analysed.</p> <p>Modified grounded theory followed by constant comparative analysis.</p> <p>Activities used in both methods of data collection.</p> <p>12 groups of pregnant women or women who hoped to be pregnant in the next 12 months and 6 groups each of formula and breastfeeding mothers.</p> <p>Women had a range of incomes and education and were first time mothers.</p>	<p>Confidence in the Process of Breastfeeding and in One's Ability to Breastfeed.</p> <p>Commitment to make breastfeeding work despite challenges or lack of support.</p>

## Appendix 2: Characteristics of reviewed studies: Midwives' Experiences

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(West & Topping 2000) UK	<p>The aim of this study was to explore with midwives their perceptions of the use of the policy (BFI) in practice.</p> <p>Relevance to initiation: Main topic of the paper.</p>	<p>Qualitative Focus groups</p> <p>1<sup>st</sup> Focus group 5 hospital based midwives. 2<sup>nd</sup> Focus group 5 community based midwives.</p> <p>A purposive convenience sample of midwives all with &gt; 3 years experience and from basic grade to more senior roles, was recruited to reflect promotion of 'Baby Friendly' in both community and hospital.</p>	<p>Themes: 'I know from my own experience...' Prioritizing</p>
(Walsh & Downe 2011) AUS	<p>The primary intention for Stage One was to examine the attitudes and directives held by hospital staff towards</p> <p>BFHI accreditation, later to be confirmed or not by the Third Stage of the project.</p> <p>Relevance to initiation: One of the paper's themes but ran through the paper.</p>	<p>Qualitative Focus groups</p> <p>10 questions to BFI accredited hospital groups. 11 questions to non BFI accredited hospital groups.</p> <p>31 in total, maternity and medical staff from senior administrative education and clinical positions.</p> <p>94% had between 11 and 30 years experience since qualifying. 25% were qualified lactation consultants.</p>	<p>Theme 1. Participant's Understandings Differed. Theme 2. Preconceptions and Mothers' Choices. Theme 3. The Accreditation Process. Theme 4. Intra-Organisational Difficulties Achieving BFHI Accreditation. Theme 5. Implementing the Ten Steps. Theme 6. Bottle Feeding Culture. Theme 7. Continuation of Breastfeeding and Employment.</p>

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(Reddin Pincombe & Darbyshire 2007) AUS	<p>What factors, in relation to the BFHI 10 steps to successful breastfeeding, influence the development of breastfeeding support practice for beginning practitioner midwives?</p> <p>Relevance to initiation: One of the paper's themes but ran through the paper.</p>	<p>Qualitative</p> <p>Longitudinal study used critical incident technique for a series of 3 semi-structured interviews with each participant.</p> <p>Bandura's social learning theory.</p> <p>17 graduating midwifery students who rotated through all maternity areas 8 of whom had breastfed their own babies and 9 had never breastfed.</p>	<p>Findings were recounted under the headings of steps 1-10 of BFHI</p> <p>Abstract summary:</p> <p>Participants highlighted experiences such as time pressure and the established clinical practices of experienced midwives that undermined their commitment to the BFHI 10 steps.</p> <p>Outdated practices by senior midwives and passive resistance to the BFHI 10 steps were commonplace even in participating hospitals which were BFHI accredited.</p>
(Dykes 2005) UK	<p>To explore the nature of interactions between midwives and breastfeeding women within postnatal wards.</p> <p>Relevance to initiation: One of the paper's themes but ran through the paper.</p>	<p>Critical ethnographic design.</p> <p>Participant observation of 97 encounters between midwives and postnatal women where breastfeeding was discussed.</p> <p>Focused interviews with 106 postnatal women and 37 with midwives.</p> <p>39 midwives (1 male), who, in site 1 most worked in teams in hospital. In site 2, most were in teams but some practiced more in hospital and others more on community.</p> <p>Their experience ranged from being newly qualified to having 25 years experience.</p> <p>61 postnatal women who were admitted to the postnatal ward and had commenced</p>	<p>The interactions between midwives and women were encompassed by the global theme of Taking time and touching base.</p> <p>Five organising themes: Communicating temporal pressure. Routines and procedures. Disconnected encounters. Managing breast feeding. Rationing information.</p>

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
		breastfeeding. 40 primigravida, 21 multipara, from high to low socio-demographic groups. 48 had normal births 11 had instrumental and 13 had caesarean sections.	
(Weddig Baker &Auld 2011)  USA	To assess the variation in breastfeeding knowledge and practices of registered nurses in hospital, women  and family-care units, and the informal and formal hospital policies related to the initiation and support of breastfeeding.  Relevance to initiation: One of the paper's themes but ran through the paper.	Qualitative  Focus groups  Used (Krueger) and Casey (2000) to develop and analyse data.  Purposeful 2x2 cross section sample of 40 qualified nurses from 8 hospitals, to compare large to small hospitals and high socioeconomic status to low socioeconomic status hospitals. 1 hospital had the BFHI award and several more were in the planning stages.  Nurses were working in neonatal or labour ward, recovery, postnatal or a combination of labour/recovery/postnatal	Hospital Policy.  Nurses Knowledge and Practices.  Topics: Initiation policies. Skin to skin and initiation within first hour of life. Breast milk only. Rooming in. Pacifier use. Patient education. Documentation.
(Furber & Thomson 2007)  UK	To explore midwives views and experiences of providing newborn feeding support.  Relevance to initiation: One of the paper's themes but ran through the paper.	Qualitative.  Grounded Theory  Unstructured interviews  30 midwives. 21 worked in hospital, 6 in community, 2 worked in both hospital and community and 1 who was a manager and not clinically based.  Their experience ranged from 8 months to 31 years.	Themes:  Demands on time.  Coping with newborn feeding in the hospital: Rationing time, Rationing of resources.

Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
(Vogel & Mitchell 1998) NZ	<p>To gain an understanding of a) the influences perceived by mothers and health care workers to be important in determining the establishment of breastfeeding.</p> <p>b) experiences with and attitudes to the use of bottles and the alternative methods of feeding.</p> <p>Relevance to initiation: Main topic of the paper.</p>	<p>Qualitative</p> <p>Focus groups</p> <p>Saturation sampling.</p> <p>7 groups total of 45 participants.</p> <p>4 Groups of Mothers:</p> <p>Immediately postpartum in hospital, mothers with babies several months old, Pacific Island mothers and mothers involved in La Leche League.</p> <p>Most women had breastfed at least briefly, duration varied between 5 days and 2 years. Mothers had from 1 to 8 children.</p> <p>3 Groups of Health care workers: lactation consultants, midwives, community child health nurses.</p>	<p>Mothers:</p> <p>Antenatal preparation.</p> <p>Initial help.</p> <p>Post operative experiences.</p> <p>Attitudes to bottles.</p> <p>Hospital environment.</p> <p>Time of discharge.</p> <p>Alternative care.</p> <p>Early problems.</p> <p>Health care workers:</p> <p>Labour and delivery.</p> <p>Early feeds.</p> <p>Nursing care in hospitals.</p> <p>Methods of assistance.</p> <p>Time of discharge.</p> <p>Bottle feeding.</p> <p>Alternative feeding methods.</p> <p>Hospital environment.</p>
(Henderson Pincombe & Stamp 2000) AUS	<p>To explore midwives understanding and practices in positioning and attachment of a newborn infant at the breast in order to identify patterns of breastfeeding care following childbirth.</p>	<p>Qualitative</p> <p>Focus groups</p> <p>Structured and sequenced trigger questions used as a discussion guide.</p>	<p>Education: a) rationale, b) timing, c) information, d) clients, e) process.</p> <p>Problem solving.</p> <p>Support.</p> <p>Midwives' views about breastfeeding.</p>



Author, year, country	Author's Aim and relevance to initiation	Methods and sample	Authors Findings- main themes
	<p>Relevance to initiation: Main topic of the paper.</p>	<p>18 midwives (1 male) who had worked in postnatal wards for at least a year.</p> <p>77.8% &gt; 10 years postnatal experience.</p> <p>72% had personal experience of breastfeeding. All had breastfeeding education.</p> <p>4 focus groups</p>	<p>Influences on midwives' practices.</p>

### Appendix 3: Quality appraisal of papers: Women and Midwives – after CASP

Author	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Comments	Assessment of quality: Meets all the criteria Meets most Meets few
(Hoddinott & Pill 1999) September	y	y	y	y  Considered but maybe leaves questions	y	y	y	Probably this is quite a ground breaking and important study.	Meets most.
(Thomson & Dykes 2010)	y	y	y	n	y	y	y  Role modelling suggested	An interesting study using an unfamiliar theory making it more challenging to understand.	Meets most.
(Entwistle Kendall & Mead 2010)	y	y	y	y	y	y	y  Role modelling suggested	Very useful to expand the use of self efficacy theory.	Meets all the criteria.
(Ryan Todres & Alexander 2011)	y	y	y	n	y	y	y	Inter embodied phenomenon of breastfeeding	Meets most.

Author	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Comments	Assessment of quality: Meets all the criteria Meets most Meets few
(Wambach & Cohen 2009)	y	y	y	y	y	y	y		Meets all the criteria.
(Dykes et al. 2003)	y	y	y	n	y	y	y		Meets most
(Tucker Wilson & Samandari 2011)	y Used both quantitative and qualitative methods	y	y	n	y Study part of a State wide monitoring system	y	y		Meets most
(Mozingo et al. 2000)	y	y	y	y Bracketing interview before study	Y	y	y	A very moving and influential study.	Meets all the criteria.
(Kelleher	n	y	n	n	n	n	y	Important emergent	Meets few.

Author	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Comments	Assessment of quality: Meets all the criteria Meets most Meets few
2006)	Aim was not clear as the study was based on a subset of total women interviewed		Not clear		Not mentioned	Not clear		material from a larger study	
(Bradfield 1996)	y	y Focus was on women who had difficulties	y	n	n Not mentioned	n Very brief account of the analysis	y		Meets few.
(Hong Callister & Schwartz 2003)	y	y	y	y	y	y	y		Meets all the criteria.
(McGrath &	y	y	y	y	y	y	y	It is a bit confusing as	Meets all the

Author	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Comments	Assessment of quality: Meets all the criteria Meets most Meets few
Philips 2009)								to why Caesarean section was involved	criteria.
(Avery et al. 2009)	y	y  This was part of a US Dept. of Health and Human Services study	y	n	y	y	y	Highlights how important confidence is in relation to breastfeeding	Meets most.
(West & Topping 2000)	y	y	y	n	y	n  Not clear	y	Quite frank statements from the staff	Meets most.
(Walsh & Downe 2011)	y	n  Not sure that staff had a choice	y	n	y	y	y		Meets most.
(Reddin Pincombe & Darbyshire	y	y	y	n	y	y	y		Meets most.

Author	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Comments	Assessment of quality: Meets all the criteria Meets most Meets few
2007)									
(Dykes 2005)	y	y	y	n	y	y	y		Meets most.
(Weddig Baker &Auld 2011)	y	y	y	n  This was suggested but not clear	y	y  Very brief description but did establish inter-rater reliability	y	Very clear results	Meets most.
(Furber & Thomson 2007)	y	y	y	y	y	y	y	Thoughtful and provokes thought for improvement	Meets all the criteria.
(Vogel & Mitchell 1998)	y	y	y	n	y	n	y	Useful information	Meets most.

Author	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Comments	Assessment of quality: Meets all the criteria Meets most Meets few
		Very brief description				Only one line about the analysis			
(Henderson Pincombe & Stamp 2000)	y	y	y	n  Researcher was not perhaps known to the participants	y	y	y	Very useful specific information.	Meets most.

Key: yes =Y, no = n

#### Appendix 4: Comments by authors and quotations from participants: Breastfeeding going well

Author and themes	Author comments	Quotes from participants	Subthemes
(Ryan Todres & Alexander 2011)  The interembodied experience of breastfeeding.  A fundamental interdependence between the woman and her baby.	The dimension of calling was characterised by a non-verbal communication between mother and baby----  It could be described as basic and primordial, especially in the moments following an uncomplicated birth.	<i>“I had this incredible, immediate, intense bond with my baby, and I’m so lucky that that happened”.</i>	Facilitation of instinctive behaviour
Fulfillment	The women described it in terms of the closeness, comfort, and bodily compatibility of successful breastfeeding	<i>“He just latched straight away, and I just remember holding him and just feeling him, and stoking him and looking at him, and just you know having that wonderful magical bonding experience and, just that sort of lovely suckling feeling and, I think he fed for quite some time then just fell asleep. And it was very, very lovely, calm and soothing”.</i>	Facilitation of instinctive behaviour
(Entwistle Kendall & Mead 2010)  The influence of maternity services on breastfeeding outcomes	She said to the midwife	<i>“Shall I breastfeed her now?” and they said “no leave her, she’s fine, not yet”---- I managed to latch her on okay myself after reading book after book for 9 months and determined to do it and she latched on immediately and took to it immediately”.</i>	Commitment/ perseverance



Author and themes	Author comments	Quotes from participants	Subthemes
(Ryan Todres & Alexander 2011)  Permission		<i>"a newborn doesn't know how to feed; you've got to learn together".</i>	Commitment/ perseverance
(Avery et al. 2009)  Commitment to make breastfeeding work despite challenges or lack of support.	Only breastfeeding mothers and some pregnant women made statements that reflected "confident commitment." Breastfeeding	<i>"I was discouraged to want to breastfeed. My mom was like, "You're not going to be able to leave the house." And I was like, "If there's a will, there's a way". (breastfeeding mother)</i>	Commitment/perseverance
(Ryan Todres & Alexander 2011)  Permission	Some women were able to create their own permissive space for breastfeeding	<i>"I went home and I sorted it out myself--- just sat in bed with my baby and spent some time getting to know her, and just doing it".</i>	Commitment/perseverance
(Dykes et al. 2003)	Visual information was particularly helpful, for example, several mothers had watched a recent program about the BfN support facilities broadcast on local television. The visual content of this was highly relevant:	<i>"You can actually see them doing it on telly, so you know they're not just saying it".</i>	Role modelling

Author and themes	Author comments	Quotes from participants	Subthemes
Network Support.	<p>At the time of the interviews (6 to 10 weeks following the birth), the adolescent mothers' strongest source of support came from their own mothers and families. When the mother's mother had breastfed, this was particularly strong:</p> <p>Indeed, most of the adolescents' mothers had breastfed and most had observed breastfeeding within their immediate or extended family during their childhood, so within the microculture of their family, there was a degree of normalization of breastfeeding.</p>	<p><i>"I wanted my mum around because she's breastfed "two children herself. . . . I can remember her feeding my youngest brother".</i></p>	Role model
(Bradfield 1996)  Knowledge of breastfeeding.	<p>The knowledge of mothers sister and friends was accepted and valued. They provided role models who could be watched and/or whose breastfeeding experiences could be reflected on.</p>	<p><i>"I've got so many relations and cousins who have babies I sort of watch them".</i></p>	Role models
(Entwistle Kendall & Mead 2010)  Breastfeeding related to women's self confidence.	<p>For some women breastfeeding was central to the task of being the prime caregiver. ----</p>	<p><i>"I think if you just put him up against here, he drifts off because that's his zone. They say they can smell the milk as well so he knows it's on hand somewhere so he goes to sleep".</i></p>	Positive achievement

Author and themes	Author comments	Quotes from participants	Subthemes
(McGrath & Philips 2009)  Group 1.Strong desire to breastfeed.	The mothers in the first group strongly expressed views that they considered breastfeeding a positive experience that helped to address a sense of disappointment associated with a birth by CS.	<i>"Yes, so if nothing else I have that. So I'm happy about that [laughs]"</i> .	Positive achievement
(Entwistle Kendall & Mead 2010)  The influence of maternity services on breastfeeding outcomes	Conversely L felt supported by the midwives ---and was given practical support	<i>"I thought he was latching on all right but he wasn't and she showed me how to do that and it was fine"</i> .	Supportive help
(Wambach & Cohen 2009)  Breastfeeding Initiation	Positive support from nurses, partners, family, and friends came via hands-on assistance and information regarding problems.		Supportive help
Support	Early support came from nurses, the teen's mother, father of the baby, and other family and friends. They helped with technique, teaching, and encouragement.	<i>"The nurse who was here, she helped her really to latch on. And plus my boyfriend helped me out a lot with that"</i> .	Supportive help
(Bradfield 1996)  Knowledge of breastfeeding.	Midwives and others--- are referred to by the women in a similar way to which they refer to their sisters and mothers and friends. They offered information as well as practical support and demonstration so that the women learned to do it for themselves.	<i>"The nurses are really good. They helped out quite a lot as to how to hold the child and how to position it and what to expect"</i> .	Supportive help

Author and themes	Author comments	Quotes from participants	Subthemes
(Hong Callister & Schwartz 2003)  Emotional support by nurses	Because correct positioning of the neonate, as well as proper latch-on from the start, are vital to future breastfeeding success, nurses' presence during the first few feedings was viewed as strongly supportive.	As one participant stated, <i>"I had already read a lot about the different positions and everything. But, in the moment, you always forget, so it is better that a nurse is there"</i> .	Supportive help
	The emotional support mothers received was identified in diverse nursing behaviors. Emotional support was significant to the mothers' breastfeeding experiences in the hospital and was distinctly recalled. Calming <b>reassurance</b> was described.	One mother reflected, <i>"I probably would have started bottle-feeding him if they hadn't have been [saying], it's okay, he's not starving"</i> .  One mother recalled, <i>"The thing that helped me most was when they'd say... 'you've got to just be patient...this is her first time doing it. She doesn't know what you or she's doing. You don't know what you're doing. You both have got to teach each other and learn together"</i> .	Encouraging communication
Informational Support by Nurses	Many mothers identified the <b>answering of questions</b> as a significant supportive behaviour.	One mother said, [the nurses] <i>"made sure that I knew what I needed to know"</i> .	Encouraging communication

Author and themes	Author comments	Quotes from participants	Subthemes
(Dykes et al. 2003)  Informational Support.	Information was valued when it was individualized and relevant to the mother's particular dilemmas and situation. The teenage pregnancy coordinator was particularly helpful in that she consistently responded to requests with individually focused practical information and backed this with written sources:	<i>"She came to see me; she said I can express it and she just said she would tell me how to do that and she told me how to do it and gave me a leaflet".</i>	Encouraging communication
Esteem Support	They needed to be praised by significant others and health professionals, and this helped them to feel that they wanted to persevere:	<i>They (midwives) said "you're doing really really well" and that's when I really wanted to persevere".</i>	Encouragement

**Appendix 5: Comments by authors and quotations from participants: When breastfeeding goes wrong at the start – Theme groupings (Women)**

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Entwistle Kendall & Mead 2010) The influence of maternity services on breastfeeding outcomes	The trauma of an emergency caesarean section led J to experiencing increasing feelings of failure. This culminated in her subsequent feelings of failure at not being able to breastfeed successfully.	<i>“It was like everything I’d expected had started to go wrong and then I tried to breastfeed and she didn’t---it just didn’t seem to work---it was like everything crumbled”.</i>	Not latching	Baby behaviour
(Ryan Todres & Alexander 2011) Calling	Calling could be interrupted by a number of factors, particularly separation of a woman and her baby after birth.	<i>“he was too sleepy to breastfeed, so I was giving him my breastmilk through a tube to his stomach, so emotionally that was very difficult”.</i>	Too sleepy	Baby behaviour

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Wambach & Cohen 2009) Breastfeeding Initiation	Four teens reported positive hospital experiences with no problems; the majority experienced some problems, mainly related to learning the mechanics of breastfeeding (e.g., latching (n = 10), positioning (n = 2),		Not latching	Baby behaviour
(Dykes et al. 2003) Esteem Support	In contrast, an unsettled baby undermined confidence. If the mother or midwife gave formula milk, this was particularly undermining to breastfeeding:	<i>"I thought well she's sleeping now, when I feed her she's not. . . . She was just screaming when I put her near"</i> .	Baby screaming	Baby behaviour
(Tucker Wilson & Samandari 2011) Difficulty latching on	Five participants encountered difficulty establishing breastfeeding and getting the baby to latch on. Three teens attributed their infants' struggles in latching on to the fact that their babies were born "small" or low birth weight.		Not latching	Baby behaviour

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	Two participants believed that their babies had trouble breastfeeding because they had been given a pacifier and formula by hospital staff before breastfeeding.		Supplements	Staff aspects
(Mozingo et al. 2000)  Clash with reality.		<i>"I expected it to be automatic---I really wanted to do it. But I just felt like I couldn't do it---She would fall asleep while she was feeding—and I didn't feel she was getting enough milk and it was just ---it just wasn't working".</i>	Sleepy baby	Baby behaviour
Incremental disillusionment and cessation of breastfeeding	The women described in great detail the steps leading up to the cessation of breastfeeding.	<i>"It would take 15 minutes to get him latched on. My milk finally did come in. It just never really let down. I had a lot of trouble doing it. I was real emotional right after having the baby and my iron was real low. She didn't know how to feed (baby)</i>	Not latching  Not latching and screaming	Baby behaviour  Baby behaviour



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
		<i>And the baby was screaming and screaming and screaming----and she would take her little hands and just sort of push me away--- that made me feel rejected”.</i>	Rejection	
(Kelleher 2006)  Packing it in or coping	A first-time mother, Diane, explained how feeling generally weak after birth and wanting to be a good caretaker for her baby led to her decision to bottle feed her son:	<i>“When they brought him to me a few hours after he was born, I tried the breastfeeding, and he couldn’t latch on properly”- ---- And I felt that I couldn’t give him my best if I did try breastfeeding him, because I’d get too exhausted”.</i>	Not latching	Baby behaviour
(McGrath & Philips 2009)  Factors associated with the experience of a CS that impact on breastfeeding.	Secondly, by the time the baby was given to the mother for the first breastfeed, the baby was in a stressed state:	<i>“and I tried to feed her but she was screaming so”.</i>	Baby screaming	Baby behaviour

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Avery et al. 2009)  Confidence in the Process of Breastfeeding		<i>"At first, when I went in, I wanted to breastfeed. Then she got used to the bottle". (formula-feeding mother)</i>	Not latching	Baby behaviour
(Hoddinott & Pill 1999) September  A perceived secrecy about the realities of the first few weeks after birth	Women committed to breastfeeding had the greatest mismatch between their antenatal expectations and reality.	<i>"Nobody really tells you beforehand how demanding it is going to be and I think if I had known, I would have been better equipped to have dealt with it".</i>	Mismatch between antenatal expectations and reality	Expectations
Unmet expectations — feeling a failure	Women with unmet expectations often lost confidence and were more likely to complain about inappropriate support and conflicting advice from family and health professionals.	<i>"But you just don't have any individual time with any of the midwives after birth, they're extremely overworked and I really did want to breastfeed but — I just didn't know what to do".</i>	Unmet expectations	Expectations

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Thomson & Dykes 2010)  “comprehensibility”  Targeting the information	Women regarded the advice on positioning and attachment for breastfeeding as “technical” and dissonant with their expectations of natural feeding	<i>“the way they are showing you how to do it, it sounds so technical.”</i>	Unexpected differences in feeding technique	Expectations
“manageability”  The birth experience.	Most of the women who had not sustained breastfeeding or who had difficulties initiating breastfeeding had not had a vaginal birth. The majority of women who experienced medical interventions/complications during the birth did not have skin to skin contact.	Some of these women felt “cheated” and “robbed” by not experiencing---skin to skin contact	Effects of operative delivery	Expectation
The value of time and accessibility of support.	A recurrent theme within the women’s stories was the value of time to provide them with the support they needed to succeed at breastfeeding.	<i>“X (health professional) said when she wakes up buzz me, I buzzed for 2 hours nobody came”.</i>	Unmet expectations	Expectation

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
<p>(Entwistle Kendall &amp; Mead 2010)</p> <p>The influence of maternity services on breastfeeding outcomes</p>	<p>The trauma of an emergency caesarean section led J to experiencing increasing feelings of failure. This culminated in her subsequent feelings of failure at not being able to breastfeed successfully.</p> <p>According to Bandura, these findings can be explained in terms of emotional arousal.</p> <p>Where women had these experiences their self-efficacy expectations in relation to breastfeeding seemed to be negatively affected.</p>	<p><i>"It was like everything I'd expected had started to go wrong and then I tried to breastfeed and she didn't---it just didn't seem to work---it was like everything crumbled".</i></p>	<p>Unexpected events</p> <p>Not latching</p>	<p>Expectation</p> <p>Baby behaviour</p>
<p>(Ryan Todres &amp; Alexander 2011)</p> <p>3 dimensions of this interembodied experience labelled:</p> <p>Calling</p>	<p>Calling could be interrupted by a number of factors, particularly separation of a woman and her baby after birth.</p>	<p><i>"My first child was delivered by C/S and he was in NICU for 10 days and I did not have access to him for about 3 days----".</i></p>	<p>Separation</p>	<p>Expectation</p>

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Wambach & Cohen 2009)  Breastfeeding Initiation	and/or nipple problems such as nipple or pain (n = 3) and inverted nipples (n = 2). Three mothers reported their baby not eating or getting enough and weight loss. Teens who initially had “infant intake” problems often supplemented their newborns with formula.		Pain	Expectations
(Mozingo et al. 2000)  Idealized Expectations	The first theme to emerge from the interviews was one of idealised expectations for one’s own performance, the infant’s behaviour, and what the process of learning to breastfeed would be like.	<i>“I had envisioned how easy and wonderful and natural it would be.  I just thought it would come naturally, that it was just something that everybody did and there was never any rejection—I just expected it to be automatic.  I wanted this to be right”.</i>	Idealised expectation	Expectations

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	Another mother described the expectations she had based on seeing a friend breastfeed her infant for the first time.	<i>“And I kept thinking back to this day. I was there when she first put him up to breast—and I was like “Oh this is going to be so simple, you know. It’s just natural”.</i>	Idealised expectation	Expectations
Clash with reality.	All of the participants described some sort of clash between their expectations and the reality of the experience	<i>“I was so excited about it. And the big day came and my child was born and I put him to my breast. And he did nothing”.</i>	Mismatch between expectation and reality	Expectations
		<i>“It was a horrible experience ---I would have big bloody blisters on my nipples”.</i>	Pain	Expectations

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
<p>(Kelleher 2006)</p> <p>No one tells you.</p>	<p>First-time mother Cristina captured the general sense of surprise at the physical challenges involved with breastfeeding by explaining that:</p>	<p><i>“no one really tells what the body will feel like.”</i></p>	<p>Unexpected physical effects</p>	<p>Expectation</p>
	<p>For other women, the unexpected nature of physical implications included more generalized pain, soreness and discomfort.</p>	<p><i>“I was surprised at their (after pains) intensity. And I had been warned that they would be worse with the second one, but (it) wasn’t really clear how much worse. But the pain in my breasts, I think it’s just because my nipples were cracked and they were just still sort of healing, like they were still a little bit raw. I think that that’s what it’s from. But no one told me about that”.</i></p>	<p>Pain</p>	<p>Expectation</p>

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Packing it in or coping		<p><i>“And because of how weak I was, and my body, my chest, and my arms were so strained----- I felt that I couldn’t give him my best if I did try breastfeeding him, because I’d get too exhausted.----- So I put him on the bottle right away”.</i></p>	Effects of delivery	Expectation
(McGrath & Philips 2009)  Factors associated with the experience of a CS that impact on breastfeeding.	The mothers listed a number of factors associated with the Caesarean experience which interfered with breastfeeding.	<p><i>“Probably had an effect mainly I felt because it was... I couldn’t breastfeed. Like I tried to breastfeed, I thought that maybe if he would have been put up on me straight away I might have been able to have the skin-to-skin contact and he might have been able to breastfeed”.</i></p>	Delay in contact/separation	Expectation



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Entwistle Kendall & Mead 2010)  Breastfeeding related to women's self confidence.	For others lack of confidence led to an overpowering sense of responsibility that they could not cope with	<i>"I just had this real fear that I wouldn't (be able to) feed her and I'd reject her".</i>	Fear of responsibility	Emotions
(Ryan Todres & Alexander 2011)  Permission	Permission was the term given to the uninterrupted and protected space or environment in which breastfeeding took place. It was the physical, psychological/emotional and social environment that allowed the woman and her baby to acknowledge their mutual calling.  Many women praised the permission to breastfeed that they received in hospital after their baby's birth--- however several spoke of the difficult environment they encountered.	<i>"So the first time the midwife attached (my baby) for me, it felt like I was a bystander watching. This woman kind of shoved my baby on my breast-----I discharged myself----a newborn</i>	Protection of esteem  Commitment/	Emotions

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
		<i>doesn't know how to feed; you've got to learn together".</i>	perseverance	Breastfeeding going well
(Dykes et al. 2003)  Focus groups: Feeling Watched and Judged.	The feeling of being watched and judged related to several contexts. First, there was the sense that older people were watching and judging because they were young mothers. This occurred both in hospital and the wider community:	<i>"I think that you always feel that you're being watched to see whether you're able to look after your baby. It puts you in a position of being so nervous about whether you're doing it right 'cause the older people are looking at what you're doing. They don't expect you to be able to do it because you're so young"</i>	Self consciousness	Emotions

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Lacking Confidence.	The adolescents sometimes expressed a lack of confidence, first in their ability to carry out breastfeeding effectively:	<i>"I don't feel confident . . . what if I'm not doing it (breastfeeding) right. Am I going to make her poorly? I'm worrying about things like that".</i>	Anxiety	Emotions
(Mozingo et al. 2000)  Personal feelings of discomfort.	Statements of being uncomfortable with the act of breastfeeding include:	<i>"I felt like it was draining me. Trying –I was trying to learn to do it---and it was really messy.  I wasn't used to a lot of people looking at me.  I was just not comfortable with it--- and he didn't do exactly what everyone said".</i>	Self conscious	Emotions
Relief versus guilt/shame/sense of failure	For most of the mothers who expressed relief at having stopped breastfeeding the sense of relief was clearly connected to concerns about the infant "getting enough"	<i>"I came to the conclusion that I wasn't producing enough milk".</i>	Insufficient milk	Emotion

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Lingering self doubts versus resolution.	Some women were able to work through their guilt relatively quickly-----for other mothers the process of resolving guilt and recrimination took months or years	<i>“Anyway, it’s funny that even this much later---it still does bother me”.</i>	Guilt	Emotion
(McGrath & Philips 2009)  Factors associated with the experience of a CS that impact on breastfeeding.	When they experienced the common problems associated with establishing breastfeeding such as blisters or bleeding nipples and concerns about quantity and quality of milk supply, the response to these problems was not to persevere but rather to change to the easy option of bottle feeding.	<i>“But he just wasn’t getting enough, my milk wasn’t coming through. And then they suggested to me that I could keep trying and trying and trying and eventually it will come through. But because it was very stressful. Just put him on the bottle”.</i>	Insufficient milk  Lack of commitment	Emotions  Area of need

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Avery et al. 2009)  Confidence in the Process of Breastfeeding	The most frequently mentioned reasons for not breastfeeding among formula-feeding mothers were that they could not produce enough milk, that the milk did not satisfy their baby, that their baby could not latch properly, or that their baby preferred formula and bottles. These were reasons for not initiating breastfeeding as well as for giving it up shortly after the birth.	<i>“My mom said that the breastmilk is the best and they get all of that nourishment, but you still are never sure. If I am giving formula, I know she’s getting 4 ounces. She’s getting this nourishment”. (formula-feeding mother)</i>	Lack of knowledge  Insufficient milk	Area of need  Emotions
(Thomson & Dykes 2010)  Where is the choice?	Information and advice was often covertly relayed. Promotion of “tools” is against the International Code of Marketing of Breastmilk substitutes (WHO, 1981)	<i>“eventually one girl said “I will be back later on” and said “ I have got these (nipple shields) for you”.</i>	Mixed messages	Staff aspect

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Manhandling of women's breasts.	A woman's self-efficacy (confidence) to breastfeed also appeared to be influenced by the "manhandling of her breasts"	<i>"I had hold of X and she (midwife) came to the bedside and got hold of X (son) round the back of the neck, and had hold of my breast and was trying to force the two together if you will. I don't know whether it's because he had a forceps delivery, he was quite tender on his head---- they kept trying, trying, trying".</i>	"Hands on" reduces confidence	Staff aspect
(Entwistle Kendall & Mead 2010)  The influence of maternity services on breastfeeding outcomes	Suzie desperately wanted to breastfeed----at delivery the baby was offered to her straight away.	<i>"This midwife tucked her right up into my nightie and covered her back up and they said it's bonding it's skin to skin which I've never heard of before----- she stayed there for about ten or fifteen minutes----- She was then dressed and she was tidied up".</i>	Ineffective communication	Staff aspect

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Wambach & Cohen 2009)  Breastfeeding initiation	There were a few reports of “negative” nursing support consisting of teens feeling ignored		Ineffective communication	Staff aspect
(Dykes et al. 2003)  Focus groups: Feeling Watched and Judged.	There was also a sense of being stereotyped by health professionals who often assumed that they would be bottle-feeding	<i>“I wasn’t asked how I was feeding. I was asked how many ounces is he having . . . then when I said I was breastfeeding they like looked and said “oh you’re breastfeeding” and I was like . . . “yes” and they said “oh . . . that’s good”.</i>	Poor communication	Staff aspect
Interviews: Emotional Support.	When they described their experiences in hospital, they appeared to feel most cared for when there was continuity of caregiver and least when they experienced what one adolescent (Sandra) referred to as “conveyor belt” care. The latter was characterized by a focus on routines rather than	<i>“At the point I decided to bottle-feed there were midwives on there that I had never met and they didn’t know me. Because I didn’t know them—I just felt uncomfortable asking. So I think if I’d stayed with the other ones I would have carried on”.</i>	Lack of continuity  Poor communication	Area of need  Staff aspect

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	individuals. They felt much more able to ask for information or help when they knew the midwife.			
Esteem Support	The baby's behaviour was a crucial esteem factor. If she or he responded positively to breastfeeding and seemed contented, the mother felt strongly reinforced and tended to describe breastfeeding as coming naturally.	<i>"When they brought her back after they'd fed her, she just slept. I thought well she's sleeping now, when I feed her she's not. . . . She was just screaming when I put her near".</i>	Supplements	Staff aspect
Instrumental Support	The adolescents valued practical support with breastfeeding, particularly with attaching their baby effectively to their breast, but they wanted to be shown how to do it:  They felt unsupported when the midwife rushed off rather than staying for a part or all of the feed:	<i>"She was putting him on for me but not showing me how to do it myself very well" (Lisa).</i>  <i>"They helped me get him on and then they were gone again" (Kerry).</i>	Lack of practical teaching  Lack of support	Staff aspect  Staff aspect



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Informational Support.	The information received was often confusing because the adolescents were exposed to several midwives who gave differing information:	<i>"They would say different things . . . all of them . . . which was confusing".</i>	Inconsistent/ conflicting communication	Staff aspect
(Tucker Wilson & Samandari 2011)  Difficulty latching on	Five participants encountered difficulty establishing breastfeeding and getting the baby to latch on. Three teens attributed their infants' struggles in latching on to the fact that their babies were born "small" or low birth weight. Two participants believed that their babies had trouble breastfeeding because they had been given a pacifier and formula by hospital staff before breastfeeding.		Not latching  Supplements	Baby behaviour  Staff aspects

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Mozingo et al. 2000)  Personal feelings of discomfort.	Women were uncomfortable with being touched by nurses --- gave a very vivid description of their perceptions.	<i>“you know they are trying to grab, grab onto your breast. And trying to get it into his mouth.” Etc. more examples!</i>	Hands on – insensitive/inappropriate	Staff aspects
Inadequate/ inappropriate assistance.	Descriptions of minimal care or teaching were also common.	<i>“They showed me how to put the breast in his mouth but that’s all they really did. So when I came home I didn’t know much about it”.</i>	Lack of practical teaching	Staff aspects
	Early introduction of bottles was singled out as being a significant source of problems in getting breastfeeding started.	<i>“So we gave him formula”.  “I should never have let them give her those bottles of sugar water. I should never have let them give her a pacifier— but at that point I was so naïve”.</i>	Supplements	Staff aspects

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
<p>(Kelleher 2006)</p> <p>Really intimidating.</p>	<p>Annie's description of how the way one nurse helped her breastfeed in the hospital emphasized the physical nature of breastfeeding assistance. For Annie, as well as others, practitioners' demonstrations of breastfeeding involved very direct and uninhibited hands-on intervention. Annie remembered both how helpful and downright physical such intervention felt to her:</p> <p>The evidence shows that women's early experiences of their postpartum bodies are affected by the intervention of health care practitioners.</p>	<p><i>"She showed me how to feed her right down to physically taking my breast and her head and latching the baby onto the breast and they really go to that extent. She did that for me eight times a day, every day that I was there. Even if I had already gotten the knack of it, she would be there just like that, like clockwork. "it can be really intimidating when a woman that you don't know comes in to pinch your nipples. I mean really".</i></p>	<p>Hands on – insensitive/inappropriate</p>	<p>Staff aspect</p>

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Bradfield 1996)  Power and control	Violence would not normally be considered part of breastfeeding in hospital; it is not part of the dominant discourse, but it is part of women's experience.	<i>"They would get the back of his head, they would lift up my dress and they would go shove.----  These midwives were quite violent and aggressive, apart from my own midwife who put him on the breast when he was born".</i>	Hands on – insensitive/inappropriate	Staff aspect
	What is described as "help" is really control--- the women remained powerless and dependent on the staff at every feed.	<i>"When I asked the nurses for help they'd just grab my breast and grab baby and shove him on and it was really sore and I was crying and they said the pain will go away in a little while".</i>	Hands on – insensitive/inappropriate	Staff aspect
(Vogel & Mitchell 1998)  Initial help	Many women felt they had received very inadequate help, especially as first time mothers---there was a perception that staff ratios were inadequate to provide sufficient help.	<i>"Took 3 hours for an answer to the bell".</i>	Staff shortage	Staff aspect

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	Some individual staff were found to be helpful. Others were described as having rammed jammed or shoved the baby on the breast then often having walked away.	<i>"I find that you don't get shown that the nurse rams the baby on and walks away---they don't stay with you".</i>	Hands on – insensitive/inappropriate	Staff aspect
(Hong Callister & Schwartz 2003)  Non supportive Behaviours by Nurses	The study participants also identified non-supportive behaviours that contrasted with the supportive nursing behaviours already described. These non-supportive behaviours had a negative effect on women's breastfeeding experiences. Some nurses failed to offer any assistance with breastfeeding or to simply ask the mothers how breastfeeding was going. These nurses spent the minimal amount of time possible	Some mothers described breastfeeding on their own as "scary" and "overwhelming."	Lack of support	Staff aspect

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	<p>with the mothers. This left mothers feeling insecure about their ability to breastfeed upon leaving the hospital</p>			
	<p>Mothers' desires to breastfeed right after the birth were not met because of failure to inform the mothers of their options.</p>	<p>One mother said, <i>"I just kind of felt a little bit like (the Labor and Delivery nurse) just thought I was supposed to know what to do. She was like, well you can (breastfeed) if you want to...but, she didn't really ask if I needed help or knew what I was doing"</i>.</p>	<p>Lack of support</p>	<p>Staff aspect</p>

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(McGrath & Phillips 2009)  Group 1.Strong desire to breastfeed.	There were descriptions from this group of mothers of being well informed on the topic of breastfeeding. Associated with this was an expressed disappointment that hospital staff did not emphasise enough the negative impact of a CS on breastfeeding; for example:	<i>"I've just read so much... But there's certain things that sometimes, I guess, like breastfeeding issues that they don't often tell you it can be harder to do when you've had a caesarean".</i>	Lack of anticipatory guidance	Staff aspect
(Hoddinott & Pill1999)  Preparation for Motherhood and infant feeding	Infant feeding was least problematic for women with high levels of antenatal exposure to their chosen method. Most women initiating breastfeeding had low levels of exposure to breastfeeding and were dissatisfied with their learning experience.	<i>"I would love at my antenatal classes to have met with a woman that had problems breastfeeding... I wasn't prepared — I don't know how to deal with my feelings when it doesn't work".</i>	Lack of experience  Lack of a role model	Area of need

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Entwistle Kendall & Mead 2009)  Knowledge of breastfeeding.	She also talked about the amount of written information---- but she found reading hard.	<i>"My problem is I'm not a very good reader".</i>	Lack of literacy knowledge	Area of need
(Dykes et al. 2003)  Interviews: Emotional Support.	The adolescents needed to feel cared for particularly by their mother and partner. Their experience of being away from family while in hospital was often one of isolation and distress:	<i>"I just felt so isolated . . . I felt quite alone. I was on a ward with 3 other ladies but I didn't feel comfortable enough to talk to them. . . . I didn't like not having my family around and things. So I would have preferred to go home straight away . . . but that wasn't possible".</i>	Lack of support	Area of need
	When they described their experiences in hospital, they appeared to feel most cared for when there was continuity of caregiver and least when they experienced what one adolescent (Sandra) referred to as "conveyor belt" care. The latter was	<i>"At the point I decided to bottle-feed there were midwives on there that I had never met and they didn't know me. Because I didn't know them—I just felt uncomfortable asking. So I think if I'd stayed with the other ones</i>	Lack of continuity  Poor communication	Area of need  Staff aspect



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	characterized by a focus on routines rather than individuals. They felt much more able to ask for information or help when they knew the midwife:	<i>I would have carried on”.</i>		
Esteem Support	In contrast, a lack of encouragement with breastfeeding led to rapid disillusionment. Kerry breastfed for 2 days while in hospital and then decided to change entirely to giving formula milk:	<i>“If they had encouraged me a bit more when I was thinking about putting him on the bottle . . . like said why don’t you give it another day I would have carried on . . . but they were just well . . . its up to you”.</i>	Lack of encouragement	Area of need
(Vogel & Mitchell1998)  Initial help	Mothers wanted continuity of staff if possible and consistent advice	<i>“Just to have someone listen in hospital and to have some consistency in what they tell you. They all tell you something different”.</i>	Lack of continuity and consistency	Area of need

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(McGrath & Phillips 2009)  Factors associated with the experience of a CS that impact on breastfeeding.	When they experienced the common problems associated with establishing breastfeeding such as blisters or bleeding nipples and concerns about quantity and quality of milk supply, the response to these problems was not to persevere but rather to change to the easy option of bottle feeding.	<i>“But he just wasn’t getting enough, my milk wasn’t coming through. And then they suggested to me that I could keep trying and trying and trying and eventually it will come through. But because it was very stressful. Just put him on the bottle”.</i>	Insufficient milk  Lack of commitment	Emotions  Area of need
(Avery et al. 2009)  Confidence in the Process of Breastfeeding	The most frequently mentioned reasons for not breastfeeding among formula-feeding mothers were that they could not produce enough milk, that the milk did not satisfy their baby, that their baby could not latch properly, or that their baby preferred formula and bottles. These were reasons for not initiating breastfeeding as well as for giving it up shortly after the birth.	<i>“My mom said that the breastmilk is the best and they get all of that nourishment, but you still are never sure. If I am giving formula, I know she’s getting 4 ounces. She’s getting this nourishment”. (formula-feeding mother)</i>	Lack of knowledge  Insufficient milk	Area of need  Emotions

## Appendix 6: Comments by authors and quotations from participants – Theme Groupings (Midwives)

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(West& Topping 2000)  Prioritizing	The second theme to emerge from this study was the influence of hospital routine and possibly rituals on the implementation of the policy. The WHO/UNICEF 10 Steps to Successful Breast-feeding (1989) state that women should be helped to breast-feed within 30 minutes of birth. This emerged in the discussions of the hospital midwives:	<p><i>Getting the baby to feed within 30 minutes, well we know that that's correct but it puts a lot of pressure on the staff on delivery suite and it's dependant on the circumstances on delivery suite at the time.(HMG)</i></p> <p><i>It's because it's busy or getting them [the client] sutured. It seems like suturing and getting the notes done is more important then we can get them upstairs [to the postnatal ward].HMG) Yeah, I mean we should really be with them throughout the first feed but it definitely doesn't work like that in practice.</i></p>	<p>Challenge to initiation</p> <p>Effort to achieve 1<sup>st</sup> feed</p> <p>Lack of priority</p>	1 <sup>st</sup> breastfeed
	Missing that early feed would appear to then initiate a whole cycle of events albeit that the midwives recognized the importance of elements to ensure success:	<p><i>If they've had an early feed that's definitely better and easier but if they haven't then you know it's going to be difficult.(HMG)</i></p> <p><i>When they [the client] come to the ward you know just by</i></p>	<p>Not latching</p> <p>Key opportunity</p>	1 <sup>st</sup> breastfeed

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
		<i>looking at them there's going to be problems because they haven't fed downstairs [on delivery suite].HMG)</i>		
	<p>The community midwives manage their own caseload and deliver their own clients' babies and expressed different experiences.</p> <p>They not only saw the first feed as critical in preventing problems, moreover intervened to ensure it. Prioritizing this activity was recognized as an important element of successful policy implementation.</p>	<i>If I spend the time positioning the baby on the breast straight after delivery I find we don't get nearly as many problems as we used to. Years ago the problems we had were horrendous, well now if I take the trouble and spend time straight after delivery I've found my women who've wanted to breastfeed haven't had so many problems.'</i> (CMG)	<p>Key opportunity</p> <p>Hands on control of feeding</p>	<p>1<sup>st</sup> breastfeed</p> <p>Negative support</p>
(Walsh Pincombe & Henderson 2011)  Implementing the Ten Steps	<p>Participants from hospitals that conduct caesarean sections described difficulty achieving skin to skin contact</p> <p>(Step 4) post operatively due to staffing, routines and the physical environment:</p>	<i>the caesarean section baby doesn't have to go to the nursery... but that doesn't mean that lots of them aren't still going there... (senior medical staff).</i>	Separation	1 <sup>st</sup> breastfeed
	Medicalisation of maternity care was seen as another cause for separation:	<i>they are taken away...and the assumption is that it won't really make much difference... get observed for a couple of hours...the breast feeding will catch up (senior medical staff).</i>	Separation	1 <sup>st</sup> breastfeed

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
<p>(Reddin Pincombe &amp; Darbyshire 2007)</p> <p>Step 4</p> <p>Help mothers initiate breastfeeding within a half-hour of birth</p>	<p>The requirement to initiate a breastfeed within half an hour of birth proved to be problematic in participating hospitals.</p> <p>The following comments reflect the experiences of graduates during their time as midwifery students as well as when they had commenced their GMP.</p> <p>Participants highlighted a culture of getting women out of labour ward as soon as possible after the birth of their baby and not allowing the women to spend time with their newborn.</p> <p>Comments such as, 'here it is, like [sic] you've had your baby, that's it, it's time to get out' (Hannah), reflect an attitude that labour ward staff have completed their part of the process and now it is time for the postnatal staff to take</p> <p>over. This is further highlighted by Joanne:</p>	<p><i>I think when you work in one area like labour and delivery your focus is on the labour and delivery. . .if. . .the baby doesn't suck you sort of think well don't worry about it, we will feed it when it goes to postnatal.</i> (Joanne)</p>	<p>Abdicating responsibility</p>	<p>1<sup>st</sup> breastfeed</p>

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	It appears that staff in labour ward do not consider breastfeeding support as part of their role and would prefer to abdicate responsibility for it onto postnatal staff. Labour ward staff seem to have other priorities, as one participant suggested:	<i>Because of time management. .we are really having to get to grips with is [sic], once the baby is born, to get all the paperwork and computer work done, all the "important stuff". . .I think that breastfeeding hasn't quite made it onto that more important than getting the paperwork done (sic) list just yet. (Moir)</i>	Abdicating responsibility	1 <sup>st</sup> breastfeed
	Many of the participants felt that senior staff were unhappy with them when they 'wasted time' with the women. This sense of frustration is mirrored in comments such as:	<i>Mum and baby were fine and there was no reason for them not to be feeding. . .other things were more a priority. . .what she was saying to me [sic] that I wasn't being efficient. . .I just wanted to point to her [sic] the business about feeding within the first hour but I thought no, just bite my tongue. (Naomi)</i>	Undermining	1 <sup>st</sup> breastfeed
Step 5 Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their	Perhaps the reluctance to spend time with the women helping them to learn to breastfeed is not limited to the first half hour after birth. The mandate to educate women regarding how to breastfeed (even after the			1 <sup>st</sup> breastfeed

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
infants	designated first half hour), reveals a reluctance by some midwives to be involved.  As one participant states:	<i>They just give the mother the baby and say "breastfeed it," and half the time that is when the blistered nipples occur because. . .there is no one there to help. . .the midwife is. . .too busy to supervise a breastfeed. (Joanne)</i>	Abdicating responsibility to mother	
	It may be that some midwives feel they are not skilled in this area:	<i>I worked with a labour ward midwife. . .and she said "I am not very good at breastfeeding stuff and I do not really like it much so I just walk out of the room and leave the woman to work it out for herself". That was her approach to supporting women to breastfeed. (Leah)</i>	Abdicating responsibility to mother	1 <sup>st</sup> breastfeed
	Participants expressed frustration that the care they observed was not as women-centred as they had expected from their theoretical education, for example:	<i>She [senior midwife] didn't seem to care and went back to the line that "I know some midwives like to do that, but we had other things that we should be doing," I thought well she is obviously very task oriented and not so much women and family and breastfeeding oriented. (Naomi)</i>	Abdicating responsibility to mother	1 <sup>st</sup> breastfeed

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	<p>Lack of time appeared to be a major issue to the point that some midwives abdicated responsibility for breastfeeding support to students, (who had limited knowledge and experience of breastfeeding), because they were supernumerary and had the time to stay with the women to encourage and support their efforts to initiate breastfeeding. Several participants made comments such as:</p>	<p><i>The midwives get the students to handle the breastfeeding..it was kind of like a job for the students because after the birth they would be busy with the paperwork and the student can help the mother with their attachment and it was considered a lesser job or something. (Wendy)</i></p>	<p>Abdicating responsibility to students</p>	<p>1<sup>st</sup> breastfeed</p>
<p>Step 6 Give newborn infants no food or drink other than breastmilk, unless medically indicated</p>	<p>One of the participants felt that:</p>	<p><i>Some midwives have lost their patience with supporting breastfeeding itself, in that if it is just too hard or mum has not arrived yet [from theatre after a caesarean section]</i></p> <p><i>“Oh! Just give him some formula”. . .what if mum really wants to breastfeed and wants to avoid the formula.(Valerie)</i></p>	<p>Undermining feeding</p>	<p>1<sup>st</sup> breastfeed</p>



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Dykes 2005)  'communicating temporal pressure'	Most of the midwives at site 1 worked in teams within the hospital. They were based in the mixed antenatal and postnatal wards, but also covered for delivery suite, theatre and antenatal clinic when required. They were almost always extremely busy:	<i>There isn't the time needed to help women let alone give them appropriate breast-feeding support. You can't do that when you're busy. You might have several antenatals, an early labourer, post-sections. You just can't do it!</i>	Frustration re lack of time	1 <sup>st</sup> breastfeed
	The midwives also constantly anticipated that, at any moment, one or more of them would be relocated to another area. This made them feel insecure and caused them to rush through the work. The dissonance this created in providing breast-feeding support was clear:	<i>The main problem is never knowing when you might be moved. Can you really get to know anyone when you may be shifted off at a moment's notice. I mean some staff can be working on the ward, clinic, delivery and theatre all in one day. On top of that there aren't enough staff. Therefore, we can only try to give breastfeeding advice but often that's not enough.</i>	Frustration re lack of time	1 <sup>st</sup> breastfeed

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
<p>(Weddig Baker &amp;Auld 2011)</p> <p>Skin-to-Skin and Initiation of Breastfeeding Within the First Hour of Life Policy</p>	<p>Immediate and uninterrupted skin-to-skin contact at birth and until first breastfeeding occurs, infant self-attachment at first and subsequent feedings</p> <p>(with nurse support if needed), and first breastfeeding in the first 1 to 2 hours of the infant's life, including in the recovery room for mothers who were stable following surgical delivery</p>	<p><i>"Our policy actually tries to encourage breastfeeding after a normal vaginal delivery a C-section [surgical delivery], within an hour. and both of those are very achievable goals" (BF/BFI hospital).</i></p>	<p>Good knowledge</p>	<p>1<sup>st</sup> breastfeed</p>
	<p>In these hospitals, the APGAR scoring is conducted by the nursing staff while the infant is on the mother's abdomen, and the infant physical assessment is delayed until breastfeeding occurs - up to 2 hours according to one hospital policy. When asked what occurs at the BF/BFI hospitals to manage the tasks that must be completed in the first hour after birth, they responded:</p>	<p><i>We don't do them [weights, footprints, vitamin K, and antibiotic eye ointment] . . . not in the first hour of life. . . Or you can do them while the baby is on the [mother's] chest. . .For a lot of us, it's been a real learning experience.( BF/BFI hospital)</i></p>	<p>Good knowledge</p>	<p>1<sup>st</sup> breastfeed</p>

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Nurses' Knowledge and Practice	At non-BF/BFI hospitals, most nurses put the baby skin-to-skin for less than 5 minutes, then take the baby away for transition, which includes physical assessment, vitamin K administration, eye antibiotic ointment, and cleaning, prior to being swaddled in a blanket and given to the mother for breastfeeding.	<i>"I think it is best for the baby to be skin-to-skin, but it never happens . . . because they're [mothers] in gowns, and then there are blankets [swaddling the infants]" (non-BF/BFI hospital).</i>	Lack of knowledge	1 <sup>st</sup> breastfeed
(Furber & Thomson 2007)  1. Rationing of resources	The rationing of resources occurred in two ways. Firstly physical resources, ----newly delivered mums were quickly moved from the labour ward to the postpartum ward to free up beds for imminent admissions.	<i>If the labour ward is busy, you can't do skin to skin contact as much. Because they need the bed. If there is someone waiting for a labour bed, the pressure is on.</i>	Lack of priority	1 <sup>st</sup> breastfeed
	However, for these midwives the rationing of birthing beds became the norm even when resources were not at a premium:	<i>You can get into the culture of : "We've got to get this woman to the ward" even when there is nobody else in labour.  It's breaking through a whole culture, but there is a big group around that is trying to do skin to skin contact. It's slow but there is a small group who will never change.</i>	Lack of priority	1 <sup>st</sup> breastfeed

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Vogel & Mitchell 1998)  Labour and delivery	Analgesia in labour was described by some as having an important influence. There was a debate about the effect of epidurals with some feeling that afterwards the baby will only suck for a short time.	<i>I've noticed that babies that have been exposed to epidural---will suckle for a very short time and then the effect of the epidural starts to work on them and they go off to sleep and they won't suck, so you're not getting your vigorous long term suckling right after birth when it is really crucial.</i>	Effects of analgesia  Sleepy baby/not latching	1 <sup>st</sup> breastfeed
	Others felt epidural made no difference.			
	A normal birth was seen as a significant advantage.	<i>One of the first things that you need for good breastfeeding is to have a normal birth. It is really important not to be drugged at birth.</i>	Effects of analgesia  Sleepy baby/not latching	1 <sup>st</sup> breastfeed
Early feeds	It was felt important that the first feed should be a breastfeed. Some felt that it was important that the first breastfeed should be early, and others that a lack of stress about timing was important.  Some midwives felt it was important for the baby to stay		Early breastfeed desirable  Conflicting ideas	1 <sup>st</sup> breastfeed  Negative support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	with the mother – others commented that the reason for the baby being taken away (eg resuscitation ) is the important challenge to the establishment of breastfeeding.		Separation	1 <sup>st</sup> breastfeed
(Henderson Pincombe & Stamp 2000)  b) Timing	Focus group participants appeared to be in favour of the first breastfeed and/or contact for the mother being initiated as soon as possible after delivery. However some midwives felt that this was not a high priority in the delivery area. For others it was seen to be a lost opportunity if the alert newborn and the calm post-delivery atmosphere was not taken advantage of for a quiet private and unhurried feed.	<i>To me I think that's the biggest thing, if that baby doesn't get the breast fairly soon after birth, it's an uphill battle isn't it.</i>	Key knowledge  Lack of knowledge  Key knowledge	1 <sup>st</sup> breastfeed  1 <sup>st</sup> breastfeed  1 <sup>st</sup> breastfeed
	Some midwives felt that the first feed on the ward warranted planned and uninterrupted time throughout the whole feed to allow adequate education and support to be given.	<i>If you get it right the first time you can watch them, it's almost magical the way it clicks, and then you'd be guaranteed they'll continue with that.</i>	Key knowledge	1 <sup>st</sup> breastfeed

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	In giving support, there appeared to be an underlying element of control by the midwife over the breastfeeding situation, the mother and her baby.	<i>What I do often , I actually take the baby myself and I'll go like this (demonstrates positioning of the baby at the breast) and I'll say this is the way you are going to do it.</i>	Control	1 <sup>st</sup> breastfeed
	Another midwife felt that at times, midwives jump in too soon and take the control away from the woman. The controversial issue of the "hands on" (control) "hands off" (empowerment) debate raised within each focus group indicated that control and empowerment were used in the learning process.			
Midwives views about breastfeeding	The midwives personal and professional feelings about breastfeeding could influence their practices in assisting the mothers with attachment.  Many midwives viewed the mothers as ignorant about breastfeeding, when they did not understand the principles of attachment.	<i>Mothers were not skilled enough to do it (breastfeed) without assistance.</i>	Control	Attachment
(West & Topping 2000)	Busy workloads and lack of time were discussed by the hospital	<i>The mum may call you and say that she thinks her baby's ready</i>	Key opportunity lost	Attachment

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Prioritizing	midwives:	<i>to feed but you're just in the middle of something and then when you get back to them the baby's asleep and of course you've lost that opportunity.(HMG)</i>		
(Walsh Pincombe & Henderson 2011)  Theme 5. Implementing the Ten Steps	The postnatal situation was seen as more complicated  with some mothers who had decided to breast feed sending contradictory signals, managing those who were already ambiguous about breastfeeding and being attentive to those who had planned to artificially feed but feel differently after having given birth. This account is from a midwife in a BF accredited hospital:	<i>day 2...they've indicated they want to breastfeed...you want to help them... they choose to formula feed on day 3 because it's got all too hard and emotional...we really do have a responsibility to give them the correct information...tell them...it may just be better in 24 hours...then on day 5 jeepers why on earth didn't somebody tell me... I've given up and no one told me it was best for my baby and the engorgement might go... that sort of dilemma...that's what's hard and that's why I think we're getting these comments because you try to do your best (BFHI co-ordinator).</i>	Challenges of care	Attachment
(Reddin Pincombe & Darbyshire 2007)	The practices' of midwives regarding the use of dummies added to the confusion of the graduates because many felt	<i>The midwife [she was working with] is quite unapproachable and. . .I was taking a cup to feed the baby and she said</i>	Undermining feeding	attachment

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<p>Step 9</p> <p>Give no artificial teats or pacifiers to breastfeeding infants</p>	<p>the staff that encouraged the use of teats and dummies were out of touch with BFHI and evidenced based practice, but were not open to discussion about such matters.</p>	<p><i>“what have you got that for?” and went and got a bottle and I just left it at that because I wasn’t the woman’s midwife and I didn’t really feel it was my place to say anything. (Bethany)</i></p>		
	<p>Participants also expressed frustration that the women who were trying to establish their breastfeeding, according to the 10 steps that they had been taught during their antenatal education, were also being undermined by inconsistent practices:</p>	<p><i>I had a woman that I had birthed with as a student. . .who had a very difficult birth and I followed her up. . .she was sitting sobbing as she was finger feeding her baby. . .and the afternoon shift midwife had said “you can’t finger feed for more than 20 min, after that you give him a bottle”, and I knew she [the mother] had consciously kept her baby away from having a bottle. . .and that midwife walked in when she was feeling really vulnerable and she ended up giving the baby the rest. . .in a bottle. . .it totally undermined the woman. (Leah)</i></p>	<p>Undermining student</p>	<p>Attachment</p>



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Dykes 2005)  Managing breast feeding	<p>There were frequent occasions, on both sites, when midwives invaded the spatial boundaries of women by attaching a baby to the breast using a 'hands on' approach. They then tended to move on to the next person or task without observing part or all of a breast feed. This physical management of women's bodies undermined women's sense of confidence in</p> <p>that they were unable to repeat the actions themselves requiring them to request help on several occasions during the course of a feed.</p> <p>Women used emotive language to describe midwives handling their breasts:</p>	<p><i>I tried expressing. The midwives tried. Theymauled at them but nothing came. (Anna P1)</i></p> <p><i>He wasn't latching on properly so one of the midwives came and said, 'be a bit more forceful'. She did it herself. (Sophie P61)</i></p>	Hands on inappropriate/ insensitive care	Attachment
(Vogel & Mitchell 1998)  Methods of assistance	Some were strongly opposed to touching the mother's breasts; others felt that it was acceptable, and at times helpful, if done carefully. A frequent comment related to babies having been rammed on the breast and subsequently fighting it.	<i>Some babies that have been rammed on to the breast – when you put the baby into that position they will start screaming that high pitched scream and fight.</i>	Hands on Insensitive/ inappropriate care  Screaming baby	Attachment

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
(Henderson Pincombe & Stamp 2000)  Education A) Rationale	Although breastfeeding was best for mother and baby, attachment is a learned complex and difficult skill.	<i>It's not automatic, mother has to learn and baby has to learn.</i>	Learned skill	Attachment
	However, midwives felt that new mothers and their families viewed attachment as a natural event	<i>A lot of women were actually surprised at how difficult it was.</i>	Mismatched expectations	Attachment
b) Timing	Other midwives held a different view, that the timing of the initial education of attachment should be based on a thorough assessment of the mother to avoid overwhelming her.	<i>You assess each mother as you come and some of them are exhausted, I mean you just go and put the baby on for them and let the baby suckle and then when they are feeling better you tackle the education side of it.</i>	Hands on inappropriate/ insensitive care	Attachment
c) Information	Specific information given to the mothers included simple breast anatomy and physiology , baby's behavioural cues, positioning the mother and baby for comfort and closeness, principles of attachment, suckling types, and maternal feeling about the baby at the breast----  An alternate view posed by other participants reflected a more low-key approach.	<i>I think in the early days, one needs to talk about the learning process</i>	Appropriate education  Less helpful	Attachment  Negative support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
e) Process	Providing “hands on” physical assistance posed a dissent in views amongst midwives. Some felt that “hands on” was acceptable at the first full postnatal feed	<i>Sometimes you need to put your hands on and actually show her (mother) what to do, and after that guide her if she is having difficulties.</i>	Hands on inappropriate/ insensitive care	Attachment
	Other midwives felt that they should be able to talk mother through attachment .  One group viewed this “hands off” as critical to successful breastfeeding	<i>and try to get her to do most of the work instead of putting your hands on the baby</i>	Facilitative	Attachment
	Participants consistently reported that the mother’s perspective was also a vital indicator of correct attachment.	<i>Get them to tune into what was happening in their body from their side or what they should be looking for from their point of view</i>	Facilitative	Attachment
Midwives views about breastfeeding	Emotional reactions to elements of a midwives role when assisting a woman to breastfeed.	<i>Attachment – a battle to be won, it’s sometimes a lost cause,</i>	Emotion  Control	Attachment  1 <sup>st</sup> breastfeed
	Midwives felt helpless and frustrated by interruption when trying to assist a woman, adequate time was vital, a lack could lead to feelings of defeat and frustration.		Frustration	Midwives views

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	Midwives spoke of the satisfaction they felt when attachment was successful.		Satisfaction	Attachment
(Dykes 2005)  'communicating temporal pressure'	The postnatal women frequently commented on the pressures experienced by midwives at site 1 This had bays that opened onto a central corridor, so that women could see the midwives rushing up and down	<i>'they seem to be pressured, panicking and anxious' (Bryony, P7). 'The midwives seem to be spread very thinly and they don't have much time'</i>	Mothers acknowledging pressure	Negative support
	At both sites, when women were aware of the pressures on midwives, they tended to struggle on quietly recognising that asking for support or information was to request scarce midwifery time.			
Disconnected encounters	When midwives were under temporal pressure, communications tended to be disconnected from the woman's context and personal agenda. This also related to the fragmented ways of working due to frequent relocation of midwives to other areas and short time that women stayed in the postnatal ward.	These monologues contrasted with women's needs: <i>It would be nice if somebody could just come and spend 10 minutes with you to talk about breast feeding. If they did that they could learn about your concerns and anything you feel you need help with. I mean I'm not very confident at all.</i>	Poor communication	Negative support

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	<p>The notion of developing any form of relationship with women was largely absent. Under these circumstances, midwives were constrained from developing what Varcoe et al. (2003) refer to as an 'authentic presence' (p. 966). Midwives tended to make rapid judgements about women that were not based on a trusting relationship. This inevitably led to labelling and stereotyping of women for the purposes of rapid action.</p>		Coping mechanism	Negative support
Managing breast feeding	<p>There was a sense of breast feeding being a technically managed activity, with the primary concern being the transfer of milk to the baby.</p> <p>Instrumental, managerial and authoritative approaches adopted by midwives related to competing demands and a lack of confidence in the bodily process of breast feeding. Many of the encounters between postnatal women and midwives relating to breast feeding involved teaching</p>	<p><i>Alex (MW9): Would you like me to show you how to hand express?</i></p> <p><i>Louise (P14): No thanks, I don't really want to.</i></p> <p><i>Alex: Well it would reassure you that you have milk.</i></p> <p><i>Louise: Oh I can see that when she feeds.</i></p> <p><i>Alex: It's a technique we like to teach ladies. I'll just show you.</i></p> <p><i>Alex then demonstrated on herself.</i></p>	<p>Coping mechanism</p> <p>Didactic teaching</p>	Negative support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	of specific techniques in reductionist ways and the issuing of predefined packages of information:			
	<p>Another aspect of the technical approach, on both sites, centred upon teaching effective positioning and attachment. Although this is crucial in supporting effective breast feeding --</p> <p>when midwives were rushed it was often simply 'chanted' as a set of technical steps. Di (MW18), for example, lifted Veronica's (P27) baby and physically attached her to her breast saying:</p>	<p><i>'Right, so point the nipple to nose, then you'll see more of the areola above than below and the bottom lip turned down. Look you can see his lips'</i></p>	<p>Coping mechanism</p> <p>Didactic teaching</p>	Negative support
Rationing information	The sense of temporal pressure upon midwives affected the ways in which they 'delivered' information, with speed being the essence:	<p><i>The nurses are very good. They tell you everything very quickly, so sometimes it's like you've got to pick up everything very quickly. They're very quick but thorough. (Jane P12)</i></p>	Coping mechanism	Negative support

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	There were several instances of conflicting information that related, in part, to a lack of continuity of carer:	<i>I've seen different people this morning and they have all had a different approach. (Kate P39) There are just so many people. Um, there isn't a consistent game plan. I find it all so confusing. It leaves me feeling guilty at not following advice. A team front is needed. They should be presenting one approach. There should be a leaflet on the problems too. That would be useful</i>	Lack of continuity	Negative support
Taking time and touching base	One example of confidence building, an aspect of esteem support, may be seen in the following dialogue:	<i>Jocelyn: Is he feeding all right? Jenny: Your body feelings are the best guide. What do you think? Jocelyn: I can hear him sucking. Jenny: Yes and I can hear him swallowing. Oh look you can see milk dribbling out on to his chin! That's good.</i>	Effective communication	Effective support
	Jocelyn's trust in Jenny seemed to be fundamental to the incremental confidence building that took place:	<i>I couldn't have done it without Jenny. She's been fantastic. She has been with me every day and has really helped me, building my confidence by</i>	Confidence development	Effective support

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		<i>praise and saying, 'You're doing fine'. She was there regular like, you know, same midwife. She knew exactly what was going on. She spends time with you.</i>		
	Jenny pointed out that the opportunity to follow a woman through and develop a relationship was quite unique:	<i>I've been involved with Jocelyn from transfer to this ward. It's one of those lovely situations where she's had the same person most of the time. I mean so often you see someone one day, you set things in motion and the next day someone else has scuppered it. The thing is; this is the exception. We've been quiet over the weekend. I've spent hours with her.</i>	Ideal situation	Effective support
	When asked about how her care might have changed in a busier situation, Jenny stated:	<i>I mean given the current situation you cannot give woman-centred care. I mean I would hope I still discuss things with women and try to discuss things with them. But it's incredibly difficult with someone who's a bit slow, who needs time; time to burst into tears and then settle down afterwards.</i>	Sensitive care	Effective support
	The encounters between Jenny and Jocelyn, when compared with some of the interactions described above, show that,		Facilitative	Effective support



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	<p>despite the organisational culture, there are different styles of caring.</p> <p>Jenny's style was facilitative in contrast to more authoritative, directive and insensitive approaches</p> <p>of some of the midwives referred to earlier.</p>			
Author and themes	Author comments	Quotes from participants	Subthemes	Themes
<p>(Weddig Baker &amp; Auld 2011)</p> <p>Policy</p> <p>Nurses Knowledge and Practices</p>	<p>When asked what the evidence-based practices were as related to breastfeeding in the first 72 hours of life, nurses' answers varied substantially. Nurses in the BF/BFI hospitals accurately reported the following as evidence-based best practices:</p> <ul style="list-style-type: none"> <li>- Perform APGAR rating and physical assessment with infant on the mother's chest</li> <li>- Keep mother and baby in full body skin to-skin contact</li> <li>- Delay physical assessment until after first feeding if the infant is clinically stable</li> <li>- Delay bath until after the first</li> </ul>		Good knowledge	Effective support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	<p>breastfeeding is complete</p> <ul style="list-style-type: none"> <li>- Encourage unrestricted breastfeeding and use of breast milk only</li> <li>- Keep mother and baby in the same room</li> <li>- Educate parents to avoid pacifiers with term infants in the first few weeks of life</li> <li>- Encourage family and visitors to leave if mother of child needs help with breastfeeding</li> <li>- Provide discharge education to include where to call for help with breastfeeding</li> </ul>			
	<p>At non-BF/BFI hospitals, the nurses discussed that breastfeeding was the ideal or “gold standard” for feeding an infant but had varied, non-evidence practices related to how they supported breastfeeding.</p>		Lack of knowledge	Negative support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
Skin-to-Skin and Initiation of Breastfeeding Within the First Hour of Life Policy	At non-BF/BFI hospitals, many of the nurses reported that they “try” to encourage breastfeeding after delivery, but that the infants usually are removed from their mothers.	<i>Nurses reported “trying” to be supportive of breastfeeding, but “in this era of many, many time constraints, a lot of times it becomes an additional effort for the nurses, especially initially post partum. It has become increasingly difficult to be 100% supportive of that mother and you say, you try for so long, and then you have to be done” (non-BF/BFI hospital).</i>	Lack of knowledge	Negative support
Nurses’ Knowledge and Practice	Nurses at the BF/BFI hospitals were aware of the physiological properties of breast milk and that skin-to-skin improves an infant’s temperature and blood sugar regulation	<i>“Skin-to-skin provides thermal regulation, regulates glucose levels in the baby, and promotes a successful breastfeeding experience” (BF/BFI hospital nurse).</i>	Good knowledge	Effective support
Breast Milk Only Policy	Policies state that a health care provider’s order is necessary for formula supplementation when latch and milk transfer are not evidenced within 10 to 12 hours after birth	<i>“If not feeding effectively, the infant can be supplemented with the mother’s breast milk, HDM or formula, in that order of preference” (BF/BFI hospital)  We do have donor milk at this hospital. That is our first [choice] . . . for supplementation</i>	Good knowledge	Effective support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	In non-BF/BFI hospitals, the nurses did not discuss having a policy on supplementation, and in most of these hospitals the amount, types, and criteria for supplementation were up to the individual nurse.	<p><i>“Some nurses are like, Oh, that baby didn’t eat, so I stuck in a little formula. He’s so much happier, and the mom can sleep better.”</i></p> <p><i>“It’s a mother’s choice . . . and a lot of them say, ‘Bottle feed [formula feed] the baby tonight.’ This nurse reported that feeding formula at night is the norm.</i></p>	Lack of knowledge	Negative support
Rooming-In Policy	The BF/BFI hospitals had policies that encouraged rooming-in.		Good knowledge	Effective support
	In contrast, several of the nurses in the non-BF/BFI group reported that they encourage rooming-in, unless the mom is tired and then they encourage sending the baby to the nursery.		Lack of knowledge	Negative support
Nurses’ Knowledge and Practice	Nurses at BF/BFI hospitals reported that they educate their patients about an infant’s nocturnal feeding schedule and view nights as an excellent, quiet opportunity to help a patient with latch and assess milk transfer	<i>Keeping that baby in the room, I think is really important. I know mom just had a 12-hour labour and she’s exhausted. But again, the evidence has shown that even tired moms, if that baby is in the room . . . will sleep much better [than] if her baby is out of</i>	Good knowledge	Effective support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
		<i>the room.(BF/BFI hospital nurse)</i>		
	At non-BF/BFI hospitals, the nurses often stated that, though rooming-in is encouraged, they often take babies to the nursery during the night at a patient's request without providing education about infant nocturnal feeding patterns.	<i>The most frequent reason for taking the baby to the nursery was to "give mom a break" or "allow mom to get some sleep." One nurse commented "I would say that the majority of our babies actually stay in the nursery at night, that the majority of women don't want it [rooming-in]" (non-BF/BFI hospital).</i>	Lack of knowledge	Negative support
Patient Education Nurses' Knowledge and Practice	BF/BFI hospital nurses reported consistent educational efforts within the first 24 to 72 hours, so that parents can recognize their newborn's cues, and so they will know how to tell that their baby is getting an adequate volume of colostrum/ breast milk, and how the mother's family can support breastfeeding.	<i>[A parent should receive] the constant reinforcement that you watch your baby's cues for feeding and you feed at least every 2 to 3 hours. And the more time that baby spends on the skin in the first few days of life [the better]; the saying that is going around in our unit is, "Babies that stay at the restaurant eat more food."(BF/BFI hospital nurse)</i>	Good knowledge	Effective support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	At the non-BF/BFI hospitals, many nurses referred to assessing adequate breastfeeding by how many minutes the infant fed on each breast, rather than physiological cues in the infant and mother that indicate milk transfer.	A nurse at a non-BF/BFI hospital stated <i>"Optimal, I'd like to see your baby at breast 15-20 minutes on each side."</i>	Lack of knowledge	Negative support
	There were very few references to teaching parents feeding cues or how to know when their baby was getting enough to eat.		Lack of knowledge	Negative support
(Furber & Thomson 2007)  1. Rationing time	These midwives prioritised the responsibilities in their workload by limiting time that they spent on certain tasks. Supporting mothers with feeding appeared to have lower priority. These midwives assisted the mother with latching the newborn to the breast, but then left her, in order to concentrate on another task.	<i>Some women aren't seen at all because they are not ringing their bell and asking for help. You have to assume that they are all right. You're perhaps popping you head in and saying "everything ok?"</i>	Coping mechanism	Negative support
(Vogel & Mitchell1998)  Nursing care in hospitals	Concerns were expressed about the lack of continuity of care, conflicting advice with every shift change, the length of time to get assistance when pressing the buzzer, and overworked staff.	<i>I think the fundamental problem</i>	Conflicting ideas	Negative support

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	Some staff ----lack knowledge about breastfeeding,	<i>lies with us midwives. The majority of midwives cannot recognise a good latch.</i>	Lack of knowledge	Negative support
(Henderson Pincombe & Stamp 2000)  e) Process	Assisting with attachment in the postnatal ward area required time, patience and encouragement.		Sensitive care	Support
	Participants consistently reported that the mother's perspective was also a vital indicator of correct attachment.	<i>Get them to tune into what was happening in their body from their side or what they should be looking for from their point of view</i>	Facilitative	Support
Support	During the learning process breastfeeding was a two way arrangement between mother and baby and mother and father, as well as mother and midwife.		Good knowledge	Support
	6 main roles to enhance learning about attachment:  Supporter		Positive strategies	Support

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	Collaborator Communicator Advocate Emancipator Technician			
(West & Topping 2000)  Two main themes emerged:  'I know from my own experience...'	<p>All participants expressed support for the policy however at times they appeared to draw on their experience rather than adhere to the 'letter' of the document.</p> <p>Personal understanding of breast-feeding gained through their own maternity experiences was reportedly used to inform their interactions with women. In addition professional experiences were also reported particularly where the policy failed.</p> <p>Experience therefore could confusingly contradict and/or complement the policy, however the end result was an individualized rather than rote interaction with mothers. The hospital midwife group</p>	<p><i>Sometimes you feel things are in the policy and you're employed by the Trust so you've got to do it.'</i> (Hospital midwives group (HMG))</p>	Role of Personal/professional experience	Midwives views



Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	particularly reported being constrained by the policy and further perceived they had to be seen to be implementing it.			
	The community midwives appeared to practice a more flexible approach using the policy in conjunction with their own experience rather than in competition.	<p><i>Yeah - It's a guide, it's not written in stone. (Community midwives group (CMG))</i></p> <p><i>I mean to me I know if she [the client] does give the odd bottle and yes I know that's definitely not in the policy, but I think if it's going to get her through then that's fair enough and you know she's happy with that. (CMG)</i></p>	Pragmatic attitude	Midwives views
	The policy states that incorrect positioning is the most common cause of sore nipples. The participants expressed doubt that this was always the case.	<i>They say you're only sore because the baby isn't on right well I know from my own experience that that's not true</i>	Pain Personal/professional experience	Midwives views

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	There were mixed views expressed about the effect of the policy on conflicting advice:	<p><i>I think that on the whole we know that people are giving the same information and they are not giving conflicting advice.</i></p> <p><i>I think people rely more on their own experience.</i></p>	Personal/professional experience	Midwives views
(Furber & Thomson 2007)  Demands on time	Several midwives commented on the difficulties of having insufficient time to cope with their workload	<i>Staffing levels don't always allow you to give the care you want to give</i>	Frustration re time	Midwives views
	Being short staffed raised the intensity of the pressures experienced	<i>---we've got too many women, we're trying to help 10 women to establish feeding and all the babies are yelling in the night and we've got to do something</i>	Frustration re time	Midwives views
	Being short staffed was confirmed by a community midwife	<i>Staff shortages---that was always where it fell down. They weren't given the support in the early days if they delivered in the hospital. Some of the mums say that nobody came if they needed help with feeding.</i>	Frustration re time	Midwives views

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	The workload was increased by women who midwives found to be challenging;	<i>We're getting a lot of ---- too much knowledge, they go too in depth and then they set themselves up---and the baby isn't doing what the book said it would do.</i>	Challenging women	Midwives views
Coping with newborn feeding in the hospital	Midwives described strategies they used to enable them to get through their workload more effectively and to deal with the competing responsibilities of their role			Midwives views
(Vogel & Mitchell 1998)  Time of discharge	There was general agreement that it required time for lactation to establish, up to a few weeks. Early discharge resulted in mothers being exposed to less conflicting information.  Babies were felt to be more settled after early discharge.	<i>That's why people go home earlier. They get more care and they get more sleep.</i>	Home early an advantage	Midwives views
(Henderson Pincombe & Stamp 2000)  Midwives views about breastfeeding	Midwives felt helpless and frustrated by interruption when trying to assist a woman, adequate time was vital, a lack could lead to feelings of defeat and frustration.		Frustration	Midwives views

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	<p>The midwives personal and professional feelings about breastfeeding could influence their practices in assisting the mothers with attachment.</p> <p>Many midwives viewed the mothers as ignorant about breastfeeding, when they did not understand the principles of attachment.</p>	<p><i>Mothers were not skilled enough to do it (breastfeed) without assistance.</i></p>	Control	<p>1<sup>st</sup> breastfeed</p> <p>Attachment</p> <p>Midwives views</p>
Influences on the midwives practice	<p>A variety.</p> <p>The mothers were not always positive about their own breastfeeding ability</p>	<p>Some women were:</p> <p><i>Not prepared to accept the challenge and work at it and deal with things. They don't give themselves a chance and they are not confident.</i></p>	Lack of confidence – mothers/challenging	Midwives views
	Alternatively another midwife noticed that	<p><i>Mums who have had their mother (or friend/sister) breastfeed successfully are more responsive to the things that you say to them.</i></p>	Positive influences on mothers	Midwives views
	Midwives felt that fathers were more involved in the decision to breastfeed---lack of father support was detrimental to breastfeeding		Importance of fathers views	Midwives views

Author and themes	Author comments	Quotes from participants	Subthemes	Themes
	Many families were inexperienced in this type of feeding.		Importance of family knowledge	Midwives views
	Visitors were seen as a frustration when they were present during breastfeeding education and assistance.		Frustration re visitors	Midwives views

## Appendix 7: Topic Guide for Breastfeeding Study: Antenatal Women

Questions	Purpose of Questions
1) What do you know about breastfeeding?	General easy opener to get people talking
2) What do you think about breastfeeding?	Again easy opener
3) What information do you feel you need/would like in order to start breastfeeding?	To gather women's views about the range of information women feel would be useful in order to start breastfeeding.
4) What would help you to feel confident about starting breastfeeding?	To explore attitudes and beliefs.
5) What would make you feel less confident about starting breastfeeding?	To explore attitudes and beliefs.
6) What does skin-to-skin contact with your baby mean to you?	To establish what women understand about skin-to-skin contact with their baby (may need to give them a prompt here if they don't know – either verbal or picture)
7) What do you think will be the benefits of skin-to-skin contact with your baby at birth?	To establish what women understand about the benefits of skin-to-skin contact.
8) What sorts of things do you think babies can do with regard to breastfeeding just after birth?	To explore what women know about pre-feeding/instinctive behaviour.
9) Looking at these photos how do you think you will feel holding your baby skin to skin?	To gauge women's attitude to the reality of skin contact and to assess response to information material.
10) How long do you think it may take for your baby to start to feed after delivery?	To explore what women understand about the first breastfeed.
11) Some babies are sleepy and don't seem keen to breastfeed at birth, how do you think you will feel if that happens?	To explore the reaction to potential difficulty in starting breastfeeding.
12) Please consider the leaflet called "Feeding Cues" (after the first few hours) and suggest how you might feel about using something like that to help you recognise when your baby might be hungry or too sleepy to breastfeed.	To assess women's response to specific information material.
13) Please consider the leaflet called "Infant Breastfeeding Assessment Tool" and suggest how you might feel about using this to follow your baby's breastfeeding progress.	To assess women's response to specific information material.
14) If your baby continues to be sleepy how would you feel about hand expressing colostrum to feed your baby?	To explore attitudes and beliefs.

## Appendix 8: Topic Guide for Breastfeeding Study: Postnatal Women

Questions	Purpose of Questions
1) What do you know about breastfeeding?	General easy opener to get people talking
2) What do you think about breastfeeding?	Again easy opener
3) What information do you feel you needed/would have liked in order to start breastfeeding?	To gather women's views about the range of information women feel would be useful in order to start breastfeeding.
4) What would have helped you to feel confident about starting breastfeeding?	To explore attitudes and beliefs.
5) What made you feel less confident about starting breastfeeding?	To explore attitudes and beliefs.
6) What does skin-to-skin contact with your baby mean to you?	To establish what women understand about skin-to-skin contact with their baby (may need to give them a prompt here if they don't know – either verbal or picture)
7) If you had skin-to-skin contact with your baby at birth, what were the benefits?	To establish what women understand about the benefits of skin-to-skin contact.
8) How did your baby behave with regard to breastfeeding just after birth?	To explore what women know about pre-feeding/instinctive behaviour.
9) How did you feel, if you held your baby skin to skin at birth and would seeing photos like this help you understand what to expect?	To gauge women's attitude to the reality of skin contact and to assess response to information material.
10) How long did it take for your baby to start to feed after delivery?	To explore what women experience in relation to the first breastfeed.
11) Were there any problems in starting breastfeeding?	To explore the reaction to potential difficulty in starting breastfeeding.
12) Please consider the leaflet called "Feeding Cues" (after the first few hours) and suggest how you might have felt about using something like that to help you recognise when your baby might be hungry or too sleepy to breastfeed in the first few days after birth.	To assess women's response to specific information material.
13) Please consider the leaflet called "Infant Breastfeeding Assessment Tool" and suggest how you might have felt about using this to follow your baby's breastfeeding progress.	To assess women's response to specific information material.
14) If your baby continued to be sleepy how would you feel (or did you feel if you have done this) about hand expressing colostrum to feed your baby?	To explore attitudes and beliefs.

## Appendix 9: Cue Cards

### Feeding Cues at Birth



**Babies love to be in skin contact with their mothers from just after birth. This helps regulate the baby's temperature and breathing and babies cry less when held this way. After birth if held in continuous contact with the mother's skin babies may:**



**Open their eyes  
Use their hands to massage their mother's breast  
Bring their hands to their mouth.**



**Turn their mouth towards their mother's nipple  
Touch the nipple with their hand**



**Lick their mother's breast**



**Suck on the breast**

**Usually babies fall asleep when they are about 2 hours old.**



**New mothers learn about their baby's behaviour very quickly in the first few weeks but in the first few days it may be helpful to learn how to recognise the very subtle cues you may see when he/she is hungry or when he/she is too sleepy to feed. Your midwife will explain how to hold the baby and how you help him/her to attach to the breast.**

**A wee note about sleepy babies: Babies can be quite sleepy after birth and may not show signs of being ready to feed, especially if mum has had an injection in labour for pain. Continuing with skin contact helps babies to be interested in feeding. If mum has had an epidural babies can go from sleepiness to crying without the stages in between or the opposite, from crying to sleepiness without the stages in between.**

**(Read more in 'Off to a good start' page 32 The Sleepy Baby)**

Photographs courtesy of Sue Saunders (Lactation Consultant Services)



**FEEDING CUES (After the first few hours)**

In the first few days look at the chart below and try to recognise the very subtle cues you may see when your baby is hungry or when he/she is too sleepy to feed

<b>Deep Sleep</b>	<b>Baby sound asleep, relaxed, no movement</b>	<b>Breastfeeding is impossible</b>
<b>Active sleep</b>	<b>Beneath the eyelids the eyes are fluttering; baby may frown and move his lips and mouth.</b>	<b>Baby may breastfeed if put to the breast</b>
<b>Drowsy, in-between state</b>	<b>Eyes may open and close may yawn. Brings hand to mouth.</b>	<b>Baby may breastfeed if put to the breast</b>
<b>Alert, awake state</b>	<b>Bright shining eyes. Easy to interest. Brings hand to mouth.</b>	<b><u>Ideal breastfeeding time.</u></b>
<b>Alert but fussy state</b>	<b>Eyes open, turns mouth to side (rooting), nearly crying. Brings hand to mouth.</b>	<b><u>Ideal breastfeeding time.</u></b>
<b>Crying</b>	<b>Baby showing he/she is hungry tired or bored.</b>	<b>Needs consoling before breastfeeding</b>

**Infant Breastfeeding Assessment Tool (IBFAT)** (Removed after Pilot)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Circle to the nearest hour that you finish breastfeeding

Midnight	12	1	2	3	4	5	6	7	8	9	10	11
Noon	12	1	2	3	4	5	6	7	8	9	10	11

Check  the score that best describes the baby's feeding behaviours at this feed.

	<b>3</b>	<b>2</b>	<b>1</b>	<b>0</b>
<b>Readiness To feed</b>	Started to feed readily without effort <input type="checkbox"/>	Needed mild stimulation to start feeding <input type="checkbox"/>	Needed lots of stimulation to feed <input type="checkbox"/>	Could not be aroused <input type="checkbox"/>
<b>Rooting</b>	Rooted effectively at once <input type="checkbox"/>	Needed coaxing <input type="checkbox"/>	Rooted poorly even with coaxing <input type="checkbox"/>	Did not try to root <input type="checkbox"/>
<b>Fixing</b>	At once <input type="checkbox"/>	Took 3-10 min. to start feeding <input type="checkbox"/>	Took over 10 min. to start feeding <input type="checkbox"/>	Did not feed <input type="checkbox"/>
<b>Sucking pattern</b>	Sucked well on one or both breasts <input type="checkbox"/>	Sucked on and off but needed encouragement <input type="checkbox"/>	Some sucking efforts for short periods <input type="checkbox"/>	Did not suck <input type="checkbox"/>

**MOTHER'S EVALUATION**

How do you feel about the way the baby fed at this feeding?

3 Very Pleased   2 Pleased   1 Fairly pleased   0 Not pleased

## Appendix 10: Semi-structured interview

### Probes

- Rephrase the question
- Can you tell me more about that?
- What exactly do you mean by that?
- In what way is that important?
- Can you explain that to me? (Tessa Parkes Aug 2009)

### Introduction

Introduce myself and give contact details.

### Consent

Give participant a copy of the consent form.

Talk through each point.

Ask if there are any questions.

Remind participant they can verify the ethical approval of the study. (how? By contacting names on the form?)

If consent confirmed then ask participant to sign both copies of the form and give one to keep and retain the other for project files.

Thank the participant and check how much time they have for the interview.

### Questions (Pope & Mays 2006)

#### Behaviour/experience

1. What does skin-to-skin mean to you?
2. How easy is it to offer this to women?
3. When would you offer this?
4. What happens when you offer this?
  - a. Regarding the mother
  - b. Regarding the baby
5. Are there any problems in offering skin-to-skin?

#### Opinion/belief

6. What is your opinion about the effect of skin-to skin on breastfeeding?
7. How worthwhile is skin-to-skin with regard to breastfeeding?

## Feelings

8. How confident do you feel about offering skin-to-skin?
9. How do you feel if the baby attaches to the breast?
10. How do you feel if the baby does not attach?

## Knowledge

11. What sorts of feeding behaviours do babies have at birth?
12. If the mother has had narcotic or epidural analgesia how likely is it that the baby attaches in the first hour?

## Problem solutions

13. If the baby is too sleepy to feed in the first hour or so, what do you suggest to the mother?
14. What sort of solutions do you have for the issues you have raised?
15. Who is best placed to take action to create improvements?

## Closing comments

16. Is there anything further you would like to add that we have not covered already?
17. Are there other people you know that I should interview for this study?

## Thank you

Thank you for your participation in this study. I will keep you informed of the study's progress.

Please contact me if you have any questions arising from our conversation.

I will be sending you a copy of the interview transcript to review and amend if necessary. Please let me know if you would like to add or amend anything that you said today and I shall be happy to do so.

## References

Pope, C. & Mays, N. 2006, *Qualitative Research in Healthcare*, 3rd edn, BMJ books, London.

## Appendix 11: Participant Information Sheet (Women)

**Name of study:**  
**Confidence in breastfeeding initiation.**  
**Name of Researcher: Margaret Edwards.**  
**Participant Information Sheet (Women)**



**UNIVERSITY OF STIRLING**

DEPARTMENT OF  
NURSING AND MIDWIFERY

### Introduction

You are being invited to take part in a research study that I am undertaking as part of my PhD degree at Stirling University, Department of Nursing and Midwifery. Before you decide to take part, I would like you to know why this research is being done and what it would involve for you. Please take the time to read the following information and if you would like to know more, please contact me or one of the other researchers listed at the end of this information sheet.

### Questions you may have (Q) and possible answers (A)

#### **Q What is the purpose of the study?**

**A** Breastfeeding is better for child health, but Scotland has not met its target of at least 50% of mothers still breastfeeding at 6 weeks. As part of understanding what is known about breastfeeding and what kind of information would help new mothers, the specific aim of this study is to explore women's knowledge of and confidence in the start of breastfeeding. The findings from this study will be used to develop information to improve the care of breastfeeding women.

#### **Q Why have I been invited to take part?**

**A** You have been invited, as you are a pregnant/ postnatal woman whose views we value, to help design information that might be useful to other women when they start to breastfeed.

#### **Q Do I have to take part?**

**A** No. Your participation in this study is completely voluntary and deciding not to take part will not affect the treatment that you will receive now or at any time in the future.

#### **Q What if I change my mind about taking part?**

**A** Your participation is voluntary and you are free to withdraw at any time, without giving any reason, without your midwifery, medical care or legal rights being affected. Any information you have given us will be destroyed and will not be used in the study or analysis.

**Q What will taking part in this study involve?**

**A** Taking part in the study would mean that you attend a discussion group (focus group) in your antenatal clinic/breastfeeding support group with up to 6 other women and 2 researchers. If you express interest in taking part, the researcher will telephone you to arrange a convenient date and time for the focus group discussion - this will last approximately 1-1½ hours. The research midwife will ask your opinion on a number of questions about breastfeeding and show photos and information. After each question is asked, the group will discuss amongst themselves what they feel about the question, then the next question will be asked and so on. We would like to record the session, with everyone's consent, to be able to analyse the content of the session and take notes to help with this. The tape will be listened to and transcribed onto paper. We are also hoping to run one further focus group to review the information and may ask you to take part.

**Q Will I benefit from taking part?**

**A** It is unlikely that you will benefit directly from taking part. However it may give you the opportunity, by participation, to improve the care of women in future pregnancies.

**Q Are there any risks involved in taking part?**

**A** None expected. If you feel that taking part has upset you in any way then the supervisor can take you out of the room and provide a quiet space where you can talk further if necessary. At the end of the session, time will be given to individuals who would like further information or who wish to make a point individually.

**Q Will I be paid to take part?**

**A** Since this is a postgraduate student project there is no funding available to pay participants but a voucher equivalent of travel expenses will be offered.

**Q Will my taking part in this study remain confidential?**

**A** Everything you say will be confidential and will be anonymised, so if for example you mention a person's name or place this will be removed from the paper transcript. In addition information personal to you will be removed.

**Q What will happen to the results of the research study?**

**A** The results will be written up as part of the student's PhD and may be published in an academic journal and presented at conferences. If a quote from you is used in the written version of the report then your name will have been removed in order that all data used and presented will be anonymous

**Q Who is organising the research?**

**A** A midwife who is a postgraduate student at the University of Stirling supported by her supervisor is organising and carrying out the study.

**Q Who has approved the research?**

**A** The study has been approved by the Ethics Committee of the Dept of Nursing and Midwifery University of Stirling and the local NHS Area Ethics Committee.(awaiting at date above)

**Q What do I have to do?**

**A** If you are interested in taking part in the study, please complete the reply slip attached to this information sheet and post in the reply paid envelope supplied. When I receive your reply I will telephone you to arrange a date and time for the focus group discussion.

**For further information please contact one of the researchers below:**

The researchers involved are:

Margaret Edwards, Midwife, Postgraduate Student

Email: [m.e.edwards2@stir.ac.uk](mailto:m.e.edwards2@stir.ac.uk)

Tel: 01786 466112

Dr Ruth Jepson, Senior Research Fellow

Email [ruth.jepson@stir.ac.uk](mailto:ruth.jepson@stir.ac.uk)

Tel: 01786 466402

Dr Rhona McInnes Senior Lecturer, Midwifery

Email [r.j.mcinnnes@stir.ac.uk](mailto:r.j.mcinnnes@stir.ac.uk)

Tel: 01786 466363

All: Dept Nursing and Midwifery University of Stirling

**If you would like to speak to someone who knows about this study who is an independent advisor, please contact:**

Professor William Lauder

Department of Nursing and Midwifery

University of Stirling STIRLING FK9 4LA

Tel: 01786 46 6345 Fax: 01786 46 6344

Email: [william.lauder@stir.ac.uk](mailto:william.lauder@stir.ac.uk)

**Reply slip**

**Confidence in Breastfeeding Initiation Study**

I am interested in taking part in a focus group to talk about confidence in breastfeeding and give my permission to be contacted by the researcher

Please initial

The best days and times for me are (please circle or tick all that apply)

<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
Morning	Morning	Morning	Morning	Morning
Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
Evening	Evening	Evening	Evening	Evening

What language do you usually use at home?

.....

Do you need help with interpreting, communicating, reading or writing?

No    Yes

Details .....

Do you have a disability that we need to know about in order to make the venue or format of the focus group accessible to you?

No    Yes (please provide details)

    .....

Name .....

Address .....

Post code .....

Mobile

Home phone no:

Please return to: Margaret Edwards, Postgraduate Student  
Dept Nursing and Midwifery, University of Stirling, FK9 4LA  
Email: [m.e.edwards2@stir.ac.uk](mailto:m.e.edwards2@stir.ac.uk)  
Tel: 01786 466112

## Appendix 12: Consent Form (Women)

**Name of study: Confidence in breastfeeding initiation.**  
**Name of Researcher: Margaret Edwards.**  
**Consent Form: Women**



**UNIVERSITY OF STIRLING**

DEPARTMENT OF  
**NURSING AND MIDWIFERY**

Please initial

I confirm that I have read and understand the information sheet version 5 for the above study.	<input type="checkbox"/>
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my midwifery, medical care or legal rights being affected. Any information I give you will be destroyed and will not be used in the study or analysis.	<input type="checkbox"/>
I understand that this form will be kept separately from any other information that I provide and will be stored in a locked drawer for the researcher's use only and will not be shared with anyone else.	<input type="checkbox"/>
I give permission for the information I provide to be used for only this research project (including reports, publications and presentations), I understand my name will not be used in any report or publication.	<input type="checkbox"/>
I understand that I will take part in a focus group discussion as part of the study.	<input type="checkbox"/>
I understand that the discussions of the focus group will be audio recorded.	<input type="checkbox"/>
I understand that any information I provide will be treated in the strictest confidence.	<input type="checkbox"/>
The information will be held securely for 5 years and will only be available to the researcher. The information will be destroyed after this time.	<input type="checkbox"/>
I agree to take part in the above research study.	<input type="checkbox"/>

Complete 2 copies: 1 copy for participant; 1 copy for researcher file

_____	_____	_____
Participant	Date:	Signature:
_____	_____	_____
Researcher	Date:	Signature:

For further information please contact one of the researchers below:  
 The researchers involved are:  
 Margaret Edwards, Midwife, Postgraduate Student  
 Email: [m.e.edwards2@stir.ac.uk](mailto:m.e.edwards2@stir.ac.uk)  
 Tel: 01786 466112



Dr Ruth Jepson, Senior Research Fellow

Email [ruth.jepson@stir.ac.uk](mailto:ruth.jepson@stir.ac.uk)

Tel: 01786 466402

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Email [r.j.mcinnnes@stir.ac.uk](mailto:r.j.mcinnnes@stir.ac.uk)

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University of Stirling STIRLING FK9 4LA

Tel: 01786 46 6345 Fax: 01786 46 6344

Email: [william.lauder@stir.ac.uk](mailto:william.lauder@stir.ac.uk)

## Appendix 13: Demographic Questionnaire (Women)

We would like to find out more about the participants in our groups. We would be very grateful if you could answer the questions below.

1) How old are you?

Under 20

20-25

26-30

31-35

36-40

41-45

2) What is your current marital status?

Single

Married

Divorced

Separated

Live with partner

3) How would you describe your ethnic group?

.....

4) What language do you usually use at home?

.....

5) What is your usual occupation?

.....

6) What is your highest educational qualification?

.....

**Antenatal women only.**

7) How many weeks pregnant are you?

---

**Postnatal women only**

8) Did you have you baby at more than 37 weeks?

No      Yes

9) Did you and your baby leave hospital together?

No      Yes

10) Are you currently still breastfeeding?

Exclusive breastfeeding (no other liquids or solids)

Partial breastfeeding (some breastfeeds and also some formula or solids)

Formula feeding

Very many thanks for providing this information that will remain confidential at all times.

## Appendix 14: Participant Information Sheet (Midwives)

**Name of study: Confidence in breastfeeding initiation.**

**Name of Researcher:**

**Margaret Edwards**

**Participant Information Sheet (Midwives)**



**UNIVERSITY OF STIRLING**

DEPARTMENT OF  
NURSING AND MIDWIFERY

### Introduction

You are being invited to take part in a research study that I am undertaking as part of my PhD degree at Stirling University, Department of Nursing and Midwifery. Before you decide to take part, I would like you to know why this research is being done and what it would involve for you. Please take the time to read the following information and if you would like to know more, please contact me or one of the other researchers listed at the end of this information sheet.

### Questions you may have (Q) and possible answers (A)

#### Q What is the purpose of the study?

**A** Breastfeeding is better for child health, but Scotland has not met its target of at least 50% of mothers still breastfeeding at 6 weeks. As part of understanding what is known about breastfeeding and what kind of information would help new mothers, the specific aim of this study is to explore aspects of women's and midwives' knowledge of and confidence in initiation of breastfeeding. The findings from this study will be used to develop information to improve the care of breastfeeding women

#### Q Why have I been invited to take part?

**A** You have been invited, as you are a Midwife, who is caring for women while they initiate breastfeeding. We value your views and hope that these views can help design information that might be useful to women when they start to breastfeed.

#### Q Do I have to take part?

**A** Your participation in this study is completely voluntary and you are free not to participate.

#### Q What if I change my mind about taking part?

**A** Your participation is voluntary and you are free to withdraw at any time, without giving any reason, without your legal rights being affected. Any information you have given us will be destroyed and will not be used in the analysis.

**Q What will taking part in this study involve?**

**A** Taking part in the study would mean that you are interviewed at a time and place convenient to you. This will take approximately 1 hour. The research midwife will ask your opinion on a number of questions about breastfeeding. We would like to record the interview, with your consent, to be able to analyse the content of the interview. The tape will be listened to and transcribed onto paper

**Q Will I benefit from taking part?**

**A** It is unlikely that you will benefit directly from taking part. However it may give you the opportunity to influence the future care of postnatal women.

**Q Are there any risks involved in taking part?**

**A** None expected. At the end of the interview you will be asked if you wish to make any further points. The transcript will send to you to review and amend if necessary.

**Q Will I be paid to take part?**

**A** Since this is a postgraduate student project there is no funding available to pay participants but if the interview takes place out with work hours you will be given a gift voucher in appreciation of your contribution.

**Q Will my taking part in this study remain confidential?**

**A** Everything you say will be confidential and will be anonymised, so if for example you mention a person's name or place this will be removed from the paper transcript. In addition information personal to you will be removed.

**Q What will happen to the results of the research study?**

**A** The results will be written up as part of the student's PhD and may be published in an academic journal and disseminated at conferences. If a quote from you is used in the written version of the report then your name will have been removed in order that all data used and presented will be anonymous.

**Q Who is organising the research?**

**A** midwife who is a postgraduate student at the University of Stirling supported by her supervisor is organising and carrying out the study.

**Q Who has approved the research?**

**A** The study has been approved by the Ethics Committee of the Dept of Nursing and Midwifery University of Stirling and the local NHS Area Ethics Committee.

**Q What do I have to do?**

**A** If you are interested in taking part in the study, please complete the reply slip attached to this information sheet and post in the reply paid envelope supplied. When I receive your reply I will telephone you to arrange a date and time for the interview.

**For further information please contact one of the researchers below:**

The researchers involved are:

Margaret Edwards, Midwife, Postgraduate Student

Email: [m.e.edwards2@stir.ac.uk](mailto:m.e.edwards2@stir.ac.uk)

Tel: 01786 466112

Dr Ruth Jepson, Senior Research Fellow

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Email: [william.lauder@stir.ac.uk](mailto:william.lauder@stir.ac.uk)

## Reply slip

### Confidence in Breastfeeding Initiation Study

I am interested in taking part in an interview to talk about knowledge of and confidence in breastfeeding and give my permission to be contacted by the researcher

Please  
initial

The best days and times for me are (please circle or tick all that apply)

<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
Morning	Morning	Morning	Morning	Morning
Afternoon	Afternoon	Afternoon	Afternoon	Afternoon
Evening	Evening	Evening	Evening	Evening

Name .....

Address ..... Post code .....

Mobile

Home phone no:

Please return to: Margaret Edwards, Postgraduate Student

Dept Nursing and Midwifery, University of Stirling, FK9 4LA

Email: [m.e.edwards2@stir.ac.uk](mailto:m.e.edwards2@stir.ac.uk)

Tel: 01786 466112

## Appendix 15: Consent Form (Midwives)

**Name of study: Confidence in breastfeeding initiation.**  
**Name of Researcher: Margaret Edwards.**  
**Consent Form: Midwives**



**UNIVERSITY OF STIRLING**

DEPARTMENT OF  
**NURSING AND MIDWIFERY**

Please initial

I confirm that I have read and understand the information sheet version 5 for the above study.	<input type="checkbox"/>
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. Deciding not to take part will not be reported to anyone. Any information I give you will be destroyed and will not be used in the study or analysis.	<input type="checkbox"/>
I understand that this form will be kept separately from any other information that I provide and will be stored in a locked drawer for the researcher's use only and will not be shared with anyone else.	<input type="checkbox"/>
I give permission for the information I provide to be used for only this research project (including reports, publications and presentations) with strict preservation of anonymity.	<input type="checkbox"/>
I understand that I will take part in an interview as part of the study.	<input type="checkbox"/>
I understand that the interview will be audio recorded.	<input type="checkbox"/>
I understand that any information I provide will be treated in the strictest confidence.	<input type="checkbox"/>
The information will be held securely for 5 years and will only be available to the researcher. The information will be destroyed after this time.	<input type="checkbox"/>
I agree to take part in the above research study.	<input type="checkbox"/>

Complete 2 copies: 1 copy for participant; 1 copy for researcher file

\_\_\_\_\_  
Participant Date: Signature:

\_\_\_\_\_  
Researcher Date: Signature:

**For further information please contact one of the researchers below:**

The researchers involved are:  
Margaret Edwards, Midwife, Postgraduate Student  
Email: [m.e.edwards2@stir.ac.uk](mailto:m.e.edwards2@stir.ac.uk)  
Tel: 01786 466112



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Email [ruth.jepson@stir.ac.uk](mailto:ruth.jepson@stir.ac.uk)

Tel: 01786 466402

Dr Rhona McInnes Senior Lecturer, Midwifery

Email [r.j.mcinnnes@stir.ac.uk](mailto:r.j.mcinnnes@stir.ac.uk)

Tel: 01786 466363

All: Dept Nursing and Midwifery University of Stirling

**If you would like to speak to someone who knows about this study who is an independent advisor, please contact:**

Professor William Lauder

Department of Nursing and Midwifery

University of Stirling STIRLING FK9 4LA

Tel: 01786 46 6345 Fax: 01786 46 6344

Email: [william.lauder@stir.ac.uk](mailto:william.lauder@stir.ac.uk)

## Appendix 16: Demographic Questionnaire (Midwives)

We would like to find out more about the participants in our study. We would be very grateful if you could answer the questions below.

1) How old are you?

Under 20

20-25

26-30

31-35

36-40

41-45

46+

2) How many years have you practised as a midwife?

1-5 years

6-15 years+

3) What is your usual area of practice?

Community

Labour ward

Postnatal ward

Other?

4) Have you attended a breastfeeding education course?

Yes

No

5) Have you breastfed a baby of your own?

Yes

No

Very many thanks for providing this information that will remain confidential at all times.

## Appendix 17: Women's Initial Tree Nodes

Type	Name	Memo Link	Sources	References	Created On	Created By	Modified On	Modified By
Node	Baby Behaviour at birth	Yes	0	0	19/11/2010 12:07	MEE	19/11/2010 12:07	MEE
Type	Name	Memo Link	Sources	References	Created On	Created By	Modified On	Modified By
Node	Attachment to the breast		4	19	19/11/2010 12:11	MEE	19/11/2010 12:11	MEE
Node	baby behaviour	Yes	4	34	19/11/2010 12:10	MEE	02/12/2010 14:31	MEE
Node	Fed in labour ward		2	3	19/11/2010 12:13	MEE	19/11/2010 12:13	MEE
Node	Not fed in labour ward		1	5	19/11/2010 14:51	MEE	19/11/2010 14:51	MEE
Node	Pre-feeding attitude		3	4	19/11/2010 12:14	MEE	19/11/2010 12:14	MEE
Node	Pre-feeding knowledge		6	20	19/11/2010 12:15	MEE	19/11/2010 12:15	MEE
Node	Skin to skin feelings		6	17	19/11/2010 12:12	MEE	19/11/2010 12:12	MEE
Node	Skin to skin feelings negative		3	6	29/11/2010 14:48	MEE	29/11/2010 14:48	MEE
Node	Skin to Skin feelings positive (2)		6	10	29/11/2010 16:16	MEE	29/11/2010 16:16	MEE
Node	Skin to skin knowledge		6	17	19/11/2010 12:11	MEE	19/11/2010 12:11	MEE
Node	women's expectations of babies behaviour		5	16	19/11/2010 12:15	MEE	19/11/2010 12:15	MEE
Node	Differing needs		0	0	19/11/2010 14:23	MEE	19/11/2010 14:23	MEE
Type	Name	Memo Link	Sources	References	Created On	Created By	Modified On	Modified By
Node	Confidence in initiation		3	8	19/11/2010 14:48	MEE	19/11/2010 14:48	MEE

Node	Differing needs		4	22	19/11/2010 14:24	MEE	19/11/2010 14:24	MEE
Node	Efficacy expectation		5	14	19/11/2010 14:25	MEE	19/11/2010 14:25	MEE
Node	expectation of help		5	26	19/11/2010 14:25	MEE	19/11/2010 14:25	MEE
Node	planning to be philosophical		4	8	19/11/2010 14:49	MEE	19/11/2010 14:49	MEE
Node	Views on breastfeeding		2	10	19/11/2010 14:46	MEE	19/11/2010 14:46	MEE
Node	Resources that could be helpful	0	0	19/11/2010 14:27	MEE	19/11/2010 14:27	MEE	
	<b>Type</b>							<b>Modified By</b>
Node	photographs of attachment		5	17	19/11/2010 14:38	MEE	19/11/2010 14:38	MEE
Node	Resources available		6	11	19/11/2010 14:29	MEE	02/12/2010 14:31	MEE
Node	Response to feeding cues after first few hours		6	15	19/11/2010 14:29	MEE	02/12/2010 14:31	MEE
Node	Response to feeding cues leaflet at birth		5	23	19/11/2010 14:30	MEE	02/12/2010 14:31	MEE
Node	Women's confidence helped by	0	0	19/11/2010 13:53	MEE	19/11/2010 13:53	MEE	
	<b>Type</b>							<b>Modified By</b>
Node	Being in control		2	9	19/11/2010 14:05	MEE	19/11/2010 14:05	MEE
Node	Communication		3	15	19/11/2010 14:01	MEE	19/11/2010 14:01	MEE
Node	Enactive attainment		2	8	19/11/2010 14:04	MEE	19/11/2010 14:04	MEE
Node	Influences Mother breastfed		4	9	19/11/2010 14:31	MEE	19/11/2010 14:31	MEE
Node	Influences on decision to breastfeed		5	18	19/11/2010 14:31	MEE	19/11/2010 14:31	MEE

Node	Knowledge of breastfeeding		2	11	19/11/2010 14:04	MEE	19/11/2010 14:04	MEE	
Node	Non directive information		2	5	19/11/2010 14:06	MEE	19/11/2010 14:06	MEE	
Node	Parent-craft attendance positive views		4	7	19/11/2010 14:26	MEE	19/11/2010 14:26	MEE	
Node	persistence		4	10	19/11/2010 14:05	MEE	02/12/2010 14:31	MEE	
Node	Social or family support		5	13	19/11/2010 14:02	MEE	19/11/2010 14:02	MEE	
Node	views of midwives positive		3	13	19/11/2010 14:02	MEE	19/11/2010 14:02	MEE	
Node	Women's confidence hindered by	0	0	19/11/2010 14:08	MEE	19/11/2010 14:08	MEE		
	<b>Type</b>		<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	Dehydration		3	6	19/11/2010 14:10	MEE	19/11/2010 14:10	MEE	
Node	Emotionality		3	16	19/11/2010 14:10	MEE	02/12/2010 14:31	MEE	
Node	expectation of help		5	26	19/11/2010 14:11	MEE	19/11/2010 14:11	MEE	
Node	Expectation to hand express		6	17	19/11/2010 14:11	MEE	02/12/2010 14:31	MEE	
Node	feeling unprepared		5	13	19/11/2010 14:12	MEE	19/11/2010 14:12	MEE	
Node	Feelings of anxiety		4	13	19/11/2010 14:13	MEE	02/12/2010 14:31	MEE	
Node	Feelings of failure		1	5	19/11/2010 14:13	MEE	19/11/2010 14:13	MEE	
Node	Feelings of helplessness		3	11	19/11/2010 14:14	MEE	19/11/2010 14:14	MEE	
Node	giving up breastfeeding		3	9	19/11/2010 14:14	MEE	19/11/2010 14:14	MEE	
Node	Hands on		3	17	19/11/2010 14:21	MEE	19/11/2010 14:21	MEE	

Node	made to feel guilty	3	6	19/11/2010 14:15	MEE	19/11/2010 14:15	MEE
Node	Parent-craft attendance negative views	5	5	19/11/2010 14:33	MEE	19/11/2010 14:33	MEE
Node	Perception of busyness of midwives	3	6	19/11/2010 14:16	MEE	19/11/2010 14:16	MEE
Node	Pressure to breastfeed	2	6	19/11/2010 14:16	MEE	19/11/2010 14:16	MEE
Node	Response to sleepy baby	6	24	19/11/2010 14:17	MEE	19/11/2010 14:17	MEE

## Appendix 18: Midwives' Initial Tree Nodes

Type Name	Memo Link	Sources	References	Created On	Created By	Modified On	Modified By	
Node Analgesia		0	0	19/04/2011 11:41	MEE	19/04/2011 11:41	MEE	
Type	Name	Memo Link	Sources	References	Created On	Created By	Modified On	Modified By
Node	Analgesia at birth		16	51	19/04/2011 12:08	MEE	26/04/2011 12:33	MEE
Node	epidurals		10	19	20/04/2011 12:50	MEE	26/04/2011 11:46	MEE
Node	labour effects		13	42	20/04/2011 12:48	MEE	25/04/2011 16:57	MEE
Node	narcotics		11	19	20/04/2011 13:39	MEE	26/04/2011 11:46	MEE
Node Baby behaviour		0	0	19/04/2011 11:58	MEE	19/04/2011 11:58	MEE	
Type	Name	Memo Link	Sources	References	Created On	Created By	Modified On	Modified By
Node	baby behaviour at birth		18	138	19/04/2011 12:11	MEE	26/04/2011 14:41	MEE
Node Care aspects		2	2	19/04/2011 11:42	MEE	25/04/2011 15:41	MEE	
Type	Name	Memo Link	Sources	References	Created On	Created By	Modified On	Modified By
Node	bottle feeding	Yes	13	37	20/04/2011 12:22	MEE	26/04/2011 12:39	MEE
Node	Hand expressing		17	97	19/04/2011 12:16	MEE	26/04/2011 14:41	MEE
Node	Hands off		8	18	19/04/2011 12:19	MEE	26/04/2011 14:26	MEE
Node	Hands on		17	60	19/04/2011 12:18	MEE	26/04/2011 14:30	MEE
Node	policy reference		8	19	20/04/2011 13:51	MEE	26/04/2011 12:28	MEE
Node	position of baby		9	21	20/04/2011	MEE	20/04/2011	MEE



Node	Positioning and attachment problems arising		14	40	13:50 20/04/2011	MEE	13:50 26/04/2011	MEE
Node			15	52	13:49 20/04/2011	MEE	14:30 26/04/2011	MEE
Node	Support		9	36	12:27 20/04/2011	MEE	12:39 26/04/2011	MEE
Node Communication		0	0	19/04/2011 11:46	12:45 MEE	19/04/2011 11:46	14:30 MEE	
<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	Communication		18	115	19/04/2011 12:13	MEE	26/04/2011 14:22	MEE
Node	verbal support or persuasion		15	39	20/04/2011 12:45	MEE	26/04/2011 14:22	MEE
Node Midwives attitudes		0	0	19/04/2011 11:24	MEE	19/04/2011 11:24	MEE	
<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	bonding	Yes	13	34	19/04/2011 12:12	MEE	26/04/2011 14:15	MEE
Node	criticism of mothers		12	42	19/04/2011 12:15	MEE	26/04/2011 14:51	MEE
Node	midwives attitude	Yes	18	262	19/04/2011 12:23	MEE	26/04/2011 11:25	MEE
Node	midwives expectation of giving help		17	110	19/04/2011 12:26	MEE	26/04/2011 14:34	MEE
Node	midwives frustration		17	97	19/04/2011 12:27	MEE	26/04/2011 14:51	MEE
Node Midwives Confidence		0	0	19/04/2011 11:26	MEE	19/04/2011 11:26	MEE	
<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	midwives confidence	Yes	15	116	19/04/2011 12:24	MEE	19/04/2011 12:24	MEE
Node	midwives power and		11	20	19/04/2011	MEE	19/04/2011	MEE

Node	Midwives Knowledge	control	0	0	19/04/2011 11:23	12:30 MEE	19/04/2011 11:23	12:30 MEE	
	<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
	Node	cluster feeds		4	10	19/04/2011 12:13	MEE	19/04/2011 12:13	MEE
	Node	Midwives embodied knowledge		8	23	19/04/2011 12:29	MEE	26/04/2011 11:41	MEE
	Node	midwives knowledge		18	245	19/04/2011 12:25	MEE	26/04/2011 12:39	MEE
Node	Midwives response to attachment		1	2	19/04/2011 11:30	12:30 MEE	25/04/2011 15:32	12:30 MEE	
	<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
	Node	Attachment to the breast		18	146	19/04/2011 12:09	MEE	26/04/2011 14:51	MEE
Node	Mothers attitudes		0	0	19/04/2011 11:33	12:30 MEE	19/04/2011 11:33	12:30 MEE	
	<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
	Node	Cultural differences		14	29	20/04/2011 12:28	MEE	20/04/2011 12:28	MEE
	Node	determination or persistence		7	27	20/04/2011 12:29	MEE	20/04/2011 12:29	MEE
	Node	enactive attainment SE		8	18	20/04/2011 12:30	MEE	20/04/2011 12:30	MEE
	Node	modesty		5	14	20/04/2011 12:32	MEE	26/04/2011 13:54	MEE
	Node	mothers attitude		18	154	20/04/2011 12:31	MEE	26/04/2011 14:44	MEE
	Node	Mothers lack of responsibility		4	7	20/04/2011 12:35	MEE	26/04/2011 14:50	MEE
	Node	mothers more likely to initiate		6	17	20/04/2011 12:36	MEE	26/04/2011 11:17	MEE
	Node	mother's reaction to baby		15	33	20/04/2011	MEE	26/04/2011	MEE

Node	psychological state SE		12	20	12:37 20/04/2011	MEE	12:00 26/04/2011	MEE
Node	Mothers' confidence	0	0	19/04/2011 11:35	12:47 MEE	19/04/2011 11:35	14:18 MEE	
<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	Giving up breastfeeding		8	24	20/04/2011 13:42	MEE	26/04/2011 14:44	MEE
Node	Mother's anxiety		9	34	20/04/2011 12:31	MEE	26/04/2011 14:18	MEE
Node	mothers confidence	Yes	18	98	20/04/2011 12:32	MEE	26/04/2011 10:49	MEE
Node	mothers expectation of help	Yes	15	61	20/04/2011 12:33	MEE	26/04/2011 14:04	MEE
Node	mother's guilt		7	11	20/04/2011 12:34	MEE	26/04/2011 14:13	MEE
Node	mothers needing permission		5	6	20/04/2011 12:36	MEE	26/04/2011 14:32	MEE
Node	Mothers' Knowledge	0	0	19/04/2011 11:34	12:36 MEE	19/04/2011 11:34	MEE	
<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	mothers knowledge		17	80	20/04/2011 12:34	MEE	26/04/2011 12:00	MEE
Node	Mothers' response to attachment	0	0	19/04/2011 11:39	12:34 MEE	19/04/2011 11:39	MEE	
<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	initiation of breastfeeding by mothers		15	41	20/04/2011 12:49	MEE	26/04/2011 14:25	MEE
Node	Mother's response to attachment		7	9	20/04/2011 12:38	MEE	26/04/2011 14:25	MEE
Node	mother's response to non attachment		14	72	20/04/2011 12:38	MEE	26/04/2011 14:47	MEE
Node	Skin to Skin	0	0	19/04/2011	12:38 MEE	19/04/2011	MEE	

<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	Skin to skin		18	172	19/04/2011 12:20	MEE	26/04/2011 14:16	MEE
Node	Work structure	Yes	0	0	19/04/2011 11:54	MEE	19/04/2011 11:54	MEE
<b>Type</b>	<b>Name</b>	<b>Memo Link</b>	<b>Sources</b>	<b>References</b>	<b>Created On</b>	<b>Created By</b>	<b>Modified On</b>	<b>Modified By</b>
Node	awareness of role of other midwives		10	14	20/04/2011 12:13	MEE	26/04/2011 10:54	MEE
Node	Criticism of other midwives		9	17	20/04/2011 12:13	MEE	26/04/2011 14:16	MEE
Node	work structure		17	68	19/04/2011 12:22	MEE	26/04/2011 14:16	MEE

## Appendix 19: Code Template – SCT

### Code 1

Label	Self –efficacy
Definition	How strongly a person believes in their ability to be able to attain a level of performance in a particular situation or whether they avoid the situation if they do not believe they are capable of achieving their desired outcome (Bandura 1977b); (Bandura 1986)
Description	Statements about how well a person thinks they can or can't do something

### Code 2

Label	Enactive attainment
Definition	Enactive attainment is explained as a mastery experience of being successful in an activity (Bandura 1986)
Description	Facilitation of instinctive behaviour/positive achievement/ breastfeeding confidence

### Code 3

Label	Lack of enactive attainment
Definition	Failure lowers self-efficacy, particularly if something goes wrong in the first few attempts despite effort and no unfavourable circumstances (Bandura 1977a); (Bandura 1977b); (Bandura 1986). Failure reduces self-efficacy if it is thought to be caused more by lack of skill than being in an unusual situation (Bandura 1977b). If the person doubts their ability they are more readily affected by what they perceive as failure and may stop

	trying and give up (Bandura 1986); (Bandura 1989)
Description	Where breastfeeding goes wrong / where women try but just don't know what to do when the baby does not attach

**Code 4**

Label	Vicarious experience
Definition	<p>By watching other people model behaviour especially social behaviour or perform an activity/task, a concept is formed of the behaviour and how the performance of this behaviour affects the other person.</p> <p>Seeing others coping and persevering can encourage performance. Watching someone like themselves succeeding, who they can identify with, helps (Bandura 1977b); (Bandura 1989); (Bandura 1986).</p> <p>Similarly if watching another person they identify with and who tries hard but fails at the activity/task then this can reduce feelings of self-efficacy (Bandura 1986).</p>
Description	Role models of people breastfeeding or hand expressing

**Code 5**

Label	Verbal/social encouragement
Definition	If a person is encouraged to think they are capable of a task they may make more effort (Bandura 1986). People can be influenced by suggestions that they could perform the activity/task especially by

	someone they find credible but only if the strategies to help them succeed are also in place (Bandura 1977).
Description	Supportive help/practical/emotional

### **Code 6**

Label	Physiological/ psychological state
Definition	<p>Success is more likely if the person is not highly anxious as the activity/task may increase the anxiety.</p> <p>A person considers how anxious or physically hampered they are when assessing their ability to complete a task (Bandura 1977); (Bandura 1986).</p>
Description	<p>Positive statements about progress</p> <p>Negative statements about feelings/emotions</p> <p>Eg. Sadness, guilt, anger</p>

### **Code 7**

Label	Outcome expectancies
Definition	<p>Outcome expectation is the judgement by a person of the likely consequences of behaviour or what the person expects will happen if the behaviour is performed.</p> <p>This influences the choice of what a person may try to do. Behaviour that can be anticipated to be beneficial can increase self-motivation (Bandura 1977a); (Bandura 1997).</p>

Description	This will be a description of what the person anticipates as the consequences of their behaviour, physical, social or self evaluative.
-------------	--

**Code 8**

Label	Motivation
Definition	<p>An ability to consider future events where people are motivated to do something by thinking about how well they might be able to perform and also to anticipate the positive and negative aspects of their actions. A person then plans to do what they think will be worthwhile and highly valued (Bandura 1997).</p> <p>A person's belief in their self-efficacy is a large part of this motivation (Bandura 1989); (Bandura 1997).</p> <p>Thinking about and anticipating what they plan to do can motivate a person even when the circumstances are not especially favourable (forethought) (Bandura 1986); (Bandura 1989).</p> <p>People who don't think of themselves as efficacious think more of how they will fail and the thought of problems can lead to exaggeration of the anticipated level of difficulty if people doubt their own abilities (Bandura 1989); (Bandura 1986)</p>
Description	<p>Influences on decision to breastfeed</p> <p>Problems arising because of lack of</p>



	awareness/ knowledge of possible events/difficulties that could occur
--	---

**Code 9**

Label	Self-regulation
Definition	<p>Self- appraisal plays a large part in the actions people take as action is not simply influenced by others. The self-directed efforts people make include arranging their surroundings to be helpful, having prompts and incentives as well as being influenced by others (Bandura 1986).</p> <p>People judge how capable they think they are to be able to achieve a level of performance which is their perceived self-efficacy (Bandura 1986).</p>
Description	Statements explaining what women thought they would be able to do

**Code 10**

Label	Agency and Goals
Definition	<p>Goals incentivise the person and the more immediate specific goals guide behaviour (Luszczynska &amp; Schwartz 2005)</p> <p>The goals people set for themselves are affected by the progress they make especially if the person has doubts about their capability (Bandura 1989).</p>

Description	<p>Statements about what the person intends to do</p> <p>Statements about changing plans</p>
-------------	--

**Code 11**

Label	Reflection
Definition	<p>An ability to think through experiences and thoughts of these experiences. This can enable a person to learn about themselves and their surroundings and to modify how they think about things (Bandura 1986).</p>
Description	<p>Statements about changing thoughts of an experience or event</p>

**Code 12**

Label	Effort and persistence
Definition	<p>Development of perseverance is important in helping to raise efficacy expectations as some difficulties that can be overcome teach that some sustained effort is needed (Bandura 1977b)</p> <p>The more self-efficacy a person feels the more effort is made and the longer he/she will keep trying even if the activity/task is not easy especially if they expect eventual success (Bandura 1977a); (Bandura 1982); (Bandura 1986).</p>
Description	<p>Statements that convey the person makes persistent effort to achieve their goal</p>