Knowledge & attitudes to breast feeding in the Eastern health board area

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KNOWLEDGE OF AND ATTITUDES TO BREASTFEEDING IN THE EASTERN HEALTH BOARD WITH SPECIAL REFERENCE TO COMMUNITY CARE AREA 1: FINAL REPORT

FOR COMMUNITY NUTRITION SERVICE, HEALTH PROMOTION DEPARTMENT, EASTERN HEALTH BOARD

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Objectives and Methods

The objective of this cross-sectional survey was to obtain views and attitudes on breastfeeding as a practice from a representative sample of the general population. Based on these results and those of focus group interviews with women who had babies within the past year appropriate interventions may be planned in the Eastern Health Board.

The instrument used was an interviewer administered questionnaire to a quota sample of adults aged over 18 years in Community Care area 1, and representative of the Eastern Health Board as a whole. A questionnaire was devised containing three main sections: knowledge, attitudes, and demographics. Several questions were of an open nature to elicit opinions from the respondents. The sample was analysed using the computer package SPSS 7.5 on a PC, and data were analysed by Chi-squared tests.

Results

Demographics

377 interviews were obtained. In order to meet the quota requirements for the Eastern Health Board as a whole, all people from social classes 4-6, and a random sample of people from social classes 1-3 were included giving a total of 257 people. The gender distribution was 117 males and 140 females (45.5% and 54.5% respectively). The proportion of respondents of social classes 1-3 was 54.5% and that of social class 4-6 was 45.5%.

Knowledge and Personal Experience

While over 80% of the respondents believed that breast feeding was the best form of feeding, significantly more people in social class 1-3 believed this to be so. Their beliefs did not translate into behaviour however, as only 35% of respondents who had children reported carrying out this practice. These numbers are similar to the national figures for breastfeeding rates.

The participants were then asked for their reasons for believing that one method was best. This was asked in two ways: as an open question and as a prompt question. Both methods of questioning revealed similar opinions i.e. that breastfeeding is most natural; and significantly more women and those in the older age groups believed that breast feeding protects against disease. The prompted question also found that the vast majority believed that breast feeding is cheapest, leads to a better bond between mother and baby, provides the best nourishment and is environmentally more friendly.

Significantly less young people (i.e. 18-34), and those from social class 4-6 believed that breast-feeding was most convenient.

Both unprompted and prompted responses were sought to obtain information on opinions of the participants with regard to barriers to breastfeeding. Unprompted responses showed that significantly more men perceived 'attitudes of other people' and 'pain' to be barriers, while more women believed that practical issues such as 'mobility/inconvenience', 'mother's health'

to pose problems. Prompted barriers to breastfeeding that were strongly agreed with were those that limited mobility away from baby e.g. 'being tied to baby', 'difficulty in working'; 'limits placed on social life'. Interestingly, significantly more younger people felt that breastfeeding was 'more tiring'.

Significantly more people in social classes 4-6 thought that breast-feeding was embarrassing for the mother, and significantly more of this group correspondingly thought that bottlefeeding 's 'acceptability in public ' conferred on it an advantage over breastfeeding. They also perceived an advantage of bottle-feeding being ' because you know how much the milk the baby is getting'.

A question designed to elicit opinions on ease or otherwise of breast feeding at work found that work conditions e.g. 'lack of facilities for mother and baby', 'irregular hours', and 'length of maternity leave 'all led to breast feeding being less easy than bottle feeding when the mother returned to work.

Less than a quarter (22.6%) of the respondents correctly estimated that one third of women start breastfeeding in Ireland, while a further 56% of respondents were of the opinion that it was practised by 50% or more of Irish women. A significant difference was seen between genders with more women believing a greater length of time was best to breastfeed.

Regarding personal experiences, almost 95% of the respondents said they had seen a baby being breastfed. Less than half of the respondents reported being breastfed themselves, and 12% did not know. if they were or not. Significantly more people in social class 1-3, and also those over 55 years said they were breastfed. Over three-quarters of the respondents knew of someone close who had breastfed.

When women who had babies were asked who had influenced them on their choice of feeding less than half of the respondents indicated that anyone had influenced them. Of those who were influenced by anyone, almost half said that the influence was husband/partner, mother, or other family members. Very few women mentioned a health professional e.g. antenatal staff, public health nurse, GP, or labour ward staff.

Less than a third of men believed that their attitudes towards breastfeeding influenced their partner's choice. An age trend was seen, with more younger men believing that they had influence over their partner's choice. This has interesting implications with regard to health education programmes.

Attitudes

When the respondents were asked their opinion on words that may be used to describe breast-feeding, over three quarters agreed with the word 'natural' but people in social class 4-6 were also more likely to agree with negative descriptions e.g.' embarrassing/disgusting'. This reinforces findings earlier, where a social class gradient was seen in a barrier to breastfeeding being 'embarrassment'.

Opinions on acceptability of breastfeeding in different locations showed interesting results. On the whole the majority of people felt it was acceptable to breast feed in locations which afforded some privacy such as a health care facility, ladies room, friend's house. However, considerably less people felt it was acceptable in more public places such as shopping centre,

public transport, recreational area, pub/restaurant. However, reasons cited by some people for the two latter places related to health and safety issues, e.g. sports being played nearby, smoky atmosphere, as well as public nature of the location.

The group who felt most disgusted by a women breastfeeding in front of them was the older age group (over 55 years), followed, surprisingly, by the youngest age group (18 -35 years).

The most popular suggestions for increasing breastfeeding rates by the respondents included an advertising campaign (felt more so by men than women), followed by better facilities (more favoured by women) and then better education (favoured by more men) and more support from medical staff, again more favoured by women.
Thus practical support was suggested by women while more education was suggested by men and this finding was reinforced by interest by men in education in school.

Over three-quarters of the respondents believed that TV was the best form of media to increase breastfeeding rates. Less than 7% felt that newspapers/ magazines and national radio would be effective.

1.2. SUMMARY OF FOCUS GROUP SUMMARY

Objectives and Methods

The aim of the focus group study was to discuss influences on infant feeding decisions, supports received by mothers while feeding and, also, community perceptions of women who breastfed.

A semi-structured interview schedule was employed for the purposes of this study. Questions pertaining to decision influences, experiences of feeding, support issues and community perceptions were included. A short socio-demographic questionnaire was also developed for administration at each focus group.

Results

Demographics

In total, 8 focus groups were conducted. A sample of 45 mothers comprising both breastfeeders and bottlefeeders (n=26 and n=19 respectively), medical card holders and non-medical card holders (n=18 and n=27 respectively) was obtained.

Reported Influences on Feeding Decisions

Lay Network and Health Professionals were identified as a source of influence on participants' feeding decisions. Breastfeeding participants referred, for instance, to family members and friends who had breastfed. In contrast, bottlefeeding participants did not identify breastfeeders within their lay networks or, if they did, they referred to women who had had negative experiences of breastfeeding.

Breastfeeding participants discussed the helpful influence of health professionals in terms of advice and literature about breastfeeding. However, bottlefeeding participants discussed contact with health professionals in a negative way because, from their perspective, breastfeeding was "*pushed*" and they felt "*pressurised*" to breastfeed. The manner in which these messages were ignored by participants who had decided to bottlefeed was evident.

Other documented influences on participants' feeding decisions were Health, Convenience, Nature, Self and School. While some discussion took place about breastfeeding being "*best for the baby*", health was not as strong an influence as might be expected for either group. Convenience was cited as an influence by bottlefeeding participants in terms of the potential for shared responsibility of feeding and more freedom for the mother. Nature was mentioned by both breastfeeders and bottlefeeders. However, interestingly, the meaning of nature was found to differ between groups. Breastfeeding participants discussed breastfeeding as something close to nature while bottlefeeding participants discussed bottlefeeding as a social norm and, therefore, natural. Self concepts were mentioned by both breastfeeders and bottlefeeders. Again, the meaning of these differed. While some breastfeeding participants indicated a sense of self-determination to breastfeed, a number of bottlefeeding participants indicated that breastfeeding "*wasn't them*" and that it was something they "*just couldn't do*". This is understood to reflect a self-image against breastfeeding or low self-efficacy about how to breastfeed. Finally, school was not identified as an influence within any focus group.

Reported Experiences of Breastfeeding and Bottlefeeding:
Negative experiences of breastfeeding were talked about in considerable detail and, moreover, were talked about in all focus groups. Thus, these data reflect the experiences of participants who were currently breastfeeding as well as those who were currently bottlefeeding but had breastfed previously. This highlights the impact of breastfeeding experiences as another significant factor influencing women's infant feeding decisions.

The documented negative experiences of breastfeeding recorded within the present study included descriptions of physical problems (soreness, tiredness, infections), 'technical' difficulties (starting to breastfeeding and weaning) as well as practical difficulties in terms of caring for other family members.

Convenience was cited as a positive experience by both breastfeeding and bottlefeeding participants. As stated above, this has been mentioned as an influencing factor for bottlefeeding participants. Participants' experiences of bottlefeeding concurred with their expectations in that they did report the convenience of having some help with feeding and being able to get out and about while bottlefeeding. For breastfeeding participants the meaning of convenience differed. References to the convenience of not making bottles and feeding in bed were cited.

Interestingly, breastfeeding participants identified two further benefits besides convenience. These were, first, emotional benefits in terms of the positive bonding feelings experienced while breastfeeding and, secondly, health benefits in terms of watching one's child grow and develop from breastfeeding.

Very few data gathered referred to negative aspects of bottlefeeding. The trouble and "hassle" involved with preparing bottles was mentioned. The cost of the infant formula food was raised by bottlefeeding participants within the GMS groups.

Support

Professional Supports:

Breastfeeding participants described and acknowledge the support received by them from health professional within the hospital and, once they had returned home. The benefits of community based support groups were emphasised. This was particularly evident within discussions from participants who had been involved with the Ballymun Community Mother Scheme.

While positive accounts of professional supports received were recorded, the scope for further support was also discussed by breastfeeding participants. The need for more individual attention in hospital and at home was emphasised. Contact with an experienced breastfeeder who has some training, not necessarily medical, was suggested as a potential support. Breastfeeding participants from the GMS group also emphasised the need for more private facilities within hospitals for breastfeeding women.

There was a notable absence of discussion within the focus groups for bottlefeeders about professional support. However, it was clear that professionals who were not critical of decisions to bottlefeed were regarded as supportive.

Lay Support:

Breastfeeders and bottlefeeders acknowledged the receipt of lay support. Family and friends who did not criticise decisions to bottlefeed were perceived as supportive for bottlefeeding nonGMS participants. This echoes these participants' views of supportive professionals.

Breastfeeders recounted many experiences of poor support from members of the general public and, to a lesser extent, family members. Examples of this poor support includes participants being stared at, being asked to move while breastfeeding or being asked to stop breastfeeding while feeding in public.

Environmental Support:

Workplace issues were discussed predominately by breastfeeding non-GMS participants. The view that breastfeeding was less compatible with returning to work than bottlefeeding was was evident.

The inadequacy of public facilities for breastfeeding was discussed at length by breastfeeding participants in terms of a complete lack of facilities or the poor quality of those provided.

POPULATION SURVEY

2.1 Introduction

In Ireland the prevalence of breastfeeding is low at 33.9%. Irish statistics compare very unfavourably with the rest of Europe: for example in the UK 64% of mothers' breastfeed, and in Norway 70% of mothers' breastfeed (Connolly, 1996).

In 1994 the Department of Health implemented a national policy to encourage breastfeeding in Irish hospitals. Their goal is to increase the percentage of breastfeeding mothers to 50% by the year 2000. The Eastern Health Board (E.H.B.) has proposed to improve the effectiveness of current initiatives on breastfeeding starting with one community care area (area 1), and if successful these initiatives will be implemented in all community care areas. The initial stage of a health promotion programme is that of 'needs assessment' based on which interventions may be planned.

The objective was to obtain from a representative sample of the general population their views and attitudes on breastfeeding as a practice, and secondly to explore attitudes and motivation among mothers who had recently had to make a decision on this issue.

Methods

Design

The study was carried out in two parts: The first part involved administration of an interviewer-assisted questionnaire to a quota sample of the general population. This interim report will report on these findings.

The second part involved qualitative data collection: Six focus groups were to be set up and focus group interviews carried out. The participants of these groups were women who had babies within the past year. Groups consisted of breastfeeding women, bottlefeeding women, across socio-economic groups. This part of the study is still in train and these findings will be reported separately.

Design of Questionnaire.

A questionnaire was devised consisting of a total of 31 questions, and was divided into 3 sections: knowledge, attitudes, and demographics.

The section on knowledge was designed to obtain information on knowledge of advantages and disadvantages of breast and bottlefeeding, rates of breastfeeding in Ireland and views on the practice of breast and bottlefeeding. It consisted of 18 questions, several of which were of an open nature to elicit opinions from the respondents (see Appendix A).

The section on attitudes was designed to obtain views on the acceptability of breastfeeding in various settings, and ways of increasing breastfeeding rates. It consisted of 5 questions of which 2 were open ended. The demographic section consisted of 7 questions, which were designed to obtain information on gender, age, social class, education, marital status, employment and smoking status.

Pilot Study
The aim of the pilot study was to refine the data collection with respect to the content of the data, and the procedures to be followed. The method used for data collection (i.e. administration of questionnaire outside a supermarket) in the pilot study was the same as for the main study. By pre-testing the questionnaire on a sample of 20 adults (both male and female) feedback was obtained on individual questions, enabling any ambiguous questions to be changed; it also allowed assessment of the length of time needed to administer each questionnaire. A second pilot was undertaken before the final instrument was completed.

As a result of the pilot study, the questionnaire was deemed too lengthy, taking over 30 minutes to administer. In addition, several questions were ambiguous, and alterations were made to these questions as a result.

Sample
Although this survey was carried out in Community Care Area 1 of the E.H.B, in the future it is planned to implement initiatives on breastfeeding in all community care areas. For this reason a quota sample representative of age, gender, and social class in the E.H.B. was calculated.

Recruitment of Field workers
Six experienced fieldworkers were recruited to carry out the administration of the questionnaire. They were either graduates of the Masters of Health Promotion course, or had other relevant post graduate qualifications. A training session was carried out prior to administration of the questionnaire to ensure that all fieldworkers understood all the questions, and to ensure consistency of administration of the questionnaire.

Administration of Questionnaire
The questionnaire was administered over a period of 3 days in 3 different shopping centres in the Community Care area 1. The shopping centres were chosen as representative of places where persons of all socio-economic groupings did their shopping. Permission was sought and obtained from the managers of each of the centres for field workers to approach customers at these locations. Each of the 6 fieldworkers had a quota sample of the general population to target.

Analysis
The sample was analysed using the computer package SPSS 7.5 on a PC. Data were analysed by Chi-squared tests. Social class was assessed using the Irish Social class register.

2.2 Results

Demographic Factors
377 interviews were obtained. In order to meet the quota requirements for the area, all people from social classes 4-6, and a random sample of people from social classes 1-3 were included giving a total of 257 people. This group was selected as being representative of the demographic breakdown of the E.H.B. as a whole. For each question, the results were analysed across age group, social class, and gender. Only statistically significant differences will be reported here (* = $p<0.05$, ** = $p<0.01$, *** = $p<0.001$).

The sample consisted of 117 males and 140 females (45.5% and 54.5% respectively) (table A). The proportion of respondents of higher socio-economic classes was 54.5% and that of lower socio-economic respondents 45.5% (table B). These distributions are identical to the E.H.B. population. Table C shows the marital status and graph 1 the employment status, number of children and smoking distribution of the respondents.

Table 2.1. Age distribution in the whole sample and analysed by gender.

		Men	Women
18-24	42 (16.3%)	21 (17.9%)	21 (15.0%)
25-34	53 (20.6%)	26 (22.2%)	27 (19.3%)
35-44	54 (21.0%)	22 (18.8%)	32 (22.9%)
45-54	37 (14.4%)	18 (15.4%)	19 (13.6%)
55-64	37 (14.4%)	17 (14.5%)	20 (14.3%)
65+	34 (13.2%)	13 (11.1%)	21 (15.0%)
overall	257 (100%)	117 (45.5%)	140 (54.5%)

Table 2.2. Social class distribution in the whole sample and analysed by gender

		Men	Women
SC 1-3	140 (54.5%)	64 (54.7%)	76 (54.3%)
SC 4-6	117 (45.5%)	53 (45.3%)	64 (45.7%)
overall	257 (100%)	117 (45.5%)	140 (54.4%)

Table 2.3. Marital Status in the whole sample and analysed by gender

		Men	Women
Married	58.3%	62.3%	55.0%
Single	24.4%	24.6%	24.3%
Cohabiting	7.5%	9.6%	5.7%
Separated	5.5%	3.5%	7.1%
Widowed	4.3%	0.0%	7.9%

Knowledge

Best method of Feeding:

The vast majority of respondents (82.9%) believed that breastfeeding was best for babies, with 12.5% who believed that bottlefeeding was best. Less than 5% answered 'Don't know'. While a greater proportion of females (85.0%) than males (80.3%) thought that breastfeeding was best, this was not significant.

However, there was a significant difference seen across social class. More people in social class groups 1-3 thought that breastfeeding was best, while almost a fifth of those in social class 4-6 thought that bottlefeeding was best. No significant difference was seen across age groups.

Table 2.4. What method of feeding do you think is best?

		SC 1-3**	SC 4-6**
Breastfeeding	82.9%	88.6%	76.1%
Bottlefeeding	12.5%	6.4%	19.7%
Don't Know	4.7%	5.0%	4.3%

Reasons for believing that this method was best:

When the participants were asked for their reasons for believing that one method was best, of those who opted for breastfeeding, the reason given by almost half (45.8%) was 'because it was natural' (significantly more men (57.5%) than women (36.6%) thought so). The second most popular answer was that it 'provided immunity/was healthy' (24.1%) and significantly more women quoted this reason. In the category of 'other' a variety of reasons were quoted such as 'unprocessed', 'digests easier', 'right temperature', no sterilisation' and 'has everything'.

Table 2.5. Why is it best (breastfeeders)?

Breastfeeders		Men*	Women*
Natural	45.8%	57.5%	36.6%
Immunity/Healthy	24.1%	19.5%	27.7%
Nutritious	16.1%	14.9%	17.0%
Bonding	7.0%	5.0%	8.0%
Other	7.0%	2.0%	10.7%

Of those who had said that bottle-feeding was best, half of the respondents gave their reason for this choice as 'handy/convenient, 14% said so because 'both partners can feed baby'. Within the group of 'Other' a variety of reasons were given e.g.: 'disease-free milk', 'keep it quieter', 'getting figure back' and 'cholesterol-free'.

Table 2.6. Why is it best (bottlefeeders)?

Bottlefeeders:	50.0%
Handy/Convenient	13.6%
Both can feed	36.4%
Other	

The field workers then read a list of statements and the participants were asked to indicate the method of feeding which would apply to each statement.

The vast majority (96.9%) believed that breastfeeding is most natural, is cheapest (95.3%), leads to a better bond between mother and baby (89.1%), provides the best nourishment (88.8%), and is environmentally most friendly (87.9%). While 82.9% of the participants' thought that breastfeeding protects against disease, significantly more women believed this was so. Significantly more people in the older age groups (particularly over 55's) also agreed with this statement.

Just over half of the respondents thought that breastfeeding was most convenient (51.2%), and middle-aged people, and those over 55 were more likely to believe this than the younger age group. Significantly less people from social class 4-6 believed breastfeeding was more convenient than those from social class 1-3.

Table 2.7. What do you think is the feeding method that:?

	Breastfeeding	Bottlefeeding	Don't Know
provides the best nourishment	88.7%	6.2%	5.1%
is most natural	96.9%	2.3%	0.8%
protects against disease	82.9% Men: 76.1%* Women: 88.6%* 18-34: 70.5%** 35-54: 86.8%** 55+: 94.4%**	7.8% Men: 12.8%* Women: 3.6%* 18-34: 14.7%** 35-54: 5.5%** 55+: 1.4%**	9.3% Men: 11.1%* Women: 7.9%* 18-34: 14.7%** 35-54: 7.7%** 55+: 4.2%**
leads to a better bond between mother and baby	89.1%	3.1%	7.8%
is easiest	44.4%	46.3%	9.3%
is cheapest	95.3%	1.2%	6.3%
is most convenient	51.2% SC 1-3: 54.0%* SC 4-6: 47.9%* 18-34: 38.3%** 35-54: 59.3%** 55+: 57.7%**	42.6% SC 1-3: 47.9%* SC 4-6: 49.6%* 18-34: 50.0%** 35-54: 38.5%** 55+: 38.0%**	6.3% SC 1-3: 9.4%* SC 4-6: 2.6%* 18-34: 11.7%** 35-54: 2.2%** 55+: 4.2%**
is environmentally most friendly	87.9%	6.6%	5.4%

Barriers to Breastfeeding:

To obtain information on opinions of the participants with regard to barriers to breastfeeding, unprompted responses were sought in the first instance. The main barrier was believed to be 'attitudes of other people', followed by inconvenience and mobility problems. Interestingly, significantly more men perceived attitudes of other people to be a barrier (38.0%), while women perceived the lack of mobility/inconvenience to be the greatest barrier (28.7%) More men believed 'pain' to be a barrier (10.9%), while more women believed practical issues such as 'implants', 'excess breast tissue', inverted nipples' and 'mothers health' to pose problems.

Table 2.8. What do you see as a barrier to breastfeeding (unprompted)?

		Men**	Women**
Attitudes of other people	30.1%	38.0%	24.2%
Mobility/Inconvenience	28.7%	22.8%	28.7%
Other	17.6%	14.1%	20.2%
Practical issues	8.8%	2.2%	8.8%
Pain	6.5%	10.9%	3.2%
Lack of facilities	6.0%	9.8%	3.2%
Lack of awareness	2.3%	2.2%	2.4%

A list of possible barriers to breastfeeding was then read out by the fieldworkers, and the respondents were asked for their opinions. The vast majority agreed that breastfeeding and working is difficult (90.6%), that breastfeeding is difficult outside the house (86.3%), and that mother is more tied to baby (83.1%). Over two thirds thought those breastfeeding limits mothers' social life (68.2), and that it requires more time (66.7%). Significantly more younger people thought that breastfeeding was more tiring (70.5% in 18-34 versus 50.7% in 55+), while a social class effect was seen in the statement that breastfeeding is embarrassing for the mother (32.4% in SC 1-3 and 51.7% in SC 4-6).

Table 2.9. What do you see as a barrier to breastfeeding (prompted)?

	Yes	**No**	**Don't Know**
Breastfeeding and working is difficult	90.6%	9.0%	4%
Breastfeeding is difficult outside the house	86.3%	12.9%	0.8%
Mother is more tied to baby	83.1%	14.9%	2.0%
Limits mother's social life	68.2%	29.8%	2.0%
More time is needed for breastfeeding	66.7% Men: 63.8%* Women: 69.1%*	26.7% Men: 25.0%* Women: 28.1%*	6.7% Men: 11.2%* Women: 6.7%*
More tiring	63.4% 18-34: 70.5%* 35-54: 65.6%* 55+: 50.7%*	19.7% 18-34: 12.6%* 35-54: 17.8%* 55+: 31.9%*	16.9% 18-34: 16.9%* 35-54: 16.7%* 55+: 17.4%*
Partner is not involved	58.4%	37.6%	3.9%
Is embarrassing for the mother	41.2% SC 1-3: 32.4%** SC 4-6: 51.7%**	49.4% SC 1-3: 56.1%** SC 4-6: 41.4%**	9.4% SC 1-3: 11.5%** SC 4-6: 6.9%**

Advantages of Bottlefeeding:

The main advantage of bottlefeeding was believed to be that 'it can be carried out by either partner' (93.4%), 'Acceptability in public' was the second perceived main advantage (86.7%), with significantly more respondents in social class 4-6 believing this to be so. This reinforces the social class effect with regards to the embarrassment of breastfeeding reported in the previous section.

Almost three quarters (74.5%) of the respondents perceived an advantage of bottlefeeding being because 'you know how much milk the baby is getting', and significantly more people in social class 4-6 agreed with this statement.

Table 2.10. Which of the following in your opinion are advantages of bottlefeeding over breastfeeding?

	Yes	No	Don't Know
Can be carried out by either partner	93.4%	6.3%	0.4%
More acceptable in public	86.7% SC 1-3: 82.7%* SC 4-6: 91.5%*	11.7% SC 1-3: 15.8%* SC 4-6: 6.8%*	1.6% SC 1-3: 1.4% SC 4-6: 1.7%
You know how much milk baby is getting	74.7% SC 1-3: 69.3%* SC 4-6: 81.2%*	19.1% SC 1-3: 25.0%* SC 4-6: 12.0%*	6.2% SC 1-3: 5.7%* SC 4-6: 6.8%*
Is more nourishing	10.2%	80.9%	9.0%

How many women start breastfeeding?

There was a wide range of opinion on this question. Less than a quarter (22.6%) of the respondents correctly estimated that one third of women start breastfeeding in Ireland, but the majority of respondents were of the opinion that it was a minority activity. There were no significant class or gender differences.

Table 2.11. Which of the following is true about starting breastfeeding in Ireland?

Nearly all	7.8%
About two-thirds	20.6%
About half	27.6%
About one third	22.6%
Hardly any	7.0%
Don't Know	14.4%

Length of time it is best to solely breastfeed

About one third (30.7%) of respondents believed that 4 months was the best length of time, and a further third (29.2%) believed that 6 months was best. A significant difference was seen between the sexes with more women believing a greater length of time was best. About one fifth of men didn't know.

Table 2.12. For what length of time do you think it is best for a mother to breastfeed her baby?

		Men*	Women*
1-2 weeks	4.3%	6.8%	2.1%
1 month	20.2%	18.8%	21.4%
4 months	30.7%	28.2%	32.9%
6 months	29.2%	23.9%	33.6%
Don't Know	15.6%	22.2%	10.0%

Ease of Breastfeeding while at work

Over three-quarters (75.3%) of the respondents felt that breastfeeding was less easy than bottlefeeding for women at work.

Table 2.13. Do you think that women at work find breastfeeding compared to bottlefeeding?

Less easy	75.3%
Don't Know	10.6%
Same	7.5%
More easy	6.7%

Difficulties associated with breastfeeding at work

All the reasons given were strongly supported. Most respondents agreed that lack of facilities for mother and baby (95.0%), and irregular hours (89.3%) would pose difficulties for the working mother to breastfeed. Just over three-quarters (76.9%) of the respondents believed that length of maternity leave would be a difficulty.

Table 2.14. What might make it more difficult for the working mother to breastfeed?

	Yes	No	Don't Know
No facilities at work	95.1%	3.9%	1%
Lack of crèche facilities	93.1%	5.4%	1.5%
Irregular hours	90.6%	7.4%	2.0%
Length of maternity leave	76.2%	76.2%	3.5%

Most common type of infant feeding on popular TV

While three-quarters of the respondents (75.1%) thought that bottlefeeding was more common on T.V., this opinion was held by significantly more younger people (88.4%). Of those who thought breastfeeding was more common, they were more likely to be in the over 55 age group.

Table 2.15. Which do you think is more common on popular TV?

		18-34**	35-54**	55+**
Breastfeed	10.1%	3.2%	12.1%	16.9%
Bottlefeed	75.1%	88.4%	67.0%	75.1%
Don't Know	14.8%	8.4%	20.9%	14.8%

Experience of seeing a baby being breastfed

Almost 95% of the respondents had seen a baby being breastfed.

Table 2.16. In real life, have you ever seen a baby breastfeed?

Yes	94.2%
No	5.8%

Experience of being breastfed themselves

45.9% of respondents reported being breastfed, while 41.0% had not; and the remaining respondents did not know. Significantly more people in social class 1-3 said they were breast fed (52.1% vs. 40.5%), but a greater proportion of people in this social class did not know if they were breastfed or not. An age trend was also seen with less younger people reporting having been breastfed (40.0% in 18-34 vs. 59.2% in 55+).

Table 2.17. Were you breastfeed yourself?

		SC 1-3**	SC 4-6**	18-34***	35-54***	55+***
Yes	45.9%	52.1%	40.5%	40.0%	44.4%	59.2%
No	41.0%	32.1%	51.7%	53.7%	44.4%	19.7%
Don't Know	12.1%	15.7%	7.8%	6.3%	11.1%	21.1%

Experience of someone close that has breastfed

Over three-quarters of the respondents answered in the affirmative (77.0%).

Table 2.18. Has anyone close to you breastfed?

Yes	77.0%
No	19.5%
Don't Know	3.5%

Choice of feeding method

Of those people who had children of their own, 34.5% chose to breastfeed, while 37.2% chose bottlefeeding. These are similar to the national figures for breastfeeding rates. For those people who had more than one child, 26.9% chose different methods of feeding for different children.

Table 2.19. What method of feeding did you choose for your baby/babies?

Breastfeeding	34.5%
Bottlefeeding	37.2%
Mixed (if more than one child)	26.9%
Don't Know	1.4%

Influences on choice of feeding

This question was unprompted and only 40% of respondents indicated that anyone had influenced their choice of feeding. Of those who were influenced by anyone, almost half said that the influence was husband/partner, mother, or other family members. Responses are given in rank order below. Less than a third who indicated an outside influence said it was a health professional e.g. antenatal staff, public health nurse, GP, or labour ward staff.

Table 2.20 Who influenced your choice of infant feeding?

None	60.5%
Mother	8.9%
Husband/Partner	7.3%
Other	6.3%
Labour Ward Staff	5.2%
Antenatal staff	3.1%
Other family members	2.6%
PHN	2.1%
Friends	2.1%
GP	1.6%

Influence of men attitude on their partner's choice of feeding

Less than a third of men (32.1%) believed that their attitudes towards breastfeeding influenced their partner's choice. An age trend was seen, with more younger men believing that they had influence over their partner's choice (48.4%).

Table 2.21. Men only: Do you think your attitude to breastfeeding would (or has) influenced your partner's choice?

		18-34	35-54	55+
Yes	32.1%	48.8%**	26.3%**	14.3%**
No	66.1%	51.2%**	68.4%**	85.7%**
Don't Know	1.8%	0.0%	5.3%	0.0%

Attitudes

Words used to describe breastfeeding

A list of words was read to the respondents and they were asked to indicate whether they agreed with them or not.

Over three-quarters (77.7%) of the respondents agreed with the word 'natural' to describe breastfeeding. People in social class 1-3 were more likely to agree with the word 'lovely' (12,2%), while more people in social class 4-6 were more likely to agree with the word 'embarrassing (7.7%). This agrees with findings earlier, when a social class gradient was seen in a barrier to breastfeeding being 'is embarrassing for the mother'.

Table 2.22. Which of the following words describes breastfeeding?

		SC 1-3	SC 4-6
Lovely	9.4%	12.2%**	6.0%**
Natural	77.7%	77.7%**	77.8%**
Acceptable	6.6%	5.8%**	7.7%**
Embarrassing	4.3%	1.4% ** 0.0%	7.7%** 0.9%
Disgusting	0.4%		
None of the above/Other	1.6%	2.9%	0.0%

Acceptability of breastfeeding in various locations

The vast majority (93.4%) felt that it was acceptable to breastfeed in a health care facility, or a ladies room (81.5%). Significantly more older people thought that it was less acceptable to breastfeed in a friend's house (This had been specified in the questionnaire as a place where there may be mixed company). While almost two thirds of the overall respondents (64.2%) felt that it was acceptable to breastfeed in a recreational area, significantly more younger people disagreed with this statement. However it is not clear whether their disapproval is because of the public nature of a recreational area or because of the proximity to games being played etc.

Significantly more women did not find it acceptable to breastfeed in a bus/train (overall 44.5%), and over half (54.7%) of the respondents did not find it acceptable to breastfeed in a pub or restaurant. This may be because of the smoky atmosphere and the noise sometimes found in these places as opposed to the public nature of them.

Table 2.23. Is it acceptable to breastfeed in the following places?

	Agree	Disagree	Don't Know
Health Care Facility	93.4%	5.9%	0.8%
Ladies Room	81.5%	17.7%	0.8%
Friend's House	79.3% 18-34: 84.0%* 35-54: 84.6%* 55+: 66.2%*	18.8% 18-34: 12.8%* 35-54: 14.3%* 55+: 32.4%*	2.0% 18-34: 3.2% 35-54: 1.1% 55+: 1.4%
Recreational Area	64.2% 18-34: 54.7%* 35-54: 72.5%* 55+: 66.2%*	33.1% 18-34: 41.1%* 35-54: 27.5%* 55+: 29.6%*	2.7% 18-34: 4.2% 35-54: 0.0% 55+: 4.2%
A Shopping Centre	61.9%	33.9%	4.3%
Bus/Train	54.7% Men: 63.2%* Women: 47.5%*	44.5% Men: 35.9%* Women: 51.8%*	0.8% Men: 0.9% Women: 0.7%
Pub/Restaurant	44.5%	54.7%	0.8%

Opinions of a women breastfeeding in front of them

While 84.1% of the respondents had 'no problem' with a women breastfeeding nearby, the middle-aged group was significantly most comfortable/positive of all the age groups (91.2%). Of those who felt 'disgusted' the middle aged group were the least, followed by the younger age group.

Table 2.24. How would you feel if a woman was feeding in front of you?

		18-35*	34-54*	55+*
Delighted/Happy	3.2%	84.2%	91.2%	74.3%
Comfortable	9.0%			
Don't bother/No problem	71.9%			
Uncomfortable/Embarrassed	12.5%	15.8%	8.8%	25.7%
Disgusted	3.5%			

Suggestions for increasing breastfeeding rates

These suggestions were unprompted from the respondents. An advertising campaign was the most popular suggestion (27.6%), felt more so by men than women, followed by better facilities (24.8%), more favoured by women, and then better education (16.6%), favoured by more men, and more support from medical staff (15.8%) again more favoured by women.

Suggestions under the category 'other' included 'role models for girls', 'less ads for bottlefeeding', 'less high expectations and less pressure', 'provision of childcare for other children' and 'make it more seen'.

Table 2.25. Do you have any suggestions for increasing breastfeeding rates (unprompted)?

		Men*	Women*
Ad campaign	27.6%	35.5%	21.7%
Better facilities	24.8%	19.4%	28.9%
Better education	16.6%	24.2%	10.8%
More support through medical staff	15.8%	6.5%	16.6%
Change peoples perception/Stigma	11.7%	11.3%	12.0%
Other	3.4%	3.2%	22.9%

Prompted suggestions were then made to the respondents. Over 90% agreed with the suggestions 'more places to breastfeed ', and 'education of mothers at antenatal class'. Significantly more men agreed with the suggestion of 'education in school' (89.6% vs. 80.9%) and this reinforced findings above that men are interested in further education. Social classes 4-6 were more likely to agree with the suggestion of financial incentives to increase breastfeeding rates (86.8% vs. 70.8%).

Table 2.26. Do you have any suggestions for increasing breastfeeding rates (prompted)?

	Agree	**Disagree**	**Don't Know**
More places where to breastfeed	96.4%	2.8%	0.8%
Education of mothers at antenatal class	91.7%	5.6%	2.8%
Education in school	84.9% Men: 89.6%* Women: 80.9%*	14.3% Men: 9.6%* Women: 18.4%*	0.8% Men: 0.9% Women: 0.7%
Financial incentives	78.1% SC 1-3: 70.8%** SC 4-6: 86.8%**	17.1% SC 1-3: 24.1%** SC 4-6: 8.8%**	4.8% SC 1-3: 5.1%** SC 4-6: 4.4%**

Best form of media to help increase breastfeeding rates

Over three-quarters of the respondents (77.1%) believed that TV was the best form of media to increase breastfeeding rates. Less than 7% felt that newspapers/magazines (6.8%) and national radio (5.6%) would be effective.

Table 2.27. Which of the following would be the best form of media to help increase breastfeeding in Ireland?

TV	77.1%
Newspaper/Magazines	6.8%
National Radio	5.6%
All of them	3.6%
Don't Know	3.6%
Local Radio	1.6%
Other (leaflets etc.)	1.6%

FOCUS GROUP STUDY

3.1 Introduction

The following section contains a detailed account of the methodology, analysis and results of the qualitative research carried out as part of the needs assessment process of the Breastfeeding Support project. The aim was to carry out discussions with mothers in order to:

- understand the issues influencing mothers feeding decisions
- to discover supports most valuable to mothers with babies
- to explore community attitudes to breast/bottle feeding mothers

The objectives of this study were to:

- conduct focus group discussions with a representative sample of mothers from Community Care Area I, who had given birth in the last two years.
- compare feeding practices, bottlefeeding and breastfeeding by socio-economic status (GMS and NON GMS).

Methodology

Design and Sampling

Although this research was to be carried out in Community Care Area I of the E.H.B., in the future, it is planned to implement initiatives in all Community Care areas within the E.H.B. For this reason the sample was designed to be representative of the whole E.H.B. Therefore, E.H.B. figures for GMS/Non GMS distribution, and National Breastfeeding figures for Breastfeeding rates were consulted. Following this consultation, it was decided to carry out six focus groups, which can be figuratively represented as follows (Table 3.1):

Table 3.1 Desired Focus Group Representation

FOCUS GROUPS	
G.M.S.	NON G.M.S.
breastfeeding 1	breastfeeding 1
bottlefeeding 2	bottlefeeding 2

Recruitment of Focus Group Participants

Initially, it was decided to recruit the participants of the focus group by letter (200). These letters, accompanied by a freephone line, were administered through developmental clinics and other key areas of mother/health care liaison within the E.H.B..

However, a very low and slow response to this method was obtained (13/200.). It was reported that those who did respond were all breastfeeding mothers and constituted one focus group. However, alternative means of recruiting were necessary.

It was then decided to approach support groups directly, e.g. breastfeeding support groups, mother/toddler and parenting groups, community development programmes and it was through this method that the remainder of our focus group participants was recruited.

It was extremely difficult to trace two groups of mothers in Community Care Area I of the E.H.B. These were breastfeeding G.M.S. mothers and bottlefeeding Non G.M.S. mothers. As a result, we had to go outside Community Care Area I for these groups. The difficulty in finding breastfeeding G.M.S. mothers is a reflection of the extremely low breastfeeding rate generally amongst G.M.S. women. The difficulty in finding bottlefeeding non G.M.S. mothers would appear to be a reflection of the lack of support groups available for bottlefeeding mothers. Further discussion on these matters will appear in analysis section.

In total, 45 mothers were interviewed in eight focus groups (see Table 3.2)

Table 3.2. Obtained Focus Group Representation

G.M.S.	NON G.M.S.
breastfeeding No. of groups ---1 No. of participants ---7	breastfeeding No. of groups --- 3 No. of participants ---19
bottlefeeding No. of groups --- 1 No. of participants --- 6	bottlefeeding No. of groups --- 1 No. of participants --- 3
bottlefeeding No. of groups --- 1 No. of participants --- 5	bottlefeeding No. of groups --- 1 No. of participants --- 4

Process

In order to obtain socio-demographic details of the participants, it was decided to administer the socio-demographic section of the questionnaire used in the quantitative section of this study. This would provide details of age, marital status, education, employment status, smoking status of the participants.

This questionnaire, (Appendix A, Section C) was administered to the mothers before the focus groups took place. Focus group questions were developed according to study aims. Following a pilot study, minor changes were made. The questions were developed under the following headings:

- decision influences
- experience of feeding
- support issues
- community perceptions

For the full list of focus group questions see Appendix B.

Conduction of Focus Groups

Each focus group was conducted by an experienced facilitator, and attended by an assistant, for recording and observation purposes. Each group interview was recorded, and subsequently transcribed. Analysis was performed on the transcribed material, and on the facilitator/assistant recorded notes and observations of the proceedings.

Content Analysis

A content analysis was conducted on the focus group data using NUD.IST software (Richards and Richards, 1984). Content analysis has been defined by Holsti (1969) as any technique for making inferences about collected data by objectively and systematically identifying characters of message. The development of a comprehensive category system which reflects the identified messages and themes and adhered to the criteria set by Holsti (1969) and Bromley (1977) followed. The category system was largely pre-determined in that it was developed from the questions asked in the focus group interview schedule. Some sub-categories reflected the prompts within the interview schedule while others emerged from the collected data as described by Strauss and Corbin (1990). Table 3.3 below shows the association between the focus group interview schedule, the main theoretical categories and, also, the sub-categories.

Table 3.3 The Development of the Infant Feeding Study Qualitative Category System

Focus Group Question	**Qualitative Category**	**Sub-Category**
Why did you decide to breastfeed? *prompts: school, mother, friend/relative, health professional*	Influences on Decision	Professional Lay Network Health Naturalness Convenience School Self
Support Issues? *prompts: highs, lows*	Experiences	Positive Breastfeeding Bottlefeeding Negative Breastfeeding Bottlefeeding
prompts: partner, family, friends, others health professionals media, structural support, workplace	Supports	Professional Supportive Unsupportive Desired Support Lay Supportive Unsupportive Desired Support Environmental Supportive Unsupportive Desired Support
Community Perceptions?	Community Perceptions	Bottlefeeding Women Breastfeeding Women

Procedural rules as described by Bromley (1977) were developed in order to ensure that coding was done in a systematic and objective way. A pilot analysis was conducted to assess the category system and, following minor modifications, was deemed suitable. As recommended by Silverman (1993) an assessment of the reliability of the category system was conducted. A 97% rate of agreement was recorded.

3.2 Results and Discussion

Details of the focus group study results will be provided in this section. The socio-demographic profile of participants will be provided. A frequency analysis for each category within the category system, outlined in Table 3.4, will be shown. Results pertaining to each category will then be presented and discussed in relation to previous research and existing literature regarding infant feeding practices.

Frequency Analysis

Focus group data were coded according to the categories shown above in Table 3.5. The entire qualitative data set comprised of 682 units of analysis. Table x below shows the frequency analysis for each category.

Table 3.5. Infant Feeding Study Category System N=682

Category	Units of Analysis N(%)
Influences on Decision	169(24)
Experiences of Feeding	165(25)
Support	299(44)
Community Perceptions	19(3)
Other	30(4)

Table 3.4.Socio/demographic details of group participants

AGE GROUP	FREQUENCY	PERCENT
18 - 24	4	8.9
25 - 34	23	51.1
35 - 44	18	40.0
Total	45	100.0
MARITAL STATUS		
Married	29	64.4
Separated	2	4.4
Cohabiting	5	11.1
Single	9	20.0
Total	45	100.0
EDUCATION		
Primary	4	8.9
Some secondary	10	22.2
Complete secondary	10	22.2
Some Third	7	15.6
Complete Third	14	31.1
Total	45	100.0
EMPLOYMENT		
Employee	15	33.3
Self-Employed	2	4.4
Homemaker	25	55.6
Unable to Work	1	2.2
Unemployed	2	4.4
Total	45	100.0
SOCIAL CLASS		
0	5	11.1
1	13	28.9
2	9	20.0
3	7	15.6
4	4	8.9
5	4	8.9
6	3	6.7
Total	45	100.0
MEDICAL CARD		
Yes	17	37.8
No	28	62.2
Total	45	100.0
SMOKER		
Smoker	14	31.1
Non-Smoker	23	51.1
Ex-Smoker	8	17.8
Total	45	100.0

Data pertaining to support issues comprised forty-four per cent of all data collected. A quarter of the complete data set referred to participants' experiences of breastfeeding and, another quarter to influences on their decisions (24%). Considerably less data pertained to community perceptions (3%). Less than five per cent of all collected data was miscellaneous and coded as 'Other' (4%). Details of each category's contents will be provided below and discussed in relation to previous research.

Reported Influences on Decision to Breastfeed or Bottlefeed

Participants were asked to indicate what factors influenced their decision to either breastfeed or bottlefeed. Seven subcategories were identified within these responses. These were labelled as professional input, lay network, health, naturalness, convenience, school and self. Professional input referred to the reported influence medical personnel, such as GPs, obstetricians and midwives, had on participants' decisions. Details of the reported influence family members and friends had on participants' decisions were coded as 'Lay Network'. Comments about the potential health impact of infant feeding were coded as 'Health'. Views that breastfeeding and bottlefeeding were natural were noted as an influence and categorised as 'Naturalness'. Another sub-category, 'Convenience' pertains to ease as an influence. The extent to which school was an influence on participants' decisions was coded as 'School' and, finally, self-images as an influence were categorised as 'Self'.

Table 3.6 below shows the frequency analysis for each of these Influences on Decision subcategories.

Table 3.6. Frequency Analysis of Reported Influences on Decision per Subcategory

Sub-Category	Units of Analysis n(%)
Professional Input	41(26)
Lay Network	54(34)
Health	21(13)
Natural	14(9)
Convenience	12(7)
School	10(6)
Self	8(5)

As Table 3.6 shows, nearly one-third of the data coded as Influences on Decision refer to people with participants' lay network and a quarter refer to professional health workers. Participants from GMS and non-GMS groups who had breastfed identified and acknowledged family members and friends as having had an influence on their decision. This was most commonly discussed in terms of sisters and friends who had also breastfed:

> my sister breastfed, my friends breastfed, everybody was.

> It was because my family, my mother and my sister who did breastfeed was in town

However, family members and friends were not always identified as a positive influence. A small number of participants explained that their in-laws, for instance, had reservations about breastfeeding: that it was difficult to know how much food the baby was getting or that breastfeeding was too time consuming.

Participants who had bottlefed tended not to identify or acknowledge family members or friends as having influenced their decision to bottlefeed. Bottlefeeders did not tend to identify breastfeeders within their lay network either. This concurs with Hoddinott and Pill's (1999) finding that exposure to breastfeeding is associated with a woman's choice of infant feeding. Interestingly, bottlefeeding participants, from both GMS and non-GMS groups, did tend to cite negative stories about people they knew who had breastfed:

> A friend of mine was in tears because the baby wouldn't take it from her breast, and she had very sore breasts, and listening to where she was coming from I said I don't know

> I do know my sister breastfed the first time and her children had an awful lot more illness than mine had

On the one hand, these data concur with previous research that people assess the validity of health messages against their observations of health practices and health status (e.g. Cornwell, 1984; Sixsmith, McCarthy and Shryane, 1988). However, these data also indicate two different phenomena: non-GMS bottlefeeders are reacting as individuals to a social norm in favour of breastfeeding while GMS bottlefeeding participants are describing a norm not to breastfeed.

A quarter of all data coded at this category referred to the influence professional health workers had, or did not have, on participants' decisions to breastfed or bottlefeed. Both breastfeeders and bottlefeeders reported that midwives and general practitioners had provided information and suggestions prior to the birth of their babies. Breastfeeding participants across the GMS and Non-GMS groups tended to report that they had received factual information through consultations or literature, such as leaflets or books, about breastfeeding. This was described in a matter of fact manner by many participants while others acknowledged the helpfulness of this input. In contrast, bottlefeeding participants were found to describe this input in a more negative manner. Participants referred to the fact that breastfeeding was "pushed," that they were "pressurised" to breastfeed or that the benefits of breastfeeding were "hammered to death". A number of participants stated that these efforts did not persuade them to breastfeed. One woman remarked that she just ignored the pressure and another stated "I will decide". Interestingly, the more positive accounts of health professionals within these data referred to those that did not push breastfeeding or pressurise women to breastfeed.

The more negative representation of interactions with health professionals from bottlefeeding participants is interesting. This could mean that while the same information was made available to participants prior to the birth of the children, the *perception* of the delivery of information differed. Specifically, a woman who had decided not to breastfeed felt annoyed by suggestions that she should do so and might, therefore, perceived such advice in a negative manner. However, it is also possible that participants reported this negative perception because

breastfeeding *was* pushed and they *were* pressurised to breastfeed. An account from one bottlefeeding participant reflects this:

> ...every single time she (the midwife) would bring it up as if we'd never talked about it. She'd say okay are you going to breastfeed and I'd say no. this was every single visit and she knew fine (that I was going to bottlefeed), she just kept bringing it up...

There was no suggestion that efforts were made to enter into a dialogue with this participant as to why she had decided not to breastfeed even though she was aware of the related health benefits. The appropriateness of such dialogue between health professionals and the people to whom they delivery health care has been argued in general terms by Tudor-Hart (1997) and, specifically in relation to breastfeeding, by Hoddinott and Pill (1999).

Although previous research abroad (e.g. Losch, Dungy, Russell and Dusdieker, 1995) and in Ireland (McSweeney and Kevany, 1982) identified health as an important influencing factor, considerably fewer data within this study pertained to health as an influencing factor (13%). Breastfeeding participants cited the health benefits of breastfeeding for babies as an influence on their decision:

> Best for the baby

> I was determined to do it. I've two other boys at home and they've both got asthma and are always very sick

The relative lack of discussion about health as an influencing factor suggests that the constant re-iteration of the health benefits of breastfeeding by health professionals to expectant mothers may be insufficient in itself. This is likely to reflect the way in which health is located within the broader context of people's lives (e.g. Graham, 1984) and health advice or health information alone will not provoke change. This finding also highlights the fact that people know well from personal experiences and observations of others that the benefits of breastfeeding are relative and not absolute which, once again, relates back to the assessment of health advice by people based on their observations and experiences of health (Cornwell, 1984).

Some bottlefeeding women from the GMS group expressed concerns about the quality of the breastmilk they would provide. One woman remarked that she would not be able to give a baby enough sustenance. Another explained that, because she was a smoker, she thought formula food would be better for her child:

> I'm going to get the can with all the good stuff is there the baby's going to be getting all the nicotine off me, ye have to be more aware of what you're eating and all that

Interestingly, breastfeeding participants from the GMS group also expressed concerns about their child's health as well as their own. One woman explained that she was afraid that she would not have enough milk for her child. Another was afraid that she would get cystitis as her sister-in-law had done.

It was noted that worries about both the mothers' health and the baby's health were cited by bottlefeeding and breastfeeding participants from GMS groups only. The absence of such worries within the discussions from non-GMS groups is considered significant and may reflect socio-economic differences in health status (Johnson and Lyons, 1993).

Nine per cent of data coded as Influences on Decision were categorised under the heading 'Naturalness'. Both bottlefeeding participants and breastfeeding participants reported that their decision to either bottlefeed or breastfeed was a natural one. For breastfeeding women from GMS and non-GMS groups breastfeeding was described as natural in that it was of nature.

> It is the most natural thing in the world

> Because I feel I was given breasts to feed my children. I feel that is their purpose

In contrast bottlefeeding participants from GMS and Non-GMS groups tended to mean bottle feeding was natural because it was normal, something automatic that was not thought about:

> I think as well its just natural. I didn't even really think about it. It was just she's going on the bottle that's it. As if it came natural to you

The meaning of natural as something normal among bottlefeeding participants concurs with the findings discussed above, that breastfeeding participants referred to people within their lay network who breastfed while bottlefeeding tended not to. The way in which different feeding options are perceived as natural or normal within an individual woman's broader social context could be very relevant for future programmes.

Convenience was cited as an influencing factor also. These data represent 7% of all data coded at this category. While one breastfeeding participant reported that she felt breastfeeding would be easier than bottle feeding because when breastfeeding she would have a hand free, convenience as an influencing factor was talked about predominately by bottlefeeding participants. Both GMS and non-GMS bottlefeeding participants explained that they thought bottlefeeding was convenient and handy, that it was easier to bottlefeed than breastfeed because it allowed you to pass the baby on to someone else at times and, thus, allowed the mother have more freedom.

The type of convenience talked about by bottlefeeding participants is noteworthy also because it refers mainly to the scope for help and support while feeding outside the hospital setting.

The ways in which help and support can be provided to breastfeeding women could prove important here (see Becker, 1997).

Participants were asked whether school had been an influencing factor. These data represent six per cent of all data coded as Influences on Decision. While the scope for health education within school has previously been identified as a suitable and effective way of influencing people in a positive way about breastfeeding (Connolly et al., 1998) all responses to this question indicated that school was not an influencing factor

Finally, 5% of these data were understood to reflect aspects of the self as influencing factors. Determination to breastfeed was evident among some breastfeeding participants while a small number of bottlefeeding participants explained that they did not consider breastfeeding because it was not consistent with their concept of self:

> I think if you want to do it (breastfeed) you're going to do it. You're committed.
>
> it (breastfeeding) just wasn't for me I just don't like it. I didn't like, as you said the idea of that

The notion that certain participants had a sense of self-determination to breastfeed was in contrast with the view among certain bottlefeeding participants that they could not. This difference could be interpreted as an "I can and I will versus I can't and I won't" type dichotomy. It seems to reflect deep-seated ideas participants had about themselves which are likely to be very central to their infant feeding choices. These may reflect self-efficacy. Confidence to breastfeed also emerged as relevant within Hoddinott and Pill's (1999) research.

Reported Experiences of Breastfeeding and Bottlefeeding

Participants reported experiences of breastfeeding and bottlefeeding, in terms of the highs and lows experienced by them during feeding, were sub-categorised as 'positive' or 'negative'. Table 3.7 below shows the frequency data for these categorise for breastfeeding participants and bottlefeeding participants.

Table 3.7 Reported Experiences of Breastfeeding and Bottlefeeding

Subcategory	n(%)
Breastfeeding Positive	48(29)
Breastfeeding Negative	63(38)
Bottlefeeding Positive	40(24)
Bottlefeeding Negative	14(8)

The most frequently discussed subcategory pertained to negative experiences of breastfeeding. These data represent over one-third of the overall category contents. This represents material from both breastfeeding women and, also, bottlefeeding participants who had previously

breastfed. In no other subcategory was such an overlap apparent, although one breastfeeding participants commented briefly on some advantages of bottlefeeding.

The least frequently discussed subcategory was about negative experiences of bottlefeeding. Less than 10% of data coded as 'Experiences' pertained to negative aspects of bottlefeeding. Details of the four subcategories' contents will now be provided.

Both breastfeeding participants and bottlefeeding participants cited ease or convenience as a positive feature of their feeding experience. This is interesting given the earlier finding within this study that convenience did not feature as an influencing factor for breastfeeding participants while did feature as an influence for those who bottlefed. It is worth noting that the meaning of convenience differed however: breastfeeding participants described the ease of feeding in bed, not having to prepare bottles and not having a lot of 'clutter' when travelling about. Bottlefeeding participants descriptions of ease and convenience centred around the fact that they had been able to receive a lot of help with feeding and, consequently, had a certain amount of freedom to go out and about. Other consequences of this were that they mothers were less tired. Also, a couple of participants commented on the fact they their partners/husbands felt more involved with the baby.

While convenience was the only positive feature of bottlefeeding identified by bottlefeeding participants, breastfeeding women identified two other positive features. Breastfeeding participants from GMS and NON-GMS groups talked at length about the emotional benefits of breastfeeding:

> it's like they are part of you, there's something between you.....really the bond is best
>
> I think the high points are the times when you are comfortable feeding, and you get that warm comfortable feeling

Apart from these reported emotional benefits, breastfeeding participants from the non-GMS group also discussed the observed health benefits of breastfeeding:

> she (mother) sees the benefits of me doing it(breastfeeding)
>
> to see them thriving and growing and knowing that you've fed them

Thus, while positive experiences of bottlefeeding focused on convenience only, it was apparent that breastfeeding participants were able to identify other benefits of breastfeeding. The emotional benefits were expressed strongly by both those within the GMS and nonGMS groups. A sense of pride as the baby grew and developed to be healthy was also evident in both groups. The strength of these accounts are considered significant in that they could be shared with expectant mothers as the real experiences of women who have breastfed. Moreover, it could be argued that the emotional and health benefits may explain, in part, the reason that some mothers continue to breastfeed despite the difficulties described earlier. Perhaps these other benefits over-ride the difficulties for some.

Analysis of the reported negative experiences of breastfeeding revealed a lot of discussion about physical problems. Tiredness and fatigue featured very much. Discussions about having sore breasts, leaking breasts, an inverted nipple, infections and excessive weight loss were also noted. Difficulties around starting and stopping breastfeeding were also discussed. Problems getting started referred to things such as the problems babies had latching on to the breast or the mothers' lack of milk, or worries about her milk supply.

Finally, concern for other family members were cited within these discussions. Some participants explained that their partners or husbands felt left out during breastfeeding. Others commented on the fact they felt less able to look after the needs of other children, especially if they were young. These concerns among breastfeeding participants about the lack of attention they were able to pay to other family members while breastfeeding a new baby are understood to reflect the role of women as health workers with in the domestic sphere (Graham, 1984) While arguments can, and have been, made against this sexual division of labour generally (e.g. Oakley, 1974) it could be argued that it is particularly inappropriate at a time when women have just been through pregnancy, labour and are assuming responsibility for feeding their infant. This draws attention, once again, to the scope for family members to participate actively in breastfeeding and support breastfeeding mothers (see Becker, 1997).

Overall, these data indicate that negative aspects and features of breastfeeding were well known to participants across groups because they had experienced problems themselves. Indeed, some participants within bottlefeeding groups explained that such negative experiences with their first child meant that they would not consider breastfeeding again. This represents another influencing factor on feeding decisions which is consistent with earlier studies (e.g. Graffy, 1992). However, it also raises an interesting question: why is that *some* participants who have had negative experiences of breastfeeding continued to breastfeed with subsequent children? The impact of self-determination among some women to breastfeed as well as the benefits associated with breastfeeding as described earlier may be relevant here. Also the issue of support received while breastfeeding is likely to be relevant. This will be addressed shortly.

Few data were recorded about negative experiences with bottlefeeding. One group of participants did not identify any negative experiences. The issues that did occur in the other groups refer to the hassle of preparing and cleaning bottles as well as carrying them around. Concerns about the cost of infant formulae were expressed by participants from the bottlefeeding GMS groups also.

Reported Supports during Breastfeeding and Bottlefeeding

Participants discussed the support experience by them while feeding in terms of support from professional health workers (public health nurses, GPs), their lay networks (family members and friends) and the broader environment (public places, workplace, media). Frequency data for these sub-categories are shown below as Table 3.8. These data will be discussed in turn: professional supports, lay supports and environmental supports.

Table 3.8 Reported Supports during Breastfeeding and Bottlefeeding

Sub-Category	n(%)
Professional Support	
Professional Support Provided	76(47)
Lack of Professional Support	49(30)
Desired Professional Support	36(22)
Lay Support	
Lay Support Provided	32(43)
Lack of Lay Support	35(47)
Desired Lay Support	7(9)
Environmental Support	
Environmental Support	22(34)
Lack of Environmental Support	29(45)
Desired Environmental Support	13(20)

Professional Support

Nearly half of these data coded under professional support refers to the support provided to participants (47%). However, nearly one-third of these data refers to a reported lack of support (30%) while nearly one-quarter contains ideas about desired professional support (22%).

The professional support described by breastfeeding participants reflects the support received during the hospital stay and within the home. Several breastfeeding participants described the great attention and care they received from hospital staff.

> especially with my first one I had an infection and I met lots and lots of nurses who were most supportive

> we were lucky because we got the private room. The midwife said we were only there because we were breast-feeding

The idea that breastfeeding women received different attention to those bottlefeeding was discussed explicitly by one participant. She felt that breastfeeding mothers had received better attention than those who were bottlefeeding:

> (the nurses on the ward) seemed to pay more attention to the mothers who were breastfeeding, We were like the queens on the ward...I found that really good

This, of course, is positive for breastfeeding mothers but raises questions about equity in health service delivery (Shaping a Healthier Future, 1994) because of implications for bottlefeeding mothers. This will be returned to shortly.

Discussions about the professional support provided once participants had returned home centred around the benefits of public health nurses and, particularly support groups for

breastfeeding mothers. The benefits of such a community based support as a means of complementing care provided in hospital settings has been described previously by Lancer Ed (1994). The way in which these groups provided participants with an opportunity to share their experiences and gain help and encouragement from each other was mentioned. Support groups were often described as "enjoyable". Some differences between socio-economic groups were evident. The LaLeche league was praised highly by the breastfeeding participants within the non-GMS groups but not mentioned by those within the GMS groups. These breastfeeding participants expressed their praise for the support group in their area which, in this case, was the Ballymun Community Mothers Scheme. The care provided by and the availability of the public health nurse for these participants was emphasised in particular:

> she (public health nurse) like your mother or your sister...you don't feel stupid, if you're doing something wrong she explains what way to do it and what would be more comfortable for you

> I think it's the fact that she is there. You know you can get her at home...the fact that you can call her...its just a phone call

These reported experiences for the GMS breastfeeding participants in the present study serve as a good example of what is required to shift attitudes and the kind of support required for women breastfeeders in a social environment where bottlefeeding is the considered normal. Indeed, the difficulty in locating such a group within Community Care area 1 might in itself be indicative of the fact that without such intensive community based support women who are within the GMS category who breastfeed are very rare.

The lack of professional support discussed by breastfeeding participants included accounts of their needs not being met. The fact that hospital staff were generally very busy and, often, too busy to spend time with patients was discussed. One woman had mastitis and, despite her efforts to draw it to the attention of hospital staff, it went untreated according to herself. Others talked about the difficulties they had trying to breastfeed and the lack of support, or insensitive treatment, received by them:

> I pleaded with the nurse to come and help me breastfeed him because he was getting bottles all the time and she grabbed the baby's head and my boob and boom the baby just went berserk. He hadn't really cried until this actual moment. I literally pushed her away and said "I don't think that is absolutely necessary"

> In hospital I had one night when she (nurse) said well you're not capable of breastfeeding. If that child hasn't gained weight in the morning you're putting him on the bottle.

Some participants felt that second time mothers were expected to be able to manage breastfeeding without any assistance and, so, were left to fend for themselves. Finally, another issue raised by participants from the GMS group was that breastfeeding in a public ward was difficult because of a lack of privacy:

> the first time around I was the only breastfeeder in a ward of ten, the second time around again I was the only one in a ward of ten. You've people coming in all day...you've got a new baby and you're self-conscious

Considerably less discussion took place about a lack of professional support once participants were at home, although, some indicated that they had not had visits from their public health nurse at all, or until their child was a number of weeks old.

The professional support desired by breastfeeding participants was for a special nurse on hospital wards who would have time to devote to breastfeeding mothers and attend to any problems they may have. Also, breastfeeding participants from all groups expressed a desire for more support groups as well as more home visits. Non-GMS breastfeeding participants indicated that they felt GP services should be free to all children under 5 years of age because of the costs encurred by them.

Overall, this suggests that while positive experiences of health care are evident within these data there is also considerable room for improvement.

There was far less discussion from the bottlefeeding participants about professional supports received either in hospital or at home. Professionals who were described as supportive within the hospital were those who did not push breastfeeding. Chemists were identified as a source of support for bottlefeeding mothers as advice about formulas was provided in some cases. Participants from one group only talked about visits from public health nurses as support received by them.

Comments about a lack of professional support focused on the poor quality attention received by bottlefeeding women in hospital. This concurs with the accounts of professional support received by breastfeeding participants, which was outlined above. One woman talked in detail about the difficulty she had getting a bottle for her child. She believed that this was because the nurses were trying to get her to breastfeed:

> They were absolutely trying anything to get you to go back and they kept saying you don't want to try breastfeeding. I kept saying no, no, no please just give me the bottle and I had no help or advise whatsoever with that and I felt quite ostracised. I though that was really wrong

This participant went on to say that she was pregnant again and very worried about the treatment she would receive and the possible consequences of pressure from hospital staff to breastfeed:

> I'm terrified of this prospect of this on-going feeding problem for three of four days in the hospital here. I think, I feel quite strongly about it...I think it's a purely personal choice and think there's immense pressure on a lot of people who then, a lot of people I know have had a terrible ordeal and have then started to breastfeed because they were

kind of pressurised into it and then ended up with either post-natal depression or kind of that sort of thing...

The professional support desired by bottlefeeding participants was straightforward. These participants wanted more help and support in their homes. Visits from public health nurses during pregnancy and after the baby's birth were discussed. The benefits of building a rapport with a particular health visitor were emphasised also. More encouragement for their feeding choice was also mentioned. Also, the desire for positive information about bottlefeeding and, particularly, infant formulae was expressed. One participant who had had a bad experience with a young health visitor who had monitored whether the she could measure out the formula correctly, stressed that positive information about bottlefeeding was needed not how to do it.

While the overrepresentation of breastfeeding women within the study sample must be acknowledged, as previously discussed, it is important to point out that within any one of those focus groups there was more discussion than in the groups of bottlefeeding women. This may reflect a sense of concern or defensiveness about bottlefeeding particularly within the context of a health promotion study. Overall, however, explicit accounts of being treated and cared for in a positive way were not provided by bottlefeeding participants. This might suggest that the needs of bottlefeeding women are less catered for than breastfeeding women's needs are by current professional practice. There is even a sense within these data that these women are somewhat invisible. Efforts to recruit bottlefeeding women for the purposes of this study were extremely difficulty. The formal structures and supports within the Health Board meant it was easiest to contact breastfeeding mothers. This is encouraging in that breastfeeding is on the health agenda but the issue of equity is relevant here. As equity within health care is a key principle of Irish health policy (Shaping a Healthier Future. 1994) the absence of explicit accounts of support from professionals within hospital and within the community requires serious consideration.

Lay Support

Support received from lay people by participants represents 43% of all data within Lay Supports. Nearly half of these data (47%) describes poor support from lay people and just under 10% refers to participants desired lay supports (see Table 3.8).

Breastfeeding participants described that they received support from their husbands, partners, mothers and friends while breastfeeding. One participant explained that she would have given up breastfeeding if it had not been for the support and encouragement of her friends.

Discussions about a lack of lay support were predominately in breastfeeding groups. Participants who had breastfed, from GMS and non-GMS groups talked at length about the embarrassment felt by members of the public if a women is breastfeeding in a pub, hotel, restaurant or on a train. Stories about breastfeeding women being asked to stop or to move to a more private area were common. Participants argued that while people thought breastfeeding was good for babies they did not want to have to see it being done. This was explained in terms of embarrassment at seeing a woman's breasts and sexual taboos in society. Details of participant's views and some accounts of how they combated such negative attitudes are shown below:

they're looking at it not as a feeding thing but as a sexual think. I think this is the problem. 'I'm just feeding here. You have the problem I don't. Someone said would you not do it the proper way and use a bottle' As I said to a woman I'm sure Mary when she gave birth to baby Jesus didn't use a bottle because they weren't invented then. That's what breasts are for so I breastfeed.

it's a kind of image problem, it's okay for the Sun or the Star and look at them there, but when you use them for what they're meant to be used for people get nervous about it.

Another related issue that emerged was that breastfeeding women experienced negative attitudes if they were feeding their child beyond a certain age. Six months was mentioned as an age at which breastfeeding, even if previously viewed in a positive manner, became less acceptable:

if you feed a child after six months you're doing it for some sexual reason
yea (all round)
yea that's definitely for her that's not for the baby. The first couple of months its okay, you've done it and you haven't got any pleasure out of it, I don't know it's like sex or something years ago, but once you do it longer than a certain amount then you are decidedly dodgy.

One participant reported that they had experienced this prejudice from her GP asked. Another acknowledged that she had "a bit of that in me myself".

The lay support desired by breastfeeding participants was interesting in that the emphasis was on individual women "being bold enough" and "having courage" to breastfeed rather than identifying possible distinct forms of lay support *per se.*

Overall, the significance of these data is why, or how, participants overcame this very unsupportive behaviour. Embarrassment has previously been identified as a barrier to breastfeeding (Clarke, 1989). Moreover, why on examination are their ideas for desired lay support so few? If anything these data reflect an individualistic focus whereby participants, particularly from nonGMS groups, reported that women needed to "be bold enough" to "do it openly" and be "more aggressive". This finding, coupled with the finding that participants had views about the way in which health professionals could be more supportive in terms of more community based input, reflect only two dimensions of the Ottawa Charter (1986): personal skills and re-orientation of health services. However, from a health promotion perspective the importance of creating supportive environments and developing community participation highlight the relevance of socio-environmental factors, which would include lay networks.

The lay support referred to by bottlefeeding participants centred around family members and friends who did not hassle them for choosing to bottle feed their child. This echoes the earlier discussion about supportive professionals as those who did not "push" breastfeeding. This was most evident in the bottlefeeding non-GMS group. Some of these women commented as follows:

As soon as the baby was born the girls said 'Are you breastfeeding' and I said no...no problems

My sister has two children a little older than both of mine and she breast fed both of hers for six months and she never criticised that I never attempted the second baby. Friends of mine although some of them would have breastfed understood the reasons I was bottlefeeding and they didn't pass any comments that they agreed or disagreed.

There were no accounts from bottlefeeding participants about a lack of lay support and these participants did not discuss desired lay support either.

Environmental Support

As shown in Table 3.8, just over one third of all data coded under the category environmental support reflected accounts of support received. Forty-five per cent related to a lack of environmental support and twenty per cent referred to participants' ideas about desired environmental support.

Discussions pertaining to environmental support were provided by the breastfeeding participants from GMS groups only. These pertained mainly to employment issues and, to a less extent, the availability of breastfeeding facilities. Supportive employers were described as "fine" or "mostly sympathetic" about breasfeeding at work. The benefits of having a specific feeding room within the workplace were emphasised by a small number of participants. The benefits of maternal leave were talked about as well as paternal leave. Some flexibility around the timing of one's working day was also mentioned as a helpful form of support from employers. In terms of public facilities, one participant talked about the benefits of a smoke free pub within a local hotel.

A lack of support within the workplace related to the fact that breastfeeding and required facilities for breastfeeding could not be discussed with an employer. It was also discussed that feeding or using a pump at work was difficult because of the stresses of work. another participant explained that she had had to "fight tooth and mail" to extend her maternity leave. Feelings that maternity leave was short were expressed also. The varied nature of participants' individual experiences was evident here.

Poor facilities in public places for breastfeeding women were discussed within this category also. Feeding in public toilets was considered both unhygienic and unpleasant. These feeding rooms were described as "terrible", "small" "obstacle courses".

The kind of environmental supports desired by breastfeeding participants were baby rooms for feeding in public places, the need for better designed and more affordable maternity wear, the need for crèches and feeding rooms within workplaces, longer maternity and paternity leave and more sensitivity on the part of employers in terms of working hours.

Few references to the media as a form of environmental support were recorded. Positive support was mentioned in terms of programmes indicating the benefits of breastfeeding for children's health. Unhelpful discussions or comments on radio programmes were cited as

unsupportive and discouraging. There were no references to media as a form of desired environmental support by breastfeeding participants.

Participants from the bottlefeeding groups said very little about environmental support. One bottlefeeding woman from a GMS group commented on the benefits of part-time work and having a supportive employer in terms of allowing time off if it was needed. Some of these participants also felt that maternity leave was short and, therefore, unsupportive. The media was seen as largely unsupportive from the perspective of bottle feeding participants as most coverage referred to breastfeeding. Also, advertisements for infant formulae were rarely seen. There was no discussion about desired environmental support from any participants in the bottlefeeding groups.

The importance of the workplace as an issue to non-GMS breastfeeding participants was striking and, not withstanding the overrepresentation of breastfeeding women within the sample, it is argued that these findings reflect the difficulties faced by women who wish to breastfeed but also wish to continue work and pursue careers. The lack of discussion about this among bottlefeeding participants could be understood to reflect the fact that bottlefeeding is somewhat more compatible with returning to work and developing one's career.

Perceptions of Breastfeeding and Bottlefeeding Women

Relatively little data were gathered about the perceptions of participants about breastfeeding and bottlefeeding women. Of the data that were collected the majority pertained to perceptions of breastfeeding women rather than bottle feeding women (63% and 47% respectively. See Table 3.9)

Table 3.9 Community Perceptions of Breastfeeders and Bottlefeeders

Sub-Category	n(%)
Perceptions of Breastfeeding Women	12(63)
Perceptions of Bottlefeeding Women	7(37)

Breastfeeding women were described by those within the breastfeeding groups as middle class, educated, confident, concerned with their baby's health and disorganised. Breastfeeding women were described by bottlefeeding women as being willing to feed anywhere and happy to be tied down to their baby. The notions that breastfeeding women were "full of milk" and old were also mentioned.

Bottlefeeding women were described by breastfeeding participants as women from low income background, women who couldn't breastfeed, who were nervous about breastfeeding. One participant was very keen not to apportion blame to women who decided not to breastfeed. She argued that there were often a combination of reasons that led someone to bottle feed and she challenged the general consensus within the group that bottle-feeding mothers are bad.

Finally, participants within the bottlefeeding groups described bottlefeeding women as being young women and working women.

CONCLUSIONS AND RECOMMENDATIONS

The vast majority of respondents in community care area 1 approve of breastfeeding as a practice. However there was relatively more support among the higher social classes. Women of social classes 4-6 breastfeed their infants relatively less, find it less acceptable as a practice and seem to have lower levels of support than women of social classes 1-3. In Community Care Area I reported rate of breastfeeding their infants by women was 34.5%.

Preliminary results from the SLAN (Survey on Lifestyles, Attitudes and Nutrition) database are highly illuminating in the context of this research project's findings. Overall breastfeeding rates reported by adult women in the Eastern Health Board area were 32.6%, significantly higher than the national average of 28.8%. Most women said they fed their babies for 1 to 3 months (36.1%), followed by those who fed for 4 to 6 months (26.9%). Rates were highest among 35-54 year olds (36.0%), followed by the younger adults (25.9%) and lowest among those over 55 years (18.5%). There was a marked social class difference; those in groups 1-3 were twice as likely to report breastfeeding compared with those in the lower income groups (36.4% compared with 18.4%). Almost half of women aged 35-54 in social classes 1-3 said they had breastfed their baby (45.6%), compared with only 19.9% of similar aged women in social classes 4 to 6. These findings suggest that breastfeeding is at an early majority stage among more affluent women in the Eastern health board area but at an innovator stage in the other groups. Those findings accord well with the attitudinal data collected in this study, through both the questionnaire survey and the qualitative focus group interviews. What emerged in the focus group material was that the prevailing social attitude among the non GMS participants was perceived to be in support of breastfeeding and the women in this socio-economic category who chose to bottle feed were articulating their reasons for rejecting this norm. Among the GMS participants breastfeeding was not the usual practice and the women who wished to adopt the practice were articulating a range of practical and social barriers.

The main barrier to breastfeeding perceived by men is the public attitude, whereas for women it is practical issues. Suggestions to increase breastfeeding rates are in line with other studies. Men for instance approve most of advertising campaigns, women want better facilities in hospital, in the community and at work and more support

It is interesting to observe these differences between men and women as they may have practical implications. They also support the qualitative study of transition year school attenders undertaken previously by Connolly et al (1998). Men are generally quite well disposed to breastfeeding as a practice, in principle, and this is more particularly true of younger men. Since the perception that the practice is more likely to exclude fathers is quite strong then practical strategies to undermine this view need to be adopted. Fathers for instance may be able to feed babies expressed milk and to help out more at night. There is a strong case for educational strategies around this issue in Lifeskills programmes in schools, based on this survey's findings. A pilot module might be introduced as part of a Lifeskills programme in Eastern Health Board area's schools. There is also a need to publicise more explicitly the fact that men are generally supportive, since women would benefit from knowing this, especially as they are much more aware of the practicalities. Types of intervention for

men would be further education on benefits and practice of breastfeeding. Types of intervention programmes for women should emphasise the practical aspects of breastfeeding.

While media campaigns were generally endorsed in the population survey, they received far less emphasis in the focus groups. This is not surprising as other evaluations we have undertaken show that advertising campaigns raise general awareness but of themselves do not foster internalising of the message. This is particularly so when people have personal experience of difficulties with the health practice that is dissonant with the media message, as is the case in our focus group reports. Campaigns, if contemplated, should focus on the environmental support issues and seek to foster changes in attitude towards women feeding their infants, the involvement of men and the barriers that could be overcome in the work setting. The involvement of Health Board representatives in multi-sectoral collaboration (as for example in the Dublin Healthy Cities network) for the development of breastfeeding facilities within public places and work organisations and the dissemination of that information would be important. The fact that the public were relatively less impressed with local radio does not mean it should not be used as a medium. It actually has much greater and more cost-effective reach power than television and would be more appropriate for a regional area strategy.

Younger people are less likely to report that they were breastfed themselves and tend to see breastfeeding as less beneficial and less convenient.

This was an unusual finding from the population survey. It might have been anticipated that because breastfeeding is enjoying resurgence among the more affluent groups at least and was so widely endorsed as natural that young people would be well disposed. However they had more reservations than older participants who were generally more convinced of the health benefits. Some of the findings from the focus groups support this attitude and illuminate its cause; for instance health issues were not a predominant motivation for women generally, whereas most of the educational messages on the part of health professionals emphasise this aspect. Connolly et al's (1998) survey also found that younger schoolgirls were inhibited by the practical issues. The SLAN data mentioned above also show that the breastfeeding rates were lower among the younger age range. This highlights the need for school based health education on the issue and for special focus to be placed on supporting younger mothers during ante natal care on the part of health professionals. The community mother support scheme is highly successful generally and was strongly endorsed by our special focus group in this study; we conclude it could be more widely adapted around this particular issue. On the other hand younger people were less conservative about the social acceptability aspects of breastfeeding in public places and in friends' homes, which is a positive shift.

The population survey highlighted the need to involve health professionals as a source of support and advice and the focus groups were very illuminating in showing that attitudes of health professionals and facilities in hospital were crucial.

There are two issues here; among those in the GMS groups there is still a huge shift in culture required. Because the rates of breast feeding are relatively low and such women are more likely to be in a public ward surrounded by women who are bottle feeding, one to one support and privacy are crucial, as is a seamless transition to the community. Health care policies should ensure more privacy for breastfeeding mothers in hospital, and adequate staff time and facilities for support. There are undoubtedly many women in these income groups who would

attempt breastfeeding if more social support were available and who need more specific education and help than a general message.

For non GMS cardholders there can be assumed to be reasonable general knowledge around the issue of breastfeeding and what is required here too is a more subtle understanding of motivation. This is a classical example of a public health message designed to produce an undoubted relative benefit for everybody, which has a small absolute benefit for individuals. In other words, the women who decide not to breast feed are aware that a bottlefed baby does less well on average than a breast fed one but most babies in both groups thrive in the first year. They also know that there can be some difficulties for some women who breastfeed and they tend to highlight these issues. Finally, some women tend to resent how they are treated by health professionals. Whereas breastfeeding women were satisfied with health professional support received there was little evidence in the population survey that health professionals were a significant factor in the overall influences on decision to breast feed or not, suggesting a still unmet need. The practical aspects are very important too. As just one example, though successful breastfeeders were aware for instance of the convenience of breast feeding, in the general population survey this was a very equivocal issue and the bottle feeding women did not rate it as an advantage at all.

Patience, experience and dialogue are all required to unseat these attitudes and at the end of the day a women's final decision has to be respected and supported. There also needs to be agreement in tackling the issue across the spectrum of primary and secondary care and between professionals of all disciplines. Because breastfeeding is so topical and has received so much attention from some highly committed practitioners in recent years there may be reluctance among some health professionals now to admit that they need more in depth training and re-skilling. However, this is clearly crucial to the success of any strategy to increase breastfeeding rates and should be widely adopted for investment.

The materials to support breast feeding produced by the Centre for Health Promotion Studies for the Health Promotion Unit in the Department of Health were designed for all categories of health professionals, including nursing and midwifery staff and general practitioners; the materials explore all these issues in depth and are now being offered as part of an outreach certificate in health promotion. However there are a number of other well established programmes in the Dublin area as well. Training programmes should be aimed at those working in the health sector to increase the support that these groups might provide. Such training should enhance health professionals' ability to adopt a consultative approach with women before and during their feeding experience. Specific aims of training should also attend to women's personal experiences and personal observations of breastfeeding, and present scientific and 'lay' health information about breastfeeding. It is appropriate to acknowledge the difficulties associated with breastfeeding in some instances and to discuss possible solutions in a highly practical manner. To provide one-to-one attention for breastfeeding mothers as they begin to breastfeed in hospital and while feeding at home, to organise and facilitate community based support groups, is also important. The use of experienced peer mentors with basic training and the support of voluntary organisations is very important, as they can communicate a rewarding and satisfactory experience for women in an inimitable way.

Main Recommendations:

1. Target women in the less affluent groups and younger women for priority intervention

2. Develop a multi-sectoral awareness raising and social support programme in the region

3. Focus on a Lifeskills schools education programme for second level students in the region, with particular emphasis on the role of men

4. Provide concerted in depth education on attitudes and practice for all health professionals dealing on a regular basis with pregnant women

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Appendix A. Population Survey Questionnaire

Section A: Knowledge

A1. **What method of feeding do you think is best for babies?**

Breast feeding ☐ (1) Bottle feeding ☐ (2) Don't know ☐ (9)

A2. **Why is it best?**

.....

.....

.....

.....

.....

.....

A3. ***I'm going to read out some statements relating to methods of infant feeding and I'd like you to choose the most appropriate answer in your opinion***

What do you think is the feeding method

	Breast Feed	Bottle Feed	Don't Know
that provides the best nourishment	☐(1)	☐ (2)	☐ (9)
that is most natural	☐(1)	☐ (2)	☐ (9)
that best protects against disease	☐(1)	☐ (2)	☐ (9)
that leads to a better bond between mother and baby	☐(1)	☐ (2)	☐ (9)
that is easiest	☐(1)	☐ (2)	☐ (9)
that is cheapest	☐(1)	☐ (2)	☐ (9)
that is most convenient	☐(1)	☐ (2)	☐ (9)
that is environmentally most friendly	☐(1)	☐ (2)	☐ (9)

A4. **What do you see as a barrier to breast feeding? (First without prompts, then read questions out)**

.....

.....

.....

.....

	Yes	No	Don't Know
breast feeding is difficult outside the home	☐(1)	☐ (2)	☐ (9)
more time is needed for breast feeding	☐(1)	☐ (2)	☐ (9)
mother is more tied to baby when breast feeding	☐(1)	☐ (2)	☐ (9)
breast feeding is more tiring.	☐(1)	☐ (2)	☐ (9)
the partner is not involved when baby is breastfed	☐(1)	☐ (2)	☐ (9)
breast feeding is embarrassing for the mother	☐(1)	☐ (2)	☐ (9)
breast feeding limits the mothers social life	☐(1)	☐ (2)	☐ (9)
breastfeeding and working is difficult	☐(1)	☐ (2)	☐ (9)

A5. ***I'd like to read a list of statements relating to bottle feeding, and would like your opinion on each one***

Which of the following in your opinion are advantages of bottle feeding over breast feeding:

	Yes	No	Don't Know
You know how much milk baby is getting out of bottle	☐(1)	☐ (2)	☐ (9)
Bottle feeding in public is more acceptable than breast feed.	☐(1)	☐ (2)	☐ (9)
It can be carried out by either partner	☐(1)	☐ (2)	☐ (9)
It is more nourishing than breast feeding	☐(1)	☐ (2)	☐ (9)

A6. **Which of the following is true about <u>starting</u> breast feeding in Ireland (tick one)?**

Nearly all mothers start breastfeeding ☐ (1) About one-third starts breastfeeding ☐ (4)

About two thirds start breastfeeding ☐ (2) Hardly any mothers start breastfeeding ☐ (5)

About half the mothers start breastfeeding ☐ (3) Don't know ☐ (9)

A7. **For what length of time do you think it is best for a mother <u>solely</u> to breast feed her baby (tick one)?**

1 week ☐ (1) 1 month ☐ (3) 6 months ☐ (5)
2 weeks ☐ (2) 4 months ☐ (4) Don't Know ☐ (9)

A8. **Do you think that women at work find breast feeding compared to bottle feeding (tick one)?**

More easy ☐ (1) ⇒ A 10 Less easy ☐ (3) ⇒ A 9
Same ☐ (2) ⇒ A 10 Don't know ☐ (9) ⇒ A 10

A9. What might make it more difficult for the working mother to breast feed?

	Yes	No	Don't Know
No facilities at work	☐(1)	☐ (2)	☐ (9)
Length of maternity leave	☐(1)	☐ (2)	☐ (9)
Irregular hours	☐(1)	☐ (2)	☐ (9)
Lack of crèche facilities	☐(1)	☐ (2)	☐ (9)

Other: (please comment).....
.....
.....
.....

A10. **Which do you think is more common on popular T.V?**

Breast feeding ☐ (1) Bottle feeding ☐ (2) Don't Know ☐ (9)

The following are some questions relating to your own experiences

A11. **In real life, have you ever seen a baby being breast fed?**

Yes ☐ (1) No ☐ (2) Don't Know ☐ (9)

A12. **Were you breast fed yourself?**

Yes ☐ (1) No ☐ (2) Don't Know ☐ (9)

A13. **Has anyone close to you breast fed?**

(The following may be used as prompts: Family, friends, other relatives, partner)

Yes ☐ (1) No ☐ (2) Don't Know ☐ (9)

A14. **Do you have children?**

Yes ☐ (1) ⇒ A15 No ☐ (2) ⇒ A18 male, B1 female

A15. **How many children do you have?**.....

A16. **What method of feeding did you choose for your baby/babies (tick one)?**

All Breast feeding ☐ (1) Mixed (if more than 1 child) ☐ (3)(please specify)
.....
All Bottle feeding ☐ (2) Don't Know ☐ (9)
.....

A17. **Who influenced your choice of infant feeding? (without prompts, tick all mentioned)**

Ante Natal Class Staff	☐ (1)	Husband/Partner	☐ (7)
Public Health Nurse	☐ (2)	Mother	☐ (8)
GP	☐ (3)	Other Family Members	☐ (9)
Voluntary Groups	☐ (4)	Friends	☐ (10)
Labour Ward Staff	☐ (5)	Other	☐ (11)
Teachers/schools	☐ (6)		

(specify).....
.....

A18. **<u>(Men only):</u> Do you think your attitude to breast feeding would (or has) influence(d) your partners decision?**

Yes ☐ (1) No ☐ (2) Don't Know ☐ (9)

Section B: Attitudes

I would like to ask you some questions about your views on breast feeding:

B1. **In your opinion which of the following words describes breast feeding (please tick one only)?**

Lovely	☐ (1)	Disgusting	☐ (5)
Natural	☐ (2)	Rude	☐ (6)
Acceptable	☐ (3)	None of the above	☐ (7)

Embarrassing ☐ (4) Other ☐

(10).....

B2. **In your opinion is it acceptable to breast feed in the following places:**

	Agree	Disagree	Don't know
A Restaurant/Pub	☐ (1)	☐ (2)	☐ (9)
Bus/Train	☐ (1)	☐ (2)	☐ (9)
A Shopping Centre	☐ (1)	☐ (2)	☐ (9)
Friend's house (mixed company)	☐ (1)	☐ (2)	☐ (9)
Health Care Facility	☐ (1)	☐ (2)	☐ (9)
Recreational area (park/playground)	☐ (1)	☐ (2)	☐ (9)
Ladies Room	☐ (1)	☐ (2)	☐ (9)

Other (Please state).....

.....

.....

.....

B3. **How would you feel if a woman was breast feeding in front of you in a public place?**

.....

.....

.....

.....

B4. **Do you have any suggestions for increasing breast feeding rates?**

.....

.....

.....

.....

What about the following?	**Agree**	**Disagree**	**Don't know**
Education of mothers at antenatal class	☐ (1)	☐ (2)	☐ (9)
Education of young men and women in secondary school	☐ (1)	☐ (2)	☐ (9)
More places in which to breast feed	☐ (1)	☐ (2)	☐ (9)
Financial incentives	☐ (1)	☐ (2)	☐ (9)

B5. **Which of the following would be the best form of media to help increase rates of breast feeding in Ireland (tick one)**

T.V.	☐ (1)	Newspapers	☐ (4)
Local Radio	☐ (2)	Don't Know	☐ (9)
National Radio	☐ (3)	Other	☐

(10).....

.....

.....

Section C: Demographic

(Note whether the person is male or female)

Male ☐ (1) Female ☐ (2)

C1. **To which age group do you belong**

18-24	☐ (1)	35-44	☐ (3)	55-64	☐ (5)
25-34	☐ (2)	45-54	☐ (4)	65+	☐ (6)

C2. **Are you currently:**

Married	☐ (1)	Cohabiting	☐ (3)	Widowed	☐ (5)
Separated	☐ (2)	Divorced	☐ (4)	Single/Never Married	☐ (6)

C3. **What did your education include?**

No schooling	☐ (1)
Primary school education only	☐ (2)
Some secondary school education	☐ (3)
Complete secondary education	☐ (4)
Some third level education at college, university, RTC	☐ (5)
Complete third level education at college, university, RTC	☐ (6)

C4. **What is your current employment situation?**

At work:	Employee	☐ (1)
	Self-employed	☐ (2)
Homemaker		☐ (3) ⇒ C6
Unable to work owing to permanent sickness/disability		☐ (4)
Wholly retired		☐ (5)
Unemployed		☐ (6)
At school, student		☐ (7) ⇒ C6
Seeking work for the first time		☐ (8) ⇒ C6

C5. **What is the title of your job?**
(If not in a wage paying job at the moment, give the title of last job)

.....

.....

.....

(If principal wage earner ⇒ C 7)

Social class 1	☐ (1)	Social class 4	☐ (4)
Social class 2	☐ (2)	Social class 5	☐ (5)
Social class 3	☐ (3)	Social class 6	☐ (6)

C6. **If you are <u>not</u> the principal wage earner, please answer the following about the principal wage earner in your household:**
What is his/her job title?
(If not in a paid job at the moment give title of last job)

.....

.....

.....

.....

Social class 1	☐ (1)	Social class 4	☐ (4)
Social class 2	☐ (2)	Social class 5	☐ (5)
Social class 3	☐ (3)	Social class 6	☐ (6)

C7. **Do you have a medical card?**
Yes ☐ (1) No ☐ (2)

C8. **Are you a ?**
Smoker ☐ (1) Non-smoker ☐ (2) Ex-Smoker ☐ (3)

Thank You for Your Co-operation

Appendix B Focus Group Protocol

Decision influences

Thinking back to before you had your baby ...

1. Why did you decide to breastfeed/bottlefeed?
   Was baby feeding discussed in school?
   Were you breastfed or bottlefed?
   Did other mothers influence you?
   Were you offered information by a health professional/friend relative?

2. What doubts did you have about your decision, if any?

Support issues

From birth onwards ...

3. What has your experience of feeding been like?
   What were the highs and the lows?

4. With regard to your baby's feeding, who encourages you?
   Partner/family/friends/other mothers/health professional/voluntary group/employer/co-workers?

5. Other than people, what else encouraged you or supported your decision?
   Books/media/experience/structural support/voluntary group/workplace/cost/environment? (note: define structural support)

6. In hindsight, what additional supports would have helped you?
   What hindered you?

7. What are your feelings about weaning?

Community perceptions

8. In your opinion, what kind of women breastfeed?

9. What kind of women do you think bottlefeed?