



A serial qualitative interview study of infant feeding experiences: idealism meets realism

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Complete List of Authors:	Hoddinott, Pat; University of Aberdeen, Public Health Nutrition Research Group Craig, Leone; University of Aberdeen, Public health Nutrition Research Group Britten, Jane; University of Stirling, School of Nursing Midwifery and Health McInnes, Rhona; University of Stirling, School of Nursing Midwifery and Health
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3 **Title: A serial qualitative interview study of infant feeding experiences: idealism**
4 **meets realism**

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6 Pat Hoddinott, Leone Craig, Jane Britten, Rhona McInnes
7

8
9 Health Services Research Unit, University of Aberdeen, 3rd Floor, Health Sciences
10 Building, Foresterhill, Aberdeen, AB25 2ZD
11

12
13 Pat Hoddinott, Senior Clinical Research Fellow
14

15
16 Public Health Nutrition Research Group, University of Aberdeen, Polwarth Building,
17 Foresterhill, Aberdeen, AB25 2ZD
18

19
20 Leone Craig, Research Fellow
21

22
23 School of Nursing, Midwifery and Health, University of Stirling
24

25
26 Jane Britten, Research Fellow
27

28
29 Rhona McInnes, Senior Lecturer
30

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41 Correspondence to: p.hoddinott@abdn.ac.uk
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ABSTRACT

Objective - To investigate the infant feeding experiences of women and their significant others from pregnancy until six months after birth to establish what would make a difference.

Design - Qualitative serial interview study.

Setting - Two Health Boards in Scotland.

Participants - 72 of 541 invited pregnant women volunteered. 220 interviews approximately every 4 weeks with 36 women, 26 partners, 8 maternal mothers, 1 sister and 2 health professionals took place.

Results - The overarching theme was a clash between overt or covert infant feeding idealism and the reality experienced. This is manifest as pivotal points where families perceive that the only solution that will restore family wellbeing is to stop breastfeeding or introduce solids. Immediate family wellbeing is the overriding goal rather than theoretical longer term health benefits. Feeding education is perceived as unrealistic, overly technical and rules based which can undermine women's confidence. Unanimously families would prefer the balance to shift away from antenatal theory towards more help immediately after birth and at three to four months when solids are being considered. Family orientated interactive discussions are valued above breastfeeding centred checklist style encounters.

Conclusions - Adopting idealistic global policy goals like exclusive breastfeeding until 6 months as individual goals for women is unhelpful. More achievable incremental goals are recommended. Using a proactive family centred narrative approach to feeding care might enable pivotal points to be anticipated and resolved. More attention to the diverse values, meanings and emotions around infant feeding within families could help to reconcile health ideals with reality.

ARTICLE SUMMARY

Article focus

- To investigate the perspectives of women and their wider family and social network on infant feeding from pregnancy until 6 months after birth
- To ascertain what would make a difference to their experiences of breastfeeding and the introduction of other fluids and solids
- To focus on health inequalities and to understand interactions between women, professionals, organisations and systems to inform policy, practice and the design of complex intervention trials to improve infant feeding outcomes

Key messages

- Clashes between overt or covert idealism and realism within and between families and the health service occur at pivotal points particularly in the early weeks after birth and around the introduction of solids
- At pivotal points, families often perceive the only solution within their control that will restore family wellbeing is to stop breastfeeding or introduce solids or other fluids. Using a family centred narrative approach could enable pivotal points to be anticipated and resolved
- Translating global policy goals like exclusive breastfeeding until 6 months into practice is unhelpful and achievable incremental goal setting is recommended

Strengths and limitations

- Original interpretation using robust and transparent methods in a relatively large data set of serial interviews about infant feeding, with recruitment of women living in more disadvantaged areas
- Findings which are relevant to current policy and practice, particularly the UNICEF Baby Friendly initiative
- An explicit aim to elicit the views of women and their significant others to inform future intervention studies, policy and practice
- Our findings are hypothesis generating rather than hypothesis testing
- It is uncertain how transferable our data is outside the UK context, particularly to countries where breastfeeding prevalence is high
- Although we targeted more disadvantaged areas for recruitment, our sample was more economically advantaged than we would have liked

INTRODUCTION

The observational evidence for the maternal and infant health benefits of breastfeeding in both developing and developed countries is growing. Accordingly many governments endorse the World Health Organisation (WHO) recommendation of exclusive breastfeeding, with no other fluids or solids, not even water, for 6 months, followed by the appropriate introduction of solids and continued breastfeeding for 2 years and beyond.¹ Yet in many developed countries rates of any breastfeeding let alone exclusive breastfeeding are a long way from this ideal. Breastfeeding incidence is increasing but internationally the duration and exclusivity of breastfeeding seem more resistant to change.²⁻⁵ Less than 1% of UK babies were reported to be breastfed exclusively at 6 months in 2005,⁶ although the percentage of babies receiving solids at 4 months fell from 85% in 2000 to 65% in 2005. Cross country comparisons are problematic due to variations in how exclusivity is measured.⁷ However there are some interesting contrasts, with Canadian data showing an increase in exclusive breastfeeding at 6 months from 17.3% in 2003 to 23.1% in 2007-2008³, but in the United States (U.S.) rates decreased from 14.1% in 2006 to 13.3% in 2010.^{2,8} In 2005, nine out of ten UK women who breastfed for less than six weeks reported that they would have liked to have breastfed for longer⁶ and recent qualitative evidence syntheses⁹⁻¹¹ and survey data¹² suggest that postnatal infant feeding services are not consistently meeting women's needs.

In the face of these statistics and in an attempt to motivate health service providers and improve outcomes, governments have set less ambitious targets. Increases in breastfeeding initiation in England and Wales from 71% in 2000 to 82% in 2010⁴ did not meet the 2006 target of increasing breastfeeding initiation by 2% per year.¹³ In 2008 this target was replaced by a requirement for each primary care trust to report breastfeeding rates at 6-8 weeks and deliver local improvements.¹⁴ Similarly in the last decade, U.S. targets for breastfeeding at 6 months were not met and have been cut from 50% to 25%.² In Scotland two recent targets have also not yet been met: a 2008 target of 50% of women breastfeeding at 6-8 weeks and the equally ambitious target of 33% of women exclusively breastfeeding at 6-8 weeks by 2011.¹⁵ A region in Northern Italy took a different approach and introduced a 0.5% payment penalty if Health Authorities failed to meet their locally set breastfeeding targets.^{16,17} UK governments are increasingly targeting care towards more disadvantaged families^{18,19} as their babies are more likely to be given formula milk and receive solids early.⁶ The implicit assumption is that more individual advice, help and support for these social groups will lead to increased breastfeeding rates and likelihood of targets being met.¹⁸ However, the jury is still out on the effectiveness of this approach.^{20,21}

Infant nutrition guidelines^{19,22} aim to help health services meet targets and are informed by evidence syntheses which consistently show that additional lay and professional support, particularly if it is multi-faceted and spans pregnancy and birth, can prolong the duration and exclusivity of breastfeeding.^{23,24} However, as this evidence comes mostly from the North Americas the extent to which it can be generalised across different health systems is unknown.²⁵ Infant feeding interventions mostly educate and/or support individual women^{23,24} or train lay supporters and/or health professionals.²⁶ They mostly assume a cognitive model of decision making where pros and cons are weighed up and behaviour changes. However the widely assumed rational approach seldom applies for more disadvantaged social groups²⁷ and automatic processes are increasingly recognised as determinants of behaviour.²⁸ This suggests that context and experience may be more influential for some

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3 than theoretical knowledge, confirming earlier research on infant feeding decision-making
4 amongst early school leavers.²⁹ An example of a widely adopted multi-faceted intervention
5 and systems approach is the UNICEF Baby Friendly Initiative (BFI) which is endorsed by the
6 National Institute of Health and Clinical Excellence (NICE)^{19,22} and provides a focus for
7 organisations to achieve an accreditation award.³⁰ The BFI combines research evidence
8 and good practice standards, covering all aspects of service provision and care.
9 Implementing the BFI in Belarus was associated with an increase in duration and exclusivity
10 of breastfeeding in the first 12 months of life³¹, however in the UK the BFI is only associated
11 with an increase in breastfeeding up to 7 days and therefore its impact remains unclear.³²
12 Furthermore, despite milk feeding being part of a feeding continuum for infants and parents,
13 the majority of infant feeding interventions in the first 6 months after birth have focused on
14 breastfeeding as the outcome rather than the appropriate introduction of solids and other
15 fluids. Goals and recommendations relating to age of introduction of solids have been
16 subject to similar controversy as those relating to breastfeeding.
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20 Our aim was to move away from a focus on the individual to investigate wider family and
21 network perspectives on what would make a difference to their experiences of breastfeeding
22 and introducing other fluids and solids. Our intention was to focus on health inequalities and
23 to understand interactions between women, professionals, organisations and systems and
24 thus inform the design of complex intervention trials³³ to improve infant feeding outcomes.
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27 **METHODS**

28 **Design, rationale and setting**

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30 This qualitative serial interview study investigates the perspectives of women and their
31 nominated significant others from late pregnancy until 6 months after birth. Serial qualitative
32 interviews allow trust to develop between the researcher and participant, allow early
33 questions generated from data analysis to be explored in depth later and can help validate
34 study findings.³⁴ Including significant others captures how relationships change over time
35 and enables infant feeding to be understood in a wider socio-cultural context. Our approach
36 is informed by environmental and ecological theory of behavioural change, which
37 understands health related decisions as constantly adapting to changes in the micro, meso
38 and macro context in which the decisions are made.³⁵ The study was conducted in two
39 contrasting Scottish Health Boards around 100 miles apart, where maternity units were
40 implementing the Baby Friendly Initiative. Two qualitative researchers were based at each
41 site. The research team brought together considerable infant feeding research experience
42 from different backgrounds: nutrition; the voluntary sector; social policy; midwifery and
43 general practice. Conducting qualitative research with a multi-disciplinary team can help
44 challenge researcher assumptions and biases, which is important when one of the aims is to
45 develop theoretically informed interventions to test in trials.
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50 **Definitions**

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52 Breastfeeding initiation refers to the baby receiving any breast milk, even if only once.
53 Exclusive breastfeeding is defined as the infant receiving only breast milk since birth with no
54 other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral
55 supplements, or medicines.³⁶ Introduction of solids is defined as the first ever solid food
56 offered to and taken by the baby, even if it is only a small amount. Pregnant women
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3 recruited to the study were considered as the index cases and relationships are described in
4 relation to them. We define significant other(s) as the person(s) identified by the woman
5 who has the strongest influence on feeding decisions, regardless of the direction of influence
6 (either for or against the decision).
7

8 **Recruitment and sampling strategy**

9
10 Maternity unit databases were used to identify 459 (site 1) and 533 (site 2) women due to
11 give birth between September to October 2009. As mothers living in disadvantaged areas
12 are less likely to breastfeed and to participate in research,⁶ we invited all women living in the
13 three more deprived postcode quintiles of the Scottish Index of Multiple Deprivation (SIMD)³⁷
14 (n= 420) and a smaller sample of women living in the two more advantaged SIMD quintile
15 areas (n=121). In more advantaged areas, we recruited families where the woman or her
16 partner had a low age of leaving full time education, a non professional occupation, or were
17 immigrants to the UK which may be a disadvantage, particularly around the time of
18 childbirth. The research commissioning brief was to aim to recruit over 75% of participants
19 from the three more disadvantaged SIMD quintiles and select women with diverse
20 characteristics who intended to breastfeed or who had breastfed a previous baby. Invitation
21 packs included an introductory letter on Maternity Unit headed paper signed by a lead health
22 professional, an information leaflet and a short opt-in characteristics questionnaire with a
23 free post envelope to inform purposive sampling. Of 541 invitation letters sent out 4-8 weeks
24 prior to a woman's estimated date of delivery 72 (13%) women volunteered to participate
25 and provided socio-demographic data. Using a sampling frame we selected 18 women from
26 each site for the characteristics listed in Table 1. The index women were asked to identify
27 significant others (partners, family, friends and health professionals) throughout the study
28 and the researcher negotiated informed consent to interview a diverse range of information
29 rich significant others at different points.
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34 **Data collection**

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36 Our aim was to interview women and their significant others every 4 weeks, at a time and
37 place to suit them. We negotiated frequency of contact, being sensitive to the emotional and
38 physical impact the arrival of a new baby can have on a family. Face to face interviews took
39 place at home during pregnancy, within 4 weeks of birth and at 6 months, with shorter,
40 mostly telephone, interviews (0-5) in between. Two participants preferred face to face
41 interviews throughout as English was not their first language. Prior to contact after birth, we
42 consulted midwives who accessed NHS records to ensure a safe delivery had occurred. A
43 website discussion forum was available throughout the study. This complemented interview
44 data and enabled contributions from volunteer parents who had not been selected to
45 participate.
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49 Interviews were semi-structured, using topic guides that were modified over the course of
50 the study to probe emerging themes in more depth and to search for disconfirming data. At
51 the end of each interview, researchers collected structured information about significant
52 others influential since the last interview (age, relationship, distance from the family and
53 feeding experience). In particular, any inconsistencies or changes in the person(s)
54 nominated as significant at different time points could be explored. Similarly researchers
55 collected structured data at each time point about breastfeeding duration, exclusivity,
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3 introduction of non-milk liquids and solids, based on the Office for National Statistics five
4 yearly UK survey questions.⁶
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6 Prior to the final interview, the research team constructed seven vignettes describing a range
7 of health or community services to help with infant feeding informed by the emergent data
8 analysis and the research evidence. The vignettes were multi-component and designed as
9 research tools to assist the development of interventions for future research. They were
10 given to participants to read and comment on at the final 6 month interview. Details are
11 provided in the full report.³⁸
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14 **Data analysis**

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16 Data collection and analysis progressed iteratively, with the four authors involved in listening
17 to interview recordings, reading verbatim transcripts, identifying and interpreting themes and
18 agreeing modifications to topic guides according to the emerging analysis. All interview
19 transcripts were entered as data units onto FrameWork software.³⁹ FrameWork is a
20 rigorous, systematic data management tool, which allows original data and researcher
21 interpretations to be transparently documented and maintains the important direct link
22 between coded themes, interpretations and the original interview data.⁴⁰ The four
23 researchers independently constructed a thematic index by reading a sample of six
24 information rich transcripts of antenatal and first postnatal interviews, then reached
25 consensus through discussion. This index was modified later in a similar manner to cover
26 the introduction of solids. A final thematic index was agreed approximately half way through
27 data collection and was used to organise, label and summarise data. Analysis proceeded by
28 researchers keeping reflective diaries, identifying interpretive themes, discussing them,
29 generating research questions, creating different FrameWork charts to explore patterns and
30 search for disconfirming data. Charts compared couples with differing attributes, e.g.
31 primiparous compared with multiparous women; early cessation of breastfeeding compared
32 with late; early introduction of solids compared with late and differences in the level of
33 partner or significant other involvement with infant feeding.
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38 **RESULTS**

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40 A total of 220 recorded individual or pair interviews took place with 36 women (Table 1) and
41 37 significant others (26 partners, 8 maternal mothers, 1 sister and 2 health professionals),
42 between 2-8 times (Table 2). All women intended to breastfeed except one who had
43 breastfed a previous baby but intended to formula feed on this occasion. Two families
44 withdrew from the study after the first postnatal interview. Both had stopped breastfeeding in
45 the first week. The remaining 34 families were each interviewed from the last trimester of
46 pregnancy until 6 months after birth.
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49 The meanings attributed to infant feeding and the competing values which influence feeding
50 decisions differ considerably both within and between families. Box 1 summarises the
51 overarching theme emerging from our data as a mismatch between idealism and realism.
52 Those involved in infant feeding – families, their social networks and the health service –
53 hold different explicit or implicit philosophical positions of idealism or realism about infant
54 feeding. By idealism we imply the construct of ideal feeding based on the research evidence
55 which optimises child and maternal health: currently exclusive breastfeeding for 6 months
56 and continued breastfeeding for 2 years and beyond.¹ Idealists are guided by high moral or
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Table 1. Characteristics of women selected for interview (n=36)

	Site 1 participants (n = 18)	Site 2 participants (n = 18)
Age (years)		
≤20	0	3
21-30	4	4
31-40	11	11
≤40	3	0
Age at leaving full time education (years)		
16 or less	1	3
17	1	5
18	3	1
19 or more	13	9
Occupational classification*		
1-3	10	6
4-6	5	8
7-9	2	3
Not employed	1	1
Parity		
0	9	10
≥1	9	8
Scottish Index of Multiple Deprivation (SIMD)**		
1-3	13	13
4-5	5	5

*Standard Occupational Classification (SOC 2000) taken from the 2000 Census.

Available at: <http://www.ons.gov.uk/about-statistics/classifications/archived/SOC2000/index.html>

1	Managers and senior officials	6	Personal service occupations
2	Professional occupations	7	Sales and customer service occupations
3	Associate professional and technical occupations	8	Process and plant and machine operatives
4	Administrative and secretarial occupation	9	Elementary occupations
5	Skilled trade occupations		

** Scottish Index of Multiple Deprivation 2009: www.scotland.gov.uk/Topics/Statistics/SIMD
SIMD 1 is the most deprived quintile. SIMD 5 is the least deprived quintile.

Table 2. Interview frequency

	Number of index cases (women) n=36	Number of interviews where a significant other was present
2 interviews	2	3
3 interviews	-	-
4 interviews	1	2
5 interviews	6	8
6 interviews	15	27
7 interviews	6	7
8 interviews	6	15

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Box 1. Idealism and realism: mismatch within and between families and health services**Idealism – women and family values**

Exclusive breastfeeding is the ideal for health and this determines feeding behaviour

Breastfeeding is the focus of the first 6 months, with other activities taking second place

Intensive mothering with demand feeding. Partners and families supportive in all other aspects of baby care

Prepared to persevere however difficult it is and put breastfeeding first

Expressing milk allows others to feed or gives mothers baby free time

Breastfeeding in public is protected by law in some countries which will empower women

Baby behavioural cues before 6 months can be resolved without giving solids

Idealism – health service^{19,22,30,41}

All health service staff fully support exclusive breastfeeding to 6 months to maximise health benefits

All health service staff are trained in core breastfeeding education and support skills

More antenatal preparation and education will result in better outcomes. A rational, cognitive, planned model of behaviour prevails

Discussing difficult breastfeeding experiences will put women off

With correct technique breastfeeding will be painless and problem free.

Staff have sufficient time to sit with mothers during breastfeeds and provide help until breastfeeding is established

The transition between hospital and home is smooth with good communication between staff

Proactive care improves feeding outcomes

Rules work. Compliance

Breastfeeding centred checklists improve quality of care

Realism – women and family values

A happy mother, baby and family are the ideal and feeding behaviour is determined by a complex balance of factors

Breastfeeding is one of many competing activities, agendas and values

Sharing responsibility for feeding allows partners, grandparents and others a unique bonding opportunity

Immediate gains of stopping (pain, anxiety, time, sleep) outweigh the delayed rewards of breastfeeding

Expressing milk can be difficult, distasteful and as time consuming as breastfeeding

Breastfeeding in public can be difficult and not widely accepted, even if legal

Giving solids has multiple meanings and delaying is counter-intuitive

Realism – health service

Not all health professionals are fully supportive of exclusive breastfeeding to 6 months. The all or nothing, breast or bottle culture is unpopular

Not all staff have the necessary skills and breastfeeding care is highly variable and determined to some extent by luck.

Help to learn breastfeeding after birth is the priority compared to antenatal preparation.

Antenatal care paints an unrealistic picture

Pain and distress are complex emotional, somatic and cultural phenomena, which are seldom resolved by a technical approach alone. Reassurance and confidence building are crucial

Staff cannot offer the support that some women require due to staff shortages and competing demands on time. Sitting through a breastfeed is crucial for confidence building and problem prevention

Care is fragmented between hospital and home, and at day 10-14 between midwife and health visitor

Reactive care when problems are established. Pivotal points occur where feeding plans change rapidly to improve wellbeing

Resistance to rules is common. Deviance

Family centred care and listening to experiences is valued

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3 intellectual feeding values and adhere to guidelines espousing optimum infant feeding. By
4 realism we imply that women, families and health professionals accept the situation as it is
5 and are prepared to deal with it practically or pragmatically. For infant feeding in the real
6 world there are multiple individual or family values that compete with the optimum health
7 ideal. In the top half of Box 1 we set out how accounts of infant feeding and wider socio-
8 cultural values of women and families in our study fit with the overarching theme of idealism
9 meeting realism. In the bottom left quadrant of Box 1, the ideal position of health service
10 providers is derived from current health service guidance.^{19,22,30,41} In the bottom right
11 quadrant we illustrate how women and families in our study perceive the reality of health
12 service care. We describe how the mismatch and conflict between idealism and realism can
13 cause tensions within families and in the professional – family relationship, and how families
14 detect these tensions amongst health professionals. Importantly, philosophical positions
15 influence how health professionals communicate with parents, including how research
16 evidence is translated visually and verbally. Our analysis builds on earlier qualitative
17 research, particularly evidence syntheses^{9,10} which we reference alongside our findings. The
18 analysis is supported by quotations in Boxes 2-5 which provide participant ID numbers to
19 enable linkage to more detailed contextual data (socio-demographic characteristics, feeding
20 patterns and significant other relationships) in the full report.³⁸ We consider parents'
21 perspectives on how the health service ideal of exclusive breastfeeding for 6 months is
22 reconciled with other values throughout the feeding journey and what would make a
23 difference to improve their feeding experiences (Box 6).

24 **Pregnancy: rosy pictures and the word on the street (Box 2)**

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30 In pregnancy many women and their significant others anticipate breastfeeding difficulties
31 and failure, describing scenarios where they would behave differently from their own ideals
32 and those of the health service. Parents hedge their feeding outcomes saying they will try
33 breastfeeding and decide from day to day rather than aim for the 6 month goal stated in
34 health service information. New parents do not want to set themselves up to fail and the
35 expectation-reality gap in women's breastfeeding experiences has been widely
36 documented.¹⁰ Frustration with this gap is particularly strongly expressed by partners, who
37 comment that antenatal information for breastfeeding did not prepare them well for reality.
38 Antenatal breastfeeding preparation "makes it sound so easy", and fails to acknowledge the
39 more negative word on the street. Most parents prefer to hear about a wide range of
40 positive and negative feeding experiences from recent parents, including those who "break
41 the rules", whereas such parents seem less likely to be selected by health professionals as
42 role models in antenatal education sessions. Some parents report feeling "pressured" to
43 breastfeed and in extreme cases view breastfeeding promotion as "propaganda" and
44 suggest that the "breast is best message" has been overdone, confirming earlier research.⁴²

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49 Breastfeeding education classes or workshops which intensively teach positioning and
50 attachment prior to birth, assisted by videos, dolls and knitted breasts are viewed negatively
51 by many as "school-like" and "patronising". Overly scientific information about anatomy,
52 physiology and the constituents of breast milk is seldom appreciated, as described by
53 others.¹⁰ A strongly stated preference is to learn about positioning a baby at the breast
54 immediately after birth, with skilled, patient and timely help. Messages are perceived as
55 "breastfeeding centric", presenting breast or bottle as a dichotomy "you can't do both". The
56 provision of separate antenatal breastfeeding preparation classes rather than general
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Box 2. Idealism meets realism before birth

Partner: [about his sister and her children] it was what was better for both her and the little ones [changing from breast to bottle feeding], because she was getting all up to high doe because she was like "oh it's not working, baby's crying all the time, how am I going to cope with this?" and that sort of thing. We're sort of the same, if it's not working we'll switch. (ID 1044. Antenatal interview)

Woman: I think a reality check actually would be good, because they make it sound so easy, you know, it's like if you just take the baby, you're going to latch it on and it's all going to be plain sailing.... you might be lucky and it might work like that, but you might be the complete opposite. (ID 1010. Antenatal interview)

Partner: Because it's so... you know, breastfeeding centric absolutely everything is, some of it you get wary after a while and go "yeah, yeah, we know, yeah okay, we've heard all that before, so what?" (ID 1173. Antenatal interview)

Woman: The class on breastfeeding, the midwife or health visitor that did it brought out a doll and, you know, it was like something you would've done at playschool, it was quite kind of... you know, made it seem... I don't know what the word is I'm looking for [laugh] but it wasn't practical, it wasn't kind of realistic. (ID 1040. Antenatal interview)

Partner: If you had mums with babies coming along (to classes before birth) I'd be interested to see where difficulties lay so that I could be there to support and say, "well that's kind of normal" and "d'you remember that woman had that particular issue for a couple of months but then it kind of came good in the end?", kind of thing. (ID 2057. Interview 24+ weeks after birth: breastfeeding, with solids introduced <16 weeks but no formula)

Woman: When I asked about expressing it was all very much about hand expressing, which I'm not particularly.... I was more trying to find out about different pumps that are available and that kind of thing. I don't think my question really got answered, did it? (ID 2039. Antenatal interview)

feeding classes assumes an ideal of fixed early rational decision-making and can infer an "all or nothing" rather than a "try it and see"⁴² breastfeeding culture. Many women prefer not to be separated according to feeding intention and welcome open discussions about both formula and breast milk, to help them to reconcile health service information with the word on the street. They want to discuss what breastfeeding feels like, how it will fit into family life, the practicalities of expressing, what health service help will realistically be available, return to work and feeding in public. Families report that health professionals vary in the extent to which they take a realist rather than an idealist approach to feeding education, with the former rarely encountered but highly valued. Voluntary sector groups and helplines were infrequently mentioned by participants in our study.

What would make a difference? Skilled facilitation of Interactive discussions with individuals, families or groups regardless of feeding intention, which cover the practical and emotional realities of breast and formula feeding and involve parents who have had feeding difficulties and not always lived up to ideals.

Care after the birth (Box 3)

Although some women are happy with the breastfeeding help available on postnatal wards, for most there is a large gap between antenatal ideals or expectations and the reality, confirming international qualitative research synthesis.¹⁰ Women value proactive help which reassures and builds confidence, continuity of care and staff who help them to latch their baby on themselves. Families describe some health care professionals as lacking good communication skills and breastfeeding expertise and, above all, staff were seen to be “rushed off their feet”, leading women to feel “really bad” about asking for help, and feeling a “burden rather than a priority”. Occasionally, staff encourage longer hospital stays to establish breastfeeding with the implied assumption that hospital care will be better than community care, although evidence does not support this.²³ Mothers are often distressed by the hospital environment and perceive that they will feel more relaxed and better able to breastfeed at home. Early discharge from hospital was a primary goal for some women above breastfeeding and it could be the trigger for introducing formula milk to expedite discharge. Women particularly value a member of staff sitting through a feed to provide reassurance that she is “doing it right”

What would make a difference? Participants unanimously prioritise the period immediately after rather than before the birth for resources to help women breastfeed. Women want someone sitting through feeds to help with breastfeeding who increases their confidence.

Box 3. Care after birth

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5 Woman: [describing qualities of the ideal helper] Patience... tolerance... listening,
6 listening to you... showing you without force ... someone that can focus all their
7 attention on you and the baby and the task at hand. (ID 1210. Interview 24 weeks
8 after birth: breastfeeding, with formula introduced at 1 week and solids at 21-24 weeks)
9

10 Woman: I asked each time I went to feed her, I buzzed the buzzer to get help. Like
11 they didn't come and offer help, I had to ask for it. So that would be...

12 Partner: Yeah someone a bit more timid or shy...

13 Woman: Might not...

14 Partner: I don't want to bother them, I'll just persevere. Or I don't want to bother them,
15 I'll just give up. (ID 1033. Interview 24 weeks after birth: breastfeeding, with formula
16 introduced at 13-16 weeks and solids at 17-20 weeks)
17

18 Woman: One of the midwives suggested that we give her a bottle and then I could go
19 back to breastfeeding, once I'd had a rest ... which was my intention until another
20 midwife told me that I couldn't do that ... once she'd been on the bottle then it was best
21 to keep her on the bottle. And she was quite firm to the extent that it was quite
22 unpleasant. (ID 2181. Interview 2 weeks after birth: formula feeding, introduced at 1
23 week, breastfeeding stopped at 1 week)
24

25 Woman: We were struggling with the feeding and I could've done with that additional
26 support right at the beginning, but because of communication not being as good as it
27 should've been, there was that four days that we went without anybody coming round. (ID
28 1057. Interview 13 weeks after birth: formula feeding; formula introduced at 1 week,
29 breastfeeding stopped 9-12 weeks)
30

31 Woman: I must say that what I have had is what I would expect to have in an ideal
32 world! I don't think I would've asked for any more than I got. Because every step that I
33 needed explaining or needed help I always got it. For me it's been a ten out of ten
34 experience, except for the pains [laugh]. (ID 1148. Interview 3 weeks after birth:
35 exclusive breastfeeding)
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37 Woman: The way it's kind of promoted sometimes, it's a lovely bonding experience and
38 when you come home, then you feel guilty yourself because you think, well I'm not
39 having this bonding and lovely experience, I'm having, you know, a kind of hard sore
40 experience. (ID 2103. Interview 3 weeks after birth: breastfeeding, with formula
41 introduced at 3 weeks)
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Goals: future health versus current wellbeing (Box 4)

New parents are aware that exclusive breastfeeding and delaying the introduction of solids until 6 months are promoted by the health service because of health benefits and many are keen to “give it a go”, confirming earlier research.⁴² Participants’ beliefs and opinions about these recommendations vary over the infant feeding journey both within and between families. At one extreme, some parents believe in the recommendations and persevere with exclusive breastfeeding – the ease of this depending largely on personal qualities like self-confidence, determination and the availability of support. For some the strongest motivator is to avoid a specific health outcome like food allergy or eczema, particularly in families with a history of the condition. For others the value of “nature” is paramount, with a desire to avoid formula milk and commercial baby foods, which are seen as artificial, processed and linked to future adverse health outcomes. At the other extreme, some families express doubt about the causal relationship between exclusive breastfeeding with introduction of solids at 6 months and longer term health outcomes, particularly obesity. There is an awareness of mixed messages from health professionals about the exact timing of introducing solids, contributing to this doubt. Later childhood sedentary lifestyles and consumption of “junk food” are perceived as stronger determinants of future health, a view expressed particularly by men. The health consequences of not exclusively breastfeeding for 6 months are not readily visible or tangible, and parents who were formula milk fed perceive themselves to be as healthy as others who were breastfed. As in earlier longitudinal qualitative research, narratives describe generations of families given formula milk or solids from 3 months, with no evidence of harm and these accounts are employed to counter any implications of being a “bad mother” or putting a child at risk.⁴³ For all families, current emotional and physical wellbeing is paramount. But those who are more sceptical about or do not prioritise health recommendations introduce formula milk or solids more readily when feeding difficulties arise, expecting immediate benefits, such as reduced breast pain, more sleep or a contented baby who is gaining weight and resolution of anxiety. Longer term future health benefits are not considered and the priority is to “make sure he’s getting enough to eat” now, “regardless of where it comes from”.

What would make a difference? Health professional-family communication about infant feeding would benefit from a move away from checklists and instead ask open questions about experiences, values, priorities and goals with discussion about how feeding will fit into family life. This could reduce the mismatch between ideals, expectations and reality and would allow infant feeding care to be tailored to the family.

Box 4. Women and family values*Goals: future health versus current wellbeing*

Woman: I think probably at some point in the middle of the night, tearing your hair out, I thought... considered it, but then... well, I kind of think as well I've got this far so I'm not going to start giving him formula now. (ID1108. Interview 24 weeks after birth: breastfeeding, with solids introduced at 24 weeks, formula not introduced)

Partner: it's [breast milk] better for your wean isn't it? It's all natural stuff, I don't like chemicals, I'm not keen on bottles at all. (ID 2037. Interview 24 weeks after birth: formula feeding, introduced at 9-12 weeks, breastfeeding stopped and solids introduced at 20-24 weeks)

Partner: Well, that's another thing, they say that if you breastfeed that your child is in sort of a lower category of being quite obese. Well, I don't know if I agree with that, because my son is quite big and he was breastfed for six months and, I don't know, I don't think he eats... lots of sweets or things like that, so I don't know if I agree with that at all going by him. But yet my daughter's not big, so I don't know if I agree with that or what. (ID1208. Antenatal interview)

Woman: I did feel a bit guilty at first [about stopping breastfeeding]. But then I thought well he wasn't settling and he needs to make sure he's getting fed and I've obviously got to look after myself as well to be able to look after him. (ID 2255. Interview 3 weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 1 week)

Family bonds and intensive mothering

Partner: For the wean's sake, breastfeeding's best, but for the woman and wean's sake, or the family and the wean's sake, breastfeeding might not be best. (ID 2287. Interview 24 weeks after birth: formula feeding, introduced at 3-4 weeks, breastfeeding stopped at 7-8 weeks, solids introduced at <16 weeks)

Partner: For the first few months, all it's doing is waking up, smiling, I want fed now, right I need changed now, and it's effectively that, that's the scenario. So not being involved in doing the nice bit, but doing the majority of the nasty bit, you know, sort of thinking, who's getting the better deal here? (ID 2061. Interview 24 weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 5-6 weeks, solids introduced at 17-20 weeks)

Woman: He [husband] really enjoys it actually, and I think he's really delighted that [baby] will finally take a bottle from him and, you know, that's kind of their time to sit and chill, ... it's really nice actually to see that. I think [husband] feels more connected as well, just being able to do that. (ID 2192. Interview 19 weeks after birth: breastfeeding, with formula introduced at 5-6 weeks)

Woman: It all seems to be, "don't ever do anything that would interfere with breastfeeding", it's all got to be very purist which is fine, but it just doesn't fit in with the rest of your life and I think in a way people just give up because it's too difficult. (ID 1075. Interview 24+ weeks after birth: breastfeeding, with formula introduced at 2 weeks and solids at 21-24 weeks)

Woman: I do think when you've had babies that they [partners] do feel a bit pushed out to be honest. And the kids are my number one, so he's just got to get on with that. (ID 2056. Interview 13 weeks after birth: exclusive breastfeeding)

Time values and strategies

Woman: He's waking up usually at around 5.30 and by the time I have fed and changed and burped and what have you, [partner] takes over which gives me time to go for a run in the morning so that's really good, so that gives me a bit of "me time". (ID 1056. Interview 12 weeks after birth: exclusive breastfeeding)

Woman: So he sort of tends to just suckle as often as he can then, but during the day... I only maybe manage to get a couple of hours at the most [laugh]. But it's fine, I'm not feeling... I feel really good this time, I don't feel drained physically or anything at all, I feel fine. (ID 2169. Interview 9 weeks after birth: exclusive breastfeeding)

Woman: I have gone back to the gym and done a couple of classes there and his dad looked after him. He's not taken any expressed milk yet, he's not taken to the bottle, but we've only really tried that a couple of times. (ID 1094. Interview 11 weeks after birth: breastfeeding, with formula introduced at 7-8 weeks)

Rules and being a "good" parent

Woman: My mum kept saying "it's just trial and error, there's no right and there's no wrong....", because I'm quite bad for getting a bit... even now I'll still sometimes be "oh it's all going wrong" and get over anxious and kind of like "oh, not doing it right and she's not getting what she needs." (ID 1167. Interview 24+ weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped 3-4 weeks, solids introduced at 24 weeks+)

Woman: one of the midwives I spoke to, she was like "and have you thought about breastfeeding?", I was like "yeah I'm going to try", and she was like "well you know that it's on demand and you can't use bottles and you can't do this and you can't do that, and it's for six months and you have to like ..", basically you are attached to this baby for six months, and she made it seem quite, negative, almost. (ID 2003. Antenatal interview)

Partner: We feel that we've done the right thing [giving solids], but there was not...

Woman: It was a hard decision for us, wasn't it?

Partner: Aye, it was a hard decision because we were going against...

Woman: The rules, if you like ...

Partner: The rules, we were breaking the rules. (ID 2294. Interview 24+ weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 21-24 weeks, solids introduced at 16 weeks)

Woman: I kind of got a bit of... not grief, but kind of... like negative tension if you want, for wanting to put him on solids at 17 weeks.....and I think if you're breastfeeding they want you to breastfeed for longer because obviously they've managed to get you to breastfeed and it's great and they want you to keep going as long as you can. (ID 2128. Interview 24 weeks after birth: breastfeeding, formula introduced at 1 week and solids at 17-20 weeks)

Woman: Well they've [health visitors] obviously got to follow the regulations about the World Health Organisation says this and that and the other. But at the end of the day, my opinion was, as his mum, it was my decision. (ID 1226. Interview 24 weeks after birth: formula feeding, introduced at 2 weeks, breastfeeding stopped and solids introduced at 17-20 weeks)

Family bonds and intensive mothering (Box 4)

The hopes and fears of the immediate family and its social network are raised by the arrival of a new baby. The overriding goal for new parents is emotional and physical wellbeing, so that the important social ritual of introducing the new baby to the social network is a joyful and fulfilling experience for all, with minimal anxiety and tension. Scenarios of changing feeding behaviour to prioritise family wellbeing over health values are described, for example not wanting to “shun to the side” a six year old daughter who is “desperate to help” by giving a bottle. Breastfeeding is widely promoted as a way for mothers to bond with their babies, leading to anxiety that partners, grandparents or older children will not bond with the baby unless they are actively involved in giving feeds. For some mothers and significant others, actively feeding the baby by bottle or spoon has a higher value than all other baby care tasks and is “therapeutic” and “relaxing”. Women are keen to express breast milk as soon as possible to enable others to bottle feed breast milk and if expressing fails some introduce formula milk or solids early to fulfil this ideal. Accounts of prioritising bonding and family emotional wellbeing are employed to counter any implications that families are not doing the best for the health of their baby by not exclusively breastfeeding. A few parents prioritise the ideal of exclusive breastfeeding above all other facets of individual or family wellbeing. A model of “intensive mothering” has been described where a strong mother-infant bond is fulfilled by exclusive breastfeeding on demand and is of paramount importance.⁴⁴ For first time parents, a mismatch can occur between expectations and the reality of how family, friends and health professionals help them practically and emotionally with feeding, parenting and household tasks. For many there are barriers to asking for help, with few feeling confident enough to ask and women prefer professionals and others to offer help.

What would make a difference? Opportunities for significant others to be involved in discussions about roles, bonding and coping with breastfeeding after birth might help families to adapt and maintain family wellbeing. Proactive offers of help are preferred.

Time values and strategies (Box 4)

A priority for many new parents is “getting the baby into a routine”, as attaining a regular feeding and sleeping pattern helps to adjust to changes in roles and use of time. First time parents in particular can find the lack of time for non-baby related activities and “me time” a major challenge for which they are not prepared. Even those who have anticipated devoting themselves to feeding may struggle with the time taken to breastfeed, feeling anxious to “get back in control” of their lives. At the other extreme, a few women who fit the “intense mothering” model willingly sacrifice other activities for their ideal and thrive on fulfilling this role. Priorities for the use of time vary but often focus on restoring pre-pregnancy activities and values, in particular sleep, image (hair, nails clothes), exercise, friendships, couple or family time including attention to other children and housework. Reconciling these ideals and values with exclusive breastfeeding can be challenging. Parents who do reconcile ideals with reality can feel empowered and those who struggle can feel guilty or inadequate as parents in relation to their own ideals or those of others. Return to work can symbolise “the end for the boob” for some, who introduce formula milk or solids prior to six months to facilitate child care arrangements. The moral work of breastfeeding and perceptions of being a good or bad mother have been explored in depth elsewhere.^{45,46}

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3 What would make a difference? Women benefit from helpers who understand the
4 tensions between ideals and reality experienced while feeding a baby, who are woman
5 and family-centred rather than focused primarily on breastfeeding, and can build
6 confidence and increase self efficacy.
7

8 **Rules and being a “good” parent (Box 4)**

9
10 In family accounts of interactions with health professionals, there is a lack of clarity about the
11 breastfeeding ideals derived from current evidence based guidance: exclusive breastfeeding
12 for 6 months is best; breastfeeding for longer than 6 months is ideal and any breast milk is
13 better than none.^{1,19} In contrast, accounts of advice about the ideal time to introduce solids
14 were more clearly recalled, but inconsistencies in health professional advice were recounted.
15 Some parents report not always being honest about their feeding behaviour with health
16 professionals if they were not following advice. This reflects the complexity and ambiguity of
17 the feeding messages within current guidance, leading to communication challenges for
18 health professionals.⁴⁷ Dichotomies of “good” or “bad”; “right” or “wrong”; “breast or bottle”
19 prevail in accounts of interactions with health professionals, with support for giving both
20 formula and breast milk or self-evaluations on a continuum like doing “well enough” less
21 common. The emphasis on the technical skills of correct positioning and attachment: “if it
22 hurts you are doing it wrong” can leave some women feeling a failure whereas other women
23 distrust this dictum and attribute success to being “lucky”, allowing their self-esteem to be
24 more protected. Rules are recounted where the rationale to parents is unclear: expressing
25 must not begin before 8 or 12 weeks; no nipple creams or shields; bottles and teats confuse
26 the baby; babies must feed within a certain time after birth. Our interpretation is that well-
27 meaning health professionals who wish to promote the ideal of exclusive breastfeeding until
28 6 months convey some advice in a black and white manner, where the supporting research
29 evidence is less clear cut.⁴⁸ Concern about doing infant feeding ‘properly’ adds to the
30 pressure on unconfident new parents, with some describing it as “just one big guilt trip” and
31 feeling “heartbroken” when a decision to stop breastfeeding is made before the woman’s
32 ideal time. It is widely acknowledged that health professionals “have always got to be seen
33 to be saying the right thing”. However, women appreciate communication with professionals
34 that embraces the reality of how difficult it is to attain feeding ideals and is attentive to the
35 emotional consequences of compromising between the different health and family values.
36 Such accounts invariably feature reassurance, confidence building, normalising experiences
37 and time spent developing a trusting relationship.
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44 What would make a difference? Whereas a woman-centred communication style can
45 ameliorate parental distress, a breastfeeding centred or formulaic guideline and rules
46 based style can increase it. The latter can influence feeding decisions and actions as it
47 can undermine women’s confidence, experience and the wider family situation.
48

49 **Pivotal points and feeding transitions (Box 5)**

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51 When physical, emotional or social difficulties arise in the first 6 months after birth, parents
52 believe that changing the feeding behaviour is one of the few immediate actions within their
53 control that might restore their primary goal of family wellbeing. Our interpretation is that
54 these pivotal points where feeding behaviour changes represent a conflict between ideals
55 and reality. The trigger for a pivotal point may be somatic; emotional; social; cultural or
56 environmental, and examples are well documented in the research literature describing the
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Box 5. Pivotal points and feeding transitions

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5 Woman: I could feel myself welling up because I had my heart set on getting out [of
6 hospital] that day ...that's why I said we'd go on to the formula. (ID 2203. Interview 3 weeks
7 after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 1 week)

8
9 Woman: I think if it hadn't been for that explanation [from the health visitor], I may well have
10 sort of said, "well I've tried my best, I'm giving up." So I'm glad I didn't, and I didn't because
11 of the health visitor, because she was so reassuring.

12 Partner: Aye. Because we were getting to the stage where we were... because at the end
13 of the day, all what you'd like to do for her [the baby], the number one priority is she's getting
14 food, getting enough goodness in her, irrespective of where it comes from. (ID 2294.
15 Interview 2 weeks after birth: breastfeeding, with formula introduced at 1 week)

16
17 Woman: That first weekend we gave him a bottle. "That's fine" ..., "we call that a crisis
18 bottle," she [health visitor] went, "and there's nothing wrong with that. If it works for you,
19 that's fine, but one bottle a day is not going to do any harm," so if anything she was a bit
20 more encouraging. (ID 2003. Interview 3 weeks after birth: breastfeeding, with formula
21 introduced at 1 week)

22
23 Woman: She was wanting fed like almost every hour on the hour, and - with me having
24 [son] and her dad being, runs about a lot, so I was mainly being home by myself and I found
25 it difficult to try and feed her and deal with him as well.....and I got to a point I just couldn't
26 cope any more, I was too tired, just wanted to sleep all the time. I thought, "No, can't do this,
27 need to stop." (ID 2287. Interview 12 weeks after birth: formula feeding, introduced at 3-4
28 weeks, breastfeeding stopped at 7-8 weeks)

29
30 Woman: I'd said that I was sort of persevering with it, and she [community midwife] said "try
31 this, try the next thing", but they didn't really sort of offer to show me. I just said that I was
32 topping him up with bottles and I was thinking that it wasn't really working very well, but I'd
33 kind of persevered with it, ...but then it was too much. (ID 2255. Interview 3 weeks after
34 birth: formula feeding, introduced at 1 week, breastfeeding stopped at 1 week)

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36 Woman: He was waking every kind of hour and a half/two hours wanting to feed, so I tried
37 him on the solids after speaking to the health visitor. I just would like to sleep and I just don't
38 know why he's not sleeping at night time, so I just have to see if the food will help. (ID 2295.
39 Interview 19 weeks after birth: breastfeeding, with formula introduced 5-6 weeks and solids
40 <16 weeks)

41
42 Woman: Kind of a joint decision with the doctor because he'd got to four weeks and he still
43 really hadn't put on any weight, so it was really his health was more important I think rather
44 than fully breastfeeding. (ID1010. Interview 8 wks after birth: breastfeeding, formula
45 introduced at 5-6 weeks)

46
47 Woman: After a second bout of mastitis caused me difficulties in finding time to express
48 during the day when my husband had returned to work, I decided effectively last Sunday to
49 stop even trying, and just to focus on the formula feeding. I think, while there's still a part of
50 me that's upset about it, I think generally speaking it's been a relief because I've been able
51 to focus much more on the baby. (ID1173 Interview 6 wks after birth: formula feeding,
52 introduced at 1 week, breastfeeding stopped at 3-4 weeks)

Box 6. Feeding care: what would make a difference?

- Prioritise the immediate period after birth for resources to help women to breastfeed and 3-4 months after birth for the introduction of solids
- Provide opportunities for realistic interactive discussions with appropriately skilled health care providers and peers before and after birth with the option to include significant others
- Offer proactive rather than reactive care and anticipate those at risk of changing feeding behaviour at pivotal points
- Set realistic rather than idealistic goals, at individual, local and national level
- Pay more attention to emotional issues than the technicalities of breastfeeding by communicating in a narrative style which is woman/family-centred and sitting with women through feeds to build confidence and self-efficacy
- Use open questions rather than a check list approach and acknowledge that there are many ways to feed a baby safely
- Consider organisational systems and structures that would provide continuity of highly skilled feeding care from pregnancy through infancy

reasons why women change their feeding behaviour.^{6,9,10} For some in our study, the pivotal points were brief, intense, accompanied by significant emotional distress and feeding behaviour changed promptly. These intense pivotal points mostly occurred with transition from breastfeeding to formula in the early weeks when the mother and baby are learning a new skill at the same time as recovering from the physical and emotional consequences of childbirth. They also occurred at crisis times like illness. For others pivotal points and feeding transitions were a more gradual cognitive process, weighing up the pros and the cons and accompanied by less emotional dissonance. More gradual pivotal points are recounted particularly by parents with older children, those with strong family and social network support and around the introduction of solids. Families provide accounts of timely intervention around pivotal points which enabled them to continue breastfeeding or delay the introduction of solids. There are missed opportunities for help, for example midwife home visits when the baby is asleep or busy ward staff who have other priorities like drug rounds. Distress can increase when care is provided by an unknown person, staff are “too busy”, conflicting advice is encountered, or where help is not available. Our analysis suggests that mothers are particularly likely to stop breastfeeding or to introduce solids early at a pivotal point if they lack health professional support at an important time; lack a readily available network of family and friends to provide emotional support and practical help; or have significant others who formula fed or had negative breastfeeding experiences.

From a new mother’s perspective availability of trusted family, friends or professionals who are able to provide emotional and practical help, are perceived as key contributors to advantage or disadvantage with regard to infant feeding. Yet not all help provided is perceived as beneficial either to breastfeeding, introduction of solids or maternal wellbeing and it can create tension and a conflict in ideals. Pivotal points are common at around 4 months, if babies change their crying, feeding or sleep behaviours. Even parents who have “persevered” with their ideals, may reach a point when they introduce formula or solids

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3 earlier than planned in search of the immediate gain of a more settled, contented baby; relief
4 from their anxiety and more sleep. Many parents collect tips and suggestions from a variety
5 of information sources, the media, family and friends, health professionals and try many
6 strategies before introducing formula or solids. Influence depends on the value and trust
7 attached to the source and what fits best with their circumstances.
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10 What would make a difference? Our interpretation is that infant feeding care would improve
11 by providing more proactive rather than reactive care, anticipating mismatches between
12 ideals and reality that underlie pivotal points and providing skilled family-centred help to
13 resolve difficulties.
14

15 DISCUSSION

16
17 In this paper, we describe how the philosophical positions of idealism and realism underpin
18 communication within and between families and health professionals about how to feed
19 infants in the first six months after birth. Idealism underpins the WHO global
20 recommendation of exclusive breastfeeding for 6 months, and the targets or indicators set by
21 governments in many countries. Six months exclusive breastfeeding is considered
22 unrealistic and unachievable by many families and promoting this is perceived as setting
23 parents up to fail. Our data were collected prior to widely publicised and contested research
24 questioning the 6 month guideline.⁴⁸ Conflicts between health and non-health ideals and
25 values for parents create tensions, leading to pivotal points whereby parents change their
26 infant feeding behaviour to restore their ultimate goal of family wellbeing. Discounting future
27 health in favour of immediate gains has been widely described particularly amongst
28 disadvantaged families.^{27,49} The willpower needed to persevere with feeding ideals may be
29 either harder to engage or more readily depleted for those who are disadvantaged either
30 economically or socially and need their willpower to struggle with other adversities.⁵⁰ An
31 argument can be made for shifting the emphasis from antenatal education to postnatal care,
32 with anticipation and prevention of pivotal points where breastfeeding ceases or solids are
33 introduced inappropriately.
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38 The strengths of this study are the serial interviews with women and their significant others,
39 which examine the interactions between individuals and families in health and social
40 contexts. They explored feeding on a continuum, from intentions in pregnancy to how these
41 translated into actions after birth. Unlike many studies our explicit focus was to ask what
42 would have made or would make a difference to breastfeeding experiences at each
43 interview, to inform future intervention studies. It is uncertain how transferable our data is
44 outside the UK, however international qualitative evidence synthesis highlights the need for
45 more realistic infant feeding support.¹⁰ Our study confirms the constructs of intensive
46 mothering⁴⁴; the give it a go breastfeeding culture⁴²; deviance and the discourses around
47 good and bad mothering^{43,44}; the expectation and reality gap¹⁰; getting breastfeeding
48 “right”¹⁰; the medicalisation of breastfeeding⁹; the guilt and failure associated with
49 stopping^{10,44}; gaps in health service provision such as prescriptive rather than individualised
50 care; the challenges of breaking the rules⁴⁷; busy postnatal wards; and lack of effective
51 practical and emotional support from health professionals at significant times.⁹ Our sample
52 was more economically advantaged than we had aimed for. Offering incentives to
53 participate in interviews was originally proposed as a strategy to improve recruitment of
54 “hard to reach” families, but this was not approved by the Ethics Committee. SIMD for
55 postcode of residence seems unreliable for selecting disadvantaged participants particularly
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3 in mixed urban and new build areas and for immigrants who are often highly educated but
4 working in low paid jobs. This is perhaps not surprising as SIMD is not intended for use at
5 an individual level and age at leaving full time education is considered the best proxy
6 measure for assessing socio-economic status.⁵¹ For infant feeding it is debateable how valid
7 it is to assess “advantage” and “disadvantage” for new parents based on traditional socio-
8 demographic characteristics alone. Not having an emotional and practical support network
9 or being surrounded by significant others who have formula fed, had negative breastfeeding
10 experiences, introduced solids early, are unaware that recommendations have changed are
11 also disadvantages which can influence feeding decisions and health inequalities.

12
13
14 The WHO guidance of exclusive breastfeeding for 6 months¹ is intended to inform
15 international government policies, yet it is being widely communicated in written and verbal
16 health service information as an individual feeding goal for parents. Similarly, the pass-fail
17 nature of the BFI accreditation scheme³⁰ may generate a “right-wrong” culture which does
18 not facilitate mothers and health professionals to work in partnership to make individual
19 choices informed by personal values and circumstances. By promoting 6 months exclusive
20 breastfeeding, policy makers are encouraging idealistic expectations and goals in
21 pregnancy, but health services are not providing the skilled help required to establish
22 breastfeeding after birth. This mismatch between idealism and realism is likely to be a
23 mechanism behind the media stories of mothers feeling pressurised to breastfeed.⁵² The
24 theory on changing and sustaining healthy lifestyle behaviours indicates that achievable
25 goals set by individuals themselves, which are mastered and then re-set incrementally,
26 known as smart goal setting is effective and builds self-efficacy.⁵³ Would changing the
27 message to “breastfeed for as long as you can” and “introduce solids as close to 6 months
28 as possible” with more individually tailored goal setting, social support and feedback make a
29 difference to breastfeeding outcomes? Or do we just need to rebalance the health service
30 input to increase the intensity and frequency of support after birth around the pivotal points
31 for ceasing to breastfeed and introducing solids, as indicated by the evidence for weight
32 management and exercise to prevent disease?⁵⁴

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37 The serial narrative interviews employed in this study with open questions and continuity
38 focusing solely on infant feeding are a tool which could be modified for use in clinical
39 encounters to anticipate families most at risk of pivotal points when feeding behaviour
40 changes. We hypothesise that this would assist in the identification of women who are more
41 likely to experience intense pivotal points in the early days with breastfeeding or at around 3-
42 4 months with the introduction of solids and facilitate discussion about any potential or actual
43 mismatch between ideals and reality. The dominant discourse in health service policy,
44 research and practice is “breastfeeding support for women”. Support is an ambiguous word
45 that can infer either a realistic woman centred or a more idealistic breastfeeding centred
46 philosophy. We advocate that this should change to “family centred feeding care” in health
47 service written and oral discourses. The word “care” has an implicit person centred meaning
48 and is less likely to be misconstrued as pressurising; “feeding” embraces solids as well as
49 milk and “family” acknowledges the important role of others in infant care. Realistic
50 information with a facilitative patient-centred style¹¹ should aim to minimise tension and
51 distress and help parents feel more confident, with avoidance of “do-don’t” discourses. More
52 acknowledgement of the importance of emotional wellbeing as an outcome that matters to
53 families is needed. Physiologically this is explained by the association between stress
54 reducing oxytocin levels and milk flow.⁵⁵ Emotional wellbeing is most precarious soon after
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3 birth and to address this the emphasis for professional breastfeeding care should be after
4 rather than before birth. The findings of this study lead us to suggest that it is time to revisit
5 the current ideal of training all health professionals to provide infant feeding care, particularly
6 with shorter hospital stays, reduced routine postnatal contact with families and staff
7 shortages. Certainly more of the same approach to promoting and supporting breastfeeding
8 would seem unlikely to be effective²⁵ and service re-organisation will be needed if care is to
9 anticipate pivotal points.
10

11
12 Almost two decades ago there was a debate around idealism in health promotion which
13 questioned the transformation of health into a political value.⁵⁶ We would argue that it is time
14 to revisit this debate for infant feeding, if we are to design and deliver successful
15 interventions to improve infant feeding outcomes and subsequent health outcomes of future
16 generations. This study is hypothesis generating and several potential changes to policy
17 and practice could arise from the study messages. However, we would argue that infant
18 feeding is too important and resources too scarce to make changes without robust evidence
19 from randomised controlled trials or other appropriate evaluation strategies.
20
21

22 **COMPETING INTERESTS**

23
24 All authors have completed the Unified Competing Interest form at
25 www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and
26 declare that PH, LC, JB and RM have no relationships with companies that might have an
27 interest in the submitted work in the previous 3 years; their spouses, partners, or children
28 have no financial relationships that may be relevant to the submitted work; and PH, LC, JB
29 and RM have no non-financial interests that may be relevant to the submitted work.
30
31

32 **DETAILS OF CONTRIBUTORS**

33
34 All authors were involved in the design of the study, the analysis of data, and the writing and
35 editing of this paper. LC and JB conducted the interviews with participants. All authors had
36 full access to all of the data in the study and can take responsibility for the integrity of the
37 data and the accuracy of the data analysis. PH wrote the first draft of the paper and all
38 authors made important intellectual contributions to the content and approved the final
39 version.
40
41

42 **ETHICS COMMITTEE APPROVAL**

43
44 Approval was obtained from the North of Scotland Research Ethics Committee (reference
45 number 09/S0802/65). All participants provided written informed consent and any details
46 that could allow identification of participants have been changed to protect confidentiality.
47

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53

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55 funding body.
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DATA SHARING

A full study report is available at <http://www.healthscotland.com/documents/4720.aspx>. Data sharing: no additional data is available as consent was not obtained.

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Checklist for reporting qualitative research

We are aware of many checklists for qualitative research and these are available on the Equator website: <http://www.equator-network.org/resource-centre/library-of-health-research-reporting/reporting-guidelines/qualitative-research/>

The checklists vary according to the research tradition and discipline, and their differing ontological approach. There is considerable debate around the use of checklists in qualitative research and currently there is no consensus that one checklist meets all reporting requirements.

There is always a balance between detail and an overly long paper. We believe that our paper meets the core requirements of robust reporting, however if peer reviewers request more detail we will readily provide it.

Pat Hoddinott (on behalf of the authors)



A serial qualitative interview study of infant feeding experiences: idealism meets realism

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3 **Title: A serial qualitative interview study of infant feeding experiences: idealism**
4 **meets realism**

5
6 Pat Hoddinott, Leone Craig, Jane Britten, Rhona McInnes
7

8
9 Health Services Research Unit, University of Aberdeen, 3rd Floor, Health Sciences
10 Building, Foresterhill, Aberdeen, AB25 2ZD
11

12
13 Pat Hoddinott, Senior Clinical Research Fellow
14

15
16 Public Health Nutrition Research Group, University of Aberdeen, Polwarth Building,
17 Foresterhill, Aberdeen, AB25 2ZD
18

19
20 Leone Craig, Research Fellow
21

22
23 School of Nursing, Midwifery and Health, University of Stirling
24

25
26 Jane Britten, Research Fellow
27

28
29 Rhona McInnes, Senior Lecturer
30

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41 Correspondence to: p.hoddinott@abdn.ac.uk
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ABSTRACT

Objective - To investigate the infant feeding experiences of women and their significant others from pregnancy until six months after birth to establish what would make a difference.

Design - Qualitative serial interview study.

Setting - Two Health Boards in Scotland.

Participants - 72 of 541 invited pregnant women volunteered. 220 interviews approximately every 4 weeks with 36 women, 26 partners, 8 maternal mothers, 1 sister and 2 health professionals took place.

Results - The overarching theme was a clash between overt or covert infant feeding idealism and the reality experienced. This is manifest as pivotal points where families perceive that the only solution that will restore family wellbeing is to stop breastfeeding or introduce solids. Immediate family wellbeing is the overriding goal rather than theoretical longer term health benefits. Feeding education is perceived as unrealistic, overly technical and rules based which can undermine women's confidence. Unanimously families would prefer the balance to shift away from antenatal theory towards more help immediately after birth and at three to four months when solids are being considered. Family orientated interactive discussions are valued above breastfeeding centred checklist style encounters.

Conclusions - Adopting idealistic global policy goals like exclusive breastfeeding until 6 months as individual goals for women is unhelpful. More achievable incremental goals are recommended. Using a proactive family centred narrative approach to feeding care might enable pivotal points to be anticipated and resolved. More attention to the diverse values, meanings and emotions around infant feeding within families could help to reconcile health ideals with reality.

ARTICLE SUMMARY

Article focus

- To investigate the perspectives of women and their wider family and social network on infant feeding from pregnancy until 6 months after birth
- To ascertain what would make a difference to their experiences of breastfeeding and the introduction of other fluids and solids
- To focus on health inequalities and to understand interactions between women, professionals, organisations and systems to inform policy, practice and the design of complex intervention trials to improve infant feeding outcomes

Key messages

- Clashes between overt or covert idealism and realism within and between families and the health service occur at pivotal points particularly in the early weeks after birth and around the introduction of solids
- At pivotal points, families often perceive the only solution within their control that will restore family wellbeing is to stop breastfeeding or introduce solids or other fluids. Using a family centred narrative approach could enable pivotal points to be anticipated and resolved
- Translating global policy goals like exclusive breastfeeding until 6 months into practice is unhelpful and achievable incremental goal setting is recommended

Strengths and limitations

- Original interpretation using robust and transparent methods in a relatively large data set of serial interviews about infant feeding, with recruitment of women living in more disadvantaged areas
- Findings which are relevant to current policy and practice, particularly the UNICEF Baby Friendly initiative
- An explicit aim to elicit the views of women and their significant others to inform future intervention studies, policy and practice
- Our findings are hypothesis generating rather than hypothesis testing
- It is uncertain how transferable our data is outside the UK context, particularly to countries where breastfeeding prevalence is high
- Although we targeted more disadvantaged areas for recruitment, our sample was more economically advantaged than we would have liked

INTRODUCTION

The observational evidence for the maternal and infant health benefits of breastfeeding in both developing and developed countries is growing. Accordingly many governments endorse the World Health Organisation (WHO) recommendation of exclusive breastfeeding, with no other fluids or solids, not even water, for 6 months, followed by the appropriate introduction of solids and continued breastfeeding for 2 years and beyond.¹ Yet in many developed countries rates of any breastfeeding let alone exclusive breastfeeding are a long way from this ideal. Breastfeeding incidence is increasing but internationally the duration and exclusivity of breastfeeding seem more resistant to change.²⁻⁵ Less than 1% of UK babies were reported to be breastfed exclusively at 6 months in 2005,⁶ although the percentage of babies receiving solids at 4 months fell from 85% in 2000 to 65% in 2005. Cross country comparisons are problematic due to variations in how exclusivity is measured.⁷ However there are some interesting contrasts, with Canadian data showing an increase in exclusive breastfeeding at 6 months from 17.3% in 2003 to 23.1% in 2007-2008³, but in the United States (U.S.) rates decreased from 14.1% in 2006 to 13.3% in 2010.^{2,8} In 2005, nine out of ten UK women who breastfed for less than six weeks reported that they would have liked to have breastfed for longer⁶ and recent qualitative evidence syntheses⁹⁻¹¹ and survey data¹² suggest that postnatal infant feeding services are not consistently meeting women's needs.

In the face of these statistics and in an attempt to motivate health service providers and improve outcomes, governments have set less ambitious targets. Increases in breastfeeding initiation in England and Wales from 71% in 2000 to 82% in 2010⁴ did not meet the 2006 target of increasing breastfeeding initiation by 2% per year.¹³ In 2008 this target was replaced by a requirement for each primary care trust to report breastfeeding rates at 6-8 weeks and deliver local improvements.¹⁴ Similarly in the last decade, U.S. targets for breastfeeding at 6 months were not met and have been cut from 50% to 25%.² In Scotland two recent targets have also not yet been met: a 2008 target of 50% of women breastfeeding at 6-8 weeks and the equally ambitious target of 33% of women exclusively breastfeeding at 6-8 weeks by 2011.¹⁵ A region in Northern Italy took a different approach and introduced a 0.5% payment penalty if Health Authorities failed to meet their locally set breastfeeding targets.^{16,17} UK governments are increasingly targeting care towards more disadvantaged families^{18,19} as their babies are more likely to be given formula milk and receive solids early.⁶ The implicit assumption is that more individual advice, help and support for these social groups will lead to increased breastfeeding rates and likelihood of targets being met.¹⁸ However, the jury is still out on the effectiveness of this approach.^{20,21}

Infant nutrition guidelines^{19,22} aim to help health services meet targets and are informed by evidence syntheses which consistently show that additional lay and professional support, particularly if it is multi-faceted and spans pregnancy and birth, can prolong the duration and exclusivity of breastfeeding.^{23,24} However, as this evidence comes mostly from the North Americas the extent to which it can be generalised across different health systems is unknown.²⁵ Infant feeding interventions mostly educate and/or support individual women^{23,24} or train lay supporters and/or health professionals.²⁶ They mostly assume a cognitive model of decision making where pros and cons are weighed up and behaviour changes. However the widely assumed rational approach seldom applies for more disadvantaged social groups²⁷ and automatic processes are increasingly recognised as determinants of behaviour.²⁸ This suggests that context and experience may be more influential for some

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3 than theoretical knowledge, confirming earlier research on infant feeding decision-making
4 amongst early school leavers.²⁹ An example of a widely adopted multi-faceted intervention
5 and systems approach is the UNICEF Baby Friendly Initiative (BFI) which is endorsed by the
6 National Institute of Health and Clinical Excellence (NICE)^{19,22} and provides a focus for
7 organisations to achieve an accreditation award.³⁰ The BFI combines research evidence
8 and good practice standards, covering all aspects of service provision and care.
9 Implementing the BFI in Belarus was associated with an increase in duration and exclusivity
10 of breastfeeding in the first 12 months of life³¹, however in the UK the BFI is only associated
11 with an increase in breastfeeding up to 7 days and therefore its impact remains unclear.³²
12 Furthermore, despite milk feeding being part of a feeding continuum for infants and parents,
13 the majority of infant feeding interventions in the first 6 months after birth have focused on
14 breastfeeding as the outcome rather than the appropriate introduction of solids and other
15 fluids. Goals and recommendations relating to age of introduction of solids have been
16 subject to similar controversy as those relating to breastfeeding.
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20 Our aim was to move away from a focus on the individual to investigate wider family and
21 network perspectives on what would make a difference to their experiences of breastfeeding
22 and introducing other fluids and solids. Our intention was to focus on health inequalities and
23 to understand interactions between women, professionals, organisations and systems and
24 thus inform the design of complex intervention trials³³ to improve infant feeding outcomes.
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27 **METHODS**

28 **Design, rationale and setting**

29
30 This qualitative serial interview study investigates the perspectives of women and their
31 nominated significant others from late pregnancy until 6 months after birth. Serial qualitative
32 interviews allow trust to develop between the researcher and participant, allow early
33 questions generated from data analysis to be explored in depth later and can help validate
34 study findings.³⁴ Including significant others captures how relationships change over time
35 and enables infant feeding to be understood in a wider socio-cultural context. Our approach
36 is informed by environmental and ecological theory of behavioural change, which
37 understands health related decisions as constantly adapting to changes in the micro, meso
38 and macro context in which the decisions are made.³⁵ The study was conducted in two
39 contrasting Scottish Health Boards around 100 miles apart, where maternity units were
40 implementing the Baby Friendly Initiative. Two qualitative researchers were based at each
41 site. The research team brought together considerable infant feeding research experience
42 from different backgrounds: nutrition; the voluntary sector; social policy; midwifery and
43 general practice. Conducting qualitative research with a multi-disciplinary team can help
44 challenge researcher assumptions and biases, which is important when one of the aims is to
45 develop theoretically informed interventions to test in trials.
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50 **Definitions**

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52 Breastfeeding initiation refers to the baby receiving any breast milk, even if only once.
53 Exclusive breastfeeding is defined as the infant receiving only breast milk since birth with no
54 other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral
55 supplements, or medicines.³⁶ Introduction of solids is defined as the first ever solid food
56 offered to and taken by the baby, even if it is only a small amount. Pregnant women
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3 recruited to the study were considered as the index cases and relationships are described in
4 relation to them. We define significant other(s) as the person(s) identified by the woman
5 who has the strongest influence on feeding decisions, regardless of the direction of influence
6 (either for or against the decision).
7

8 **Recruitment and sampling strategy**

9
10 Maternity unit databases were used to identify 459 (site 1) and 533 (site 2) women due to
11 give birth between September to October 2009. As mothers living in disadvantaged areas
12 are less likely to breastfeed and to participate in research,⁶ we invited all women living in the
13 three more deprived postcode quintiles of the Scottish Index of Multiple Deprivation (SIMD)³⁷
14 (n= 420) and a smaller sample of women living in the two more advantaged SIMD quintile
15 areas (n=121). In more advantaged areas, we recruited families where the woman or her
16 partner had a low age of leaving full time education, a non professional occupation, or were
17 immigrants to the UK which may be a disadvantage, particularly around the time of
18 childbirth. The research commissioning brief was to aim to recruit over 75% of participants
19 from the three more disadvantaged SIMD quintiles and select women with diverse
20 characteristics who intended to breastfeed or who had breastfed a previous baby. Invitation
21 packs included an introductory letter on Maternity Unit headed paper signed by a lead health
22 professional, an information leaflet and a short opt-in characteristics questionnaire (S1) with
23 a free post envelope to inform purposive sampling. Of 541 invitation letters sent out 4-8
24 weeks prior to a woman's estimated date of delivery 72 (13%) women volunteered to
25 participate and provided socio-demographic data. Using a sampling frame we selected 18
26 women from each site for the characteristics listed in Table 1. The index women were asked
27 to identify significant others (partners, family, friends and health professionals) throughout
28 the study and the researcher negotiated informed consent to interview a diverse range of
29 information rich significant others at different points.
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34 **Data collection**

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36 Our aim was to interview women and their significant others every 4 weeks, at a time and
37 place to suit them. We negotiated frequency of contact, being sensitive to the emotional and
38 physical impact the arrival of a new baby can have on a family. Face to face interviews took
39 place at home during pregnancy, within 4 weeks of birth and at 6 months, with shorter,
40 mostly telephone, interviews (0-5) in between. Two participants preferred face to face
41 interviews throughout as English was not their first language. Prior to contact after birth, we
42 consulted midwives who accessed NHS records to ensure a safe delivery had occurred. A
43 website discussion forum was available throughout the study. This complemented interview
44 data and enabled contributions from volunteer parents who had not been selected to
45 participate. However, only 25 people registered; one was a woman participating in the study
46 (4 posts) and two of the 72 volunteers who were not selected for the study posted twice
47 each. The research team posted five questions to stimulate discussion (S2)
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51 Interviews were semi-structured, using topic guides that were modified over the course of
52 the study to probe emerging themes in more depth and to search for disconfirming data (S3).
53 At the end of each interview, researchers collected structured information about significant
54 others influential since the last interview (age, relationship, distance from the family and
55 feeding experience). In particular, any inconsistencies or changes in the person(s)
56 nominated as significant at different time points could be explored. Similarly researchers
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3 collected structured data at each time point about breastfeeding duration, exclusivity,
4 introduction of non-milk liquids and solids, based on the Office for National Statistics five
5 yearly UK survey questions.⁶
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8 Prior to the final interview, the research team constructed seven vignettes describing a range
9 of health or community services to help with infant feeding informed by the emergent data
10 analysis and the research evidence (S3). The vignettes were multi-component and
11 designed as research tools to assist the development of interventions for future research.
12 They were given to participants to read and comment on at the final 6 month interview.
13 Details are provided in the full report.³⁸
14

15 **Data analysis**

16
17 Data collection and analysis progressed iteratively, with the four authors involved in listening
18 to interview recordings, reading verbatim transcripts, identifying and interpreting themes and
19 agreeing modifications to topic guides according to the emerging analysis. All interview
20 transcripts were entered as data units onto FrameWork software.³⁹ FrameWork is a
21 rigorous, systematic data management tool, which allows original data and researcher
22 interpretations to be transparently documented and maintains the important direct link
23 between coded themes, interpretations and the original interview data.⁴⁰ The four
24 researchers independently constructed a thematic index by reading a sample of six
25 information rich and diverse transcripts of antenatal and first postnatal interviews, then
26 reached consensus through discussion. A further six interviews were selected This index
27 was modified later in a similar manner to add to the index to cover the introduction of solids.
28 A final thematic index for the antenatal and early postnatal interviews was agreed
29 approximately half way through data collection when these interviews were complete, and
30 finalised for the introduction of solids towards the end of data collection. The index and
31 was used to organise, label and summarise data, which facilitated the construction of different
32 charts, with cases (rows) and themes (columns). Analysis proceeded by researchers
33 keeping reflective diaries, identifying interpretive themes, discussing them, generating
34 research questions, creating different FrameWork charts to explore patterns and search for
35 disconfirming data. Charts compared summarised theme data for couples with differing
36 attributes, e.g. primiparous compared with multiparous women; early cessation of
37 breastfeeding compared with late; early introduction of solids compared with late and
38 differences in the level of partner or significant other involvement with infant feeding.
39 Analysis proceeded by researchers listening to interviews, reading transcripts, keeping
40 reflective diaries, identifying interpretive themes, discussing them, generating research
41 questions, creating different FrameWork charts to explore patterns and to search for
42 disconfirming data. Towards the end of our analysis, we returned to the web discussion
43 forum data to search for any disconfirming data and no such data were found.
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49 **RESULTS**

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51 A total of 220 recorded individual or pair interviews took place with 36 women (Table 1) and
52 37 significant others (26 partners, 8 maternal mothers, 1 sister and 2 health professionals),
53 between 2-8 times (Table 2). All women intended to breastfeed except one who had
54 breastfed a previous baby but intended to formula feed on this occasion. Two families
55 withdrew from the study after the first postnatal interview. Both had stopped breastfeeding in
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the first week. The remaining 34 families were each interviewed from the last trimester of pregnancy until 6 months after birth.

Table 1. Characteristics of women selected for interview (n=36)

	Site 1 participants (n = 18)	Site 2 participants (n = 18)
Age (years)		
≤20	0	3
21-30	4	4
31-40	11	11
≥40	3	0
Age at leaving full time education (years)		
16 or less	1	3
17	1	5
18	3	1
19 or more	13	9
Occupational classification*		
1-3	10	6
4-6	5	8
7-9	2	3
Not employed	1	1
Parity		
0	9	10
≥1	9	8
Scottish Index of Multiple Deprivation (SIMD)**		
1-3	13	13
4-5	5	5

*Standard Occupational Classification (SOC 2000) taken from the 2000 Census.

Available at: <http://www.ons.gov.uk/about-statistics/classifications/archived/SOC2000/index.html>

1	Managers and senior officials	6	Personal service occupations
2	Professional occupations	7	Sales and customer service occupations
3	Associate professional and technical occupations	8	Process and plant and machine operatives
4	Administrative and secretarial occupation	9	Elementary occupations
5	Skilled trade occupations		

** Scottish Index of Multiple Deprivation 2009: www.scotland.gov.uk/Topics/Statistics/SIMD
SIMD 1 is the most deprived quintile. SIMD 5 is the least deprived quintile.

Table 2. Interview frequency

	Number of index cases (women) n=36	Number of interviews where a significant other was present
2 interviews	2	3
3 interviews	-	-
4 interviews	1	2
5 interviews	6	8
6 interviews	15	27
7 interviews	6	7
8 interviews	6	15

The meanings attributed to infant feeding and the competing values which influence feeding decisions differ considerably both within and between families. Box 1 summarises the overarching theme emerging from our data as a mismatch between idealism and realism. Those involved in infant feeding – families, their social networks and the health service – hold different explicit or implicit philosophical positions of idealism or realism about infant feeding. By idealism we imply the construct of ideal feeding based on the research evidence which optimises child and maternal health: currently exclusive breastfeeding for 6 months and continued breastfeeding for 2 years and beyond.¹ Idealists are guided by high moral or intellectual feeding values and adhere to guidelines espousing optimum infant feeding. By realism we imply that women, families and health professionals accept the situation as it is and are prepared to deal with it practically or pragmatically. For infant feeding in the real world there are multiple individual or family values that compete with the optimum health ideal. In the top half of Box 1 we set out how accounts of infant feeding and wider socio-cultural values of women and families in our study fit with the overarching theme of idealism meeting realism. In the bottom left quadrant of Box 1, the ideal position of health service providers is derived from current health service guidance.^{19,22,30,41} In the bottom right quadrant we illustrate how women and families in our study perceive the reality of health service care. We describe how the mismatch and conflict between idealism and realism can cause tensions within families and in the professional – family relationship, and how families detect these tensions amongst health professionals. Importantly, philosophical positions influence how health professionals communicate with parents, including how research evidence is translated visually and verbally. Our analysis builds on earlier qualitative research, particularly evidence syntheses^{9,10} which we reference alongside our findings. The analysis is supported by quotations in Boxes 2-5 which provide participant ID numbers to enable linkage to more detailed contextual data (socio-demographic characteristics, feeding patterns and significant other relationships) in the full report.³⁸ We consider parents' perspectives on how the health service ideal of exclusive breastfeeding for 6 months is reconciled with other values throughout the feeding journey and what would make a difference to improve their feeding experiences (Box 6).

Box 1. Idealism and realism: mismatch within and between families and health services**Idealism – women and family values**

Exclusive breastfeeding is the ideal for health and this determines feeding behaviour

Breastfeeding is the focus of the first 6 months, with other activities taking second place

Intensive mothering with demand feeding. Partners and families supportive in all other aspects of baby care

Prepared to persevere however difficult it is and put breastfeeding first

Expressing milk allows others to feed or gives mothers baby free time

Breastfeeding in public is protected by law in some countries which will empower women

Baby behavioural cues before 6 months can be resolved without giving solids

Idealism – health service^{19,22,30,41}

All health service staff fully support exclusive breastfeeding to 6 months to maximise health benefits

All health service staff are trained in core breastfeeding education and support skills

More antenatal preparation and education will result in better outcomes. A rational, cognitive, planned model of behaviour prevails

Discussing difficult breastfeeding experiences will put women off

With correct technique breastfeeding will be painless and problem free.

Staff have sufficient time to sit with mothers during breastfeeds and provide help until breastfeeding is established

The transition between hospital and home is smooth with good communication between staff

Proactive care improves feeding outcomes

Rules work. Compliance

Breastfeeding centred checklists improve quality of care

Realism – women and family values

A happy mother, baby and family are the ideal and feeding behaviour is determined by a complex balance of factors

Breastfeeding is one of many competing activities, agendas and values

Sharing responsibility for feeding allows partners, grandparents and others a unique bonding opportunity

Immediate gains of stopping (pain, anxiety, time, sleep) outweigh the delayed rewards of breastfeeding

Expressing milk can be difficult, distasteful and as time consuming as breastfeeding

Breastfeeding in public can be difficult and not widely accepted, even if legal

Giving solids has multiple meanings and delaying is counter-intuitive

Realism – health service

Not all health professionals are fully supportive of exclusive breastfeeding to 6 months. The all or nothing, breast or bottle culture is unpopular

Not all staff have the necessary skills and breastfeeding care is highly variable and determined to some extent by luck.

Help to learn breastfeeding after birth is the priority compared to antenatal preparation.

Antenatal care paints an unrealistic picture

Pain and distress are complex emotional, somatic and cultural phenomena, which are seldom resolved by a technical approach alone. Reassurance and confidence building are crucial

Staff cannot offer the support that some women require due to staff shortages and competing demands on time. Sitting through a breastfeed is crucial for confidence building and problem prevention

Care is fragmented between hospital and home, and at day 10-14 between midwife and health visitor

Reactive care when problems are established. Pivotal points occur where feeding plans change rapidly to improve wellbeing

Resistance to rules is common. Deviance

Family centred care and listening to experiences is valued

Pregnancy: rosy pictures and the word on the street (Box 2)

In pregnancy many women and their significant others anticipate breastfeeding difficulties and failure, describing scenarios where they would behave differently from their own ideals and those of the health service. Parents hedge their feeding outcomes saying they will try breastfeeding and decide from day to day rather than aim for the 6 month goal stated in health service information. New parents do not want to set themselves up to fail and the expectation-reality gap in women's breastfeeding experiences has been widely documented.¹⁰ Frustration with this gap is particularly strongly expressed by partners, who comment that antenatal information for breastfeeding did not prepare them well for reality. Antenatal breastfeeding preparation "makes it sound so easy", and fails to acknowledge the more negative word on the street. Most parents prefer to hear about a wide range of positive and negative feeding experiences from recent parents, including those who "break the rules", whereas such parents seem less likely to be selected by health professionals as role models in antenatal education sessions. Some parents report feeling "pressured" to breastfeed and in extreme cases view breastfeeding promotion as "propaganda" and suggest that the "breast is best message" has been overdone, confirming earlier research.⁴²

Breastfeeding education classes or workshops which intensively teach positioning and attachment prior to birth, assisted by videos, dolls and knitted breasts are viewed negatively by many as "school-like" and "patronising". Overly scientific information about anatomy, physiology and the constituents of breast milk is seldom appreciated, as described by others.¹⁰ A strongly stated preference is to learn about positioning a baby at the breast immediately after birth, with skilled, patient and timely help. Messages are perceived as "breastfeeding centric", presenting breast or bottle as a dichotomy "you can't do both". The provision of separate antenatal breastfeeding preparation classes rather than general

Box 2. Idealism meets realism before birth

Partner: [about his sister and her children] it was what was better for both her and the little ones [changing from breast to bottle feeding], because she was getting all up to high doe because she was like "oh it's not working, baby's crying all the time, how am I going to cope with this?" and that sort of thing. We're sort of the same, if it's not working we'll switch. (ID 1044. Antenatal interview)

Woman: I think a reality check actually would be good, because they make it sound so easy, you know, it's like if you just take the baby, you're going to latch it on and it's all going to be plain sailing.... you might be lucky and it might work like that, but you might be the complete opposite. (ID 1010. Antenatal interview)

Partner: Because it's so... you know, breastfeeding centric absolutely everything is, some of it you get wary after a while and go "yeah, yeah, we know, yeah okay, we've heard all that before, so what?" (ID 1173. Antenatal interview)

Woman: The class on breastfeeding, the midwife or health visitor that did it brought out a doll and, you know, it was like something you would've done at playschool, it was quite kind of... you know, made it seem... I don't know what the word is I'm looking for [laugh] but it wasn't practical, it wasn't kind of realistic. (ID 1040. Antenatal interview)

Partner: If you had mums with babies coming along (to classes before birth) I'd be interested to see where difficulties lay so that I could be there to support and say, "well that's kind of normal" and "d'you remember that woman had that particular issue for a couple of months but then it kind of came good in the end?", kind of thing. (ID 2057. Interview 24+ weeks after birth: breastfeeding, with solids introduced <16 weeks but no formula)

Woman: When I asked about expressing it was all very much about hand expressing, which I'm not particularly.... I was more trying to find out about different pumps that are available and that kind of thing. I don't think my question really got answered, did it? (ID 2039. Antenatal interview)

feeding classes assumes an ideal of fixed early rational decision-making and can infer an "all or nothing" rather than a "try it and see"⁴² breastfeeding culture. Many women prefer not to be separated according to feeding intention and welcome open discussions about both formula and breast milk, to help them to reconcile health service information with the word on the street. They want to discuss what breastfeeding feels like, how it will fit into family life, the practicalities of expressing, what health service help will realistically be available, return to work and feeding in public. Families report that health professionals vary in the extent to which they take a realist rather than an idealist approach to feeding education, with the former rarely encountered but highly valued. Voluntary sector groups and helplines were infrequently mentioned by participants in our study.

What would make a difference? Skilled facilitation of Interactive discussions with individuals, families or groups regardless of feeding intention, which cover the practical and emotional realities of breast and formula feeding and involve parents who have had feeding difficulties and not always lived up to ideals.

Care after the birth (Box 3)

Although some women are happy with the breastfeeding help available on postnatal wards, for most there is a large gap between antenatal ideals or expectations and the reality, confirming international qualitative research synthesis.¹⁰ Women value proactive help which reassures and builds confidence, continuity of care and staff who help them to latch their baby on themselves. Families describe some health care professionals as lacking good communication skills and breastfeeding expertise and, above all, staff were seen to be “rushed off their feet”, leading women to feel “really bad” about asking for help, and feeling a “burden rather than a priority”. Occasionally, staff encourage longer hospital stays to establish breastfeeding with the implied assumption that hospital care will be better than community care, although evidence does not support this.²³ Mothers are often distressed by the hospital environment and perceive that they will feel more relaxed and better able to breastfeed at home. Early discharge from hospital was a primary goal for some women above breastfeeding and it could be the trigger for introducing formula milk to expedite discharge. Women particularly value a member of staff sitting through a feed to provide reassurance that she is “doing it right”

What would make a difference? Participants unanimously prioritise the period immediately after rather than before the birth for resources to help women breastfeed. Women want someone sitting through feeds to help with breastfeeding who increases their confidence.

Box 3. Care after birth

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5 Woman: [describing qualities of the ideal helper] Patience... tolerance... listening,
6 listening to you... showing you without force ... someone that can focus all their
7 attention on you and the baby and the task at hand. (ID 1210. Interview 24 weeks
8 after birth: breastfeeding, with formula introduced at 1 week and solids at 21-24 weeks)
9

10 Woman: I asked each time I went to feed her, I buzzed the buzzer to get help. Like
11 they didn't come and offer help, I had to ask for it. So that would be...

12 Partner: Yeah someone a bit more timid or shy...

13 Woman: Might not...

14 Partner: I don't want to bother them, I'll just persevere. Or I don't want to bother them,
15 I'll just give up. (ID 1033. Interview 24 weeks after birth: breastfeeding, with formula
16 introduced at 13-16 weeks and solids at 17-20 weeks)
17

18 Woman: One of the midwives suggested that we give her a bottle and then I could go
19 back to breastfeeding, once I'd had a rest ... which was my intention until another
20 midwife told me that I couldn't do that ... once she'd been on the bottle then it was best
21 to keep her on the bottle. And she was quite firm to the extent that it was quite
22 unpleasant. (ID 2181. Interview 2 weeks after birth: formula feeding, introduced at 1
23 week, breastfeeding stopped at 1 week)
24

25 Woman: We were struggling with the feeding and I could've done with that additional
26 support right at the beginning, but because of communication not being as good as it
27 should've been, there was that four days that we went without anybody coming round. (ID
28 1057. Interview 13 weeks after birth: formula feeding; formula introduced at 1 week,
29 breastfeeding stopped 9-12 weeks)
30

31 Woman: I must say that what I have had is what I would expect to have in an ideal
32 world! I don't think I would've asked for any more than I got. Because every step that I
33 needed explaining or needed help I always got it. For me it's been a ten out of ten
34 experience, except for the pains [laugh]. (ID 1148. Interview 3 weeks after birth:
35 exclusive breastfeeding)
36

37 Woman: The way it's kind of promoted sometimes, it's a lovely bonding experience and
38 when you come home, then you feel guilty yourself because you think, well I'm not
39 having this bonding and lovely experience, I'm having, you know, a kind of hard sore
40 experience. (ID 2103. Interview 3 weeks after birth: breastfeeding, with formula
41 introduced at 3 weeks)
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Goals: future health versus current wellbeing (Box 4)

New parents are aware that exclusive breastfeeding and delaying the introduction of solids until 6 months are promoted by the health service because of health benefits and many are keen to “give it a go”, confirming earlier research.⁴² Participants’ beliefs and opinions about these recommendations vary over the infant feeding journey both within and between families. At one extreme, some parents believe in the recommendations and persevere with exclusive breastfeeding – the ease of this depending largely on personal qualities like self-confidence, determination and the availability of support. For some the strongest motivator is to avoid a specific health outcome like food allergy or eczema, particularly in families with a history of the condition. For others the value of “nature” is paramount, with a desire to avoid formula milk and commercial baby foods, which are seen as artificial, processed and linked to future adverse health outcomes. At the other extreme, some families express doubt about the causal relationship between exclusive breastfeeding with introduction of solids at 6 months and longer term health outcomes, particularly obesity. There is an awareness of mixed messages from health professionals about the exact timing of introducing solids, contributing to this doubt. Later childhood sedentary lifestyles and consumption of “junk food” are perceived as stronger determinants of future health, a view expressed particularly by men. The health consequences of not exclusively breastfeeding for 6 months are not readily visible or tangible, and parents who were formula milk fed perceive themselves to be as healthy as others who were breastfed. As in earlier longitudinal qualitative research, narratives describe generations of families given formula milk or solids from 3 months, with no evidence of harm and these accounts are employed to counter any implications of being a “bad mother” or putting a child at risk.⁴³ For all families, current emotional and physical wellbeing is paramount. But those who are more sceptical about or do not prioritise health recommendations introduce formula milk or solids more readily when feeding difficulties arise, expecting immediate benefits, such as reduced breast pain, more sleep or a contented baby who is gaining weight and resolution of anxiety. Longer term future health benefits are not considered and the priority is to “make sure he’s getting enough to eat” now, “regardless of where it comes from”.

What would make a difference? Health professional-family communication about infant feeding would benefit from a move away from checklists and instead ask open questions about experiences, values, priorities and goals with discussion about how feeding will fit into family life. This could reduce the mismatch between ideals, expectations and reality and would allow infant feeding care to be tailored to the family.

Box 4. Women and family values*Goals: future health versus current wellbeing*

Woman: I think probably at some point in the middle of the night, tearing your hair out, I thought... considered it, but then... well, I kind of think as well I've got this far so I'm not going to start giving him formula now. (ID1108. Interview 24 weeks after birth: breastfeeding, with solids introduced at 24 weeks, formula not introduced)

Partner: it's [breast milk] better for your wean isn't it? It's all natural stuff, I don't like chemicals, I'm not keen on bottles at all. (ID 2037. Interview 24 weeks after birth: formula feeding, introduced at 9-12 weeks, breastfeeding stopped and solids introduced at 20-24 weeks)

Partner: Well, that's another thing, they say that if you breastfeed that your child is in sort of a lower category of being quite obese. Well, I don't know if I agree with that, because my son is quite big and he was breastfed for six months and, I don't know, I don't think he eats... lots of sweets or things like that, so I don't know if I agree with that at all going by him. But yet my daughter's not big, so I don't know if I agree with that or what. (ID1208. Antenatal interview)

Woman: I did feel a bit guilty at first [about stopping breastfeeding]. But then I thought well he wasn't settling and he needs to make sure he's getting fed and I've obviously got to look after myself as well to be able to look after him. (ID 2255. Interview 3 weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 1 week)

Family bonds and intensive mothering

Partner: For the wean's sake, breastfeeding's best, but for the woman and wean's sake, or the family and the wean's sake, breastfeeding might not be best. (ID 2287. Interview 24 weeks after birth: formula feeding, introduced at 3-4 weeks, breastfeeding stopped at 7-8 weeks, solids introduced at <16 weeks)

Partner: For the first few months, all it's doing is waking up, smiling, I want fed now, right I need changed now, and it's effectively that, that's the scenario. So not being involved in doing the nice bit, but doing the majority of the nasty bit, you know, sort of thinking, who's getting the better deal here? (ID 2061. Interview 24 weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 5-6 weeks, solids introduced at 17-20 weeks)

Woman: He [husband] really enjoys it actually, and I think he's really delighted that [baby] will finally take a bottle from him and, you know, that's kind of their time to sit and chill, ... it's really nice actually to see that. I think [husband] feels more connected as well, just being able to do that. (ID 2192. Interview 19 weeks after birth: breastfeeding, with formula introduced at 5-6 weeks)

Woman: It all seems to be, "don't ever do anything that would interfere with breastfeeding", it's all got to be very purist which is fine, but it just doesn't fit in with the rest of your life and I think in a way people just give up because it's too difficult. (ID 1075. Interview 24+ weeks after birth: breastfeeding, with formula introduced at 2 weeks and solids at 21-24 weeks)

Woman: I do think when you've had babies that they [partners] do feel a bit pushed out to be honest. And the kids are my number one, so he's just got to get on with that. (ID 2056. Interview 13 weeks after birth: exclusive breastfeeding)

Time values and strategies

Woman: He's waking up usually at around 5.30 and by the time I have fed and changed and burped and what have you, [partner] takes over which gives me time to go for a run in the morning so that's really good, so that gives me a bit of "me time". (ID 1056. Interview 12 weeks after birth: exclusive breastfeeding)

Woman: So he sort of tends to just suckle as often as he can then, but during the day... I only maybe manage to get a couple of hours at the most [laugh]. But it's fine, I'm not feeling... I feel really good this time, I don't feel drained physically or anything at all, I feel fine. (ID 2169. Interview 9 weeks after birth: exclusive breastfeeding)

Woman: I have gone back to the gym and done a couple of classes there and his dad looked after him. He's not taken any expressed milk yet, he's not taken to the bottle, but we've only really tried that a couple of times. (ID 1094. Interview 11 weeks after birth: breastfeeding, with formula introduced at 7-8 weeks)

Rules and being a "good" parent

Woman: My mum kept saying "it's just trial and error, there's no right and there's no wrong....", because I'm quite bad for getting a bit... even now I'll still sometimes be "oh it's all going wrong" and get over anxious and kind of like "oh, not doing it right and she's not getting what she needs." (ID 1167. Interview 24+ weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped 3-4 weeks, solids introduced at 24 weeks+)

Woman: one of the midwives I spoke to, she was like "and have you thought about breastfeeding?", I was like "yeah I'm going to try", and she was like "well you know that it's on demand and you can't use bottles and you can't do this and you can't do that, and it's for six months and you have to like ..", basically you are attached to this baby for six months, and she made it seem quite, negative, almost. (ID 2003. Antenatal interview)

Partner: We feel that we've done the right thing [giving solids], but there was not...

Woman: It was a hard decision for us, wasn't it?

Partner: Aye, it was a hard decision because we were going against...

Woman: The rules, if you like ...

Partner: The rules, we were breaking the rules. (ID 2294. Interview 24+ weeks after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 21-24 weeks, solids introduced at 16 weeks)

Woman: I kind of got a bit of... not grief, but kind of... like negative tension if you want, for wanting to put him on solids at 17 weeks.....and I think if you're breastfeeding they want you to breastfeed for longer because obviously they've managed to get you to breastfeed and it's great and they want you to keep going as long as you can. (ID 2128. Interview 24 weeks after birth: breastfeeding, formula introduced at 1 week and solids at 17-20 weeks)

Woman: Well they've [health visitors] obviously got to follow the regulations about the World Health Organisation says this and that and the other. But at the end of the day, my opinion was, as his mum, it was my decision. (ID 1226. Interview 24 weeks after birth: formula feeding, introduced at 2 weeks, breastfeeding stopped and solids introduced at 17-20 weeks)

Family bonds and intensive mothering (Box 4)

The hopes and fears of the immediate family and its social network are raised by the arrival of a new baby. The overriding goal for new parents is emotional and physical wellbeing, so that the important social ritual of introducing the new baby to the social network is a joyful and fulfilling experience for all, with minimal anxiety and tension. Scenarios of changing feeding behaviour to prioritise family wellbeing over health values are described, for example not wanting to “shun to the side” a six year old daughter who is “desperate to help” by giving a bottle. Breastfeeding is widely promoted as a way for mothers to bond with their babies, leading to anxiety that partners, grandparents or older children will not bond with the baby unless they are actively involved in giving feeds. For some mothers and significant others, actively feeding the baby by bottle or spoon has a higher value than all other baby care tasks and is “therapeutic” and “relaxing”. Women are keen to express breast milk as soon as possible to enable others to bottle feed breast milk and if expressing fails some introduce formula milk or solids early to fulfil this ideal. Accounts of prioritising bonding and family emotional wellbeing are employed to counter any implications that families are not doing the best for the health of their baby by not exclusively breastfeeding. A few parents prioritise the ideal of exclusive breastfeeding above all other facets of individual or family wellbeing. A model of “intensive mothering” has been described where a strong mother-infant bond is fulfilled by exclusive breastfeeding on demand and is of paramount importance.⁴⁴ For first time parents, a mismatch can occur between expectations and the reality of how family, friends and health professionals help them practically and emotionally with feeding, parenting and household tasks. For many there are barriers to asking for help, with few feeling confident enough to ask and women prefer professionals and others to offer help.

What would make a difference? Opportunities for significant others to be involved in discussions about roles, bonding and coping with breastfeeding after birth might help families to adapt and maintain family wellbeing. Proactive offers of help are preferred.

Time values and strategies (Box 4)

A priority for many new parents is “getting the baby into a routine”, as attaining a regular feeding and sleeping pattern helps to adjust to changes in roles and use of time. First time parents in particular can find the lack of time for non-baby related activities and “me time” a major challenge for which they are not prepared. Even those who have anticipated devoting themselves to feeding may struggle with the time taken to breastfeed, feeling anxious to “get back in control” of their lives. At the other extreme, a few women who fit the “intense mothering” model willingly sacrifice other activities for their ideal and thrive on fulfilling this role. Priorities for the use of time vary but often focus on restoring pre-pregnancy activities and values, in particular sleep, image (hair, nails clothes), exercise, friendships, couple or family time including attention to other children and housework. Reconciling these ideals and values with exclusive breastfeeding can be challenging. Parents who do reconcile ideals with reality can feel empowered and those who struggle can feel guilty or inadequate as parents in relation to their own ideals or those of others. Return to work can symbolise “the end for the boob” for some, who introduce formula milk or solids prior to six months to facilitate child care arrangements. The moral work of breastfeeding and perceptions of being a good or bad mother have been explored in depth elsewhere.^{45,46}

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3 What would make a difference? Women benefit from helpers who understand the
4 tensions between ideals and reality experienced while feeding a baby, who are woman
5 and family-centred rather than focused primarily on breastfeeding, and can build
6 confidence and increase self efficacy.
7

8 **Rules and being a “good” parent (Box 4)**

9
10 In family accounts of interactions with health professionals, there is a lack of clarity about the
11 breastfeeding ideals derived from current evidence based guidance: exclusive breastfeeding
12 for 6 months is best; breastfeeding for longer than 6 months is ideal and any breast milk is
13 better than none.^{1,19} In contrast, accounts of advice about the ideal time to introduce solids
14 were more clearly recalled, but inconsistencies in health professional advice were recounted.
15 Some parents report not always being honest about their feeding behaviour with health
16 professionals if they were not following advice. This reflects the complexity and ambiguity of
17 the feeding messages within current guidance, leading to communication challenges for
18 health professionals.⁴⁷ Dichotomies of “good” or “bad”; “right” or “wrong”; “breast or bottle”
19 prevail in accounts of interactions with health professionals, with support for giving both
20 formula and breast milk or self-evaluations on a continuum like doing “well enough” less
21 common. The emphasis on the technical skills of correct positioning and attachment: “if it
22 hurts you are doing it wrong” can leave some women feeling a failure whereas other women
23 distrust this dictum and attribute success to being “lucky”, allowing their self-esteem to be
24 more protected. Rules are recounted where the rationale to parents is unclear: expressing
25 must not begin before 8 or 12 weeks; no nipple creams or shields; bottles and teats confuse
26 the baby; babies must feed within a certain time after birth. Our interpretation is that well-
27 meaning health professionals who wish to promote the ideal of exclusive breastfeeding until
28 6 months convey some advice in a black and white manner, where the supporting research
29 evidence is less clear cut.⁴⁸ Concern about doing infant feeding ‘properly’ adds to the
30 pressure on unconfident new parents, with some describing it as “just one big guilt trip” and
31 feeling “heartbroken” when a decision to stop breastfeeding is made before the woman’s
32 ideal time. It is widely acknowledged that health professionals “have always got to be seen
33 to be saying the right thing”. However, women appreciate communication with professionals
34 that embraces the reality of how difficult it is to attain feeding ideals and is attentive to the
35 emotional consequences of compromising between the different health and family values.
36 Such accounts invariably feature reassurance, confidence building, normalising experiences
37 and time spent developing a trusting relationship.
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44 What would make a difference? Whereas a woman-centred communication style can
45 ameliorate parental distress, a breastfeeding centred or formulaic guideline and rules
46 based style can increase it. The latter can influence feeding decisions and actions as it
47 can undermine women’s confidence, experience and the wider family situation.
48

49 **Pivotal points and feeding transitions (Box 5)**

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51 When physical, emotional or social difficulties arise in the first 6 months after birth, parents
52 believe that changing the feeding behaviour is one of the few immediate actions within their
53 control that might restore their primary goal of family wellbeing. Our interpretation is that
54 these pivotal points where feeding behaviour changes represent a conflict between ideals
55 and reality. The trigger for a pivotal point may be somatic; emotional; social; cultural or
56 environmental, and examples are well documented in the research literature describing the
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59
60

Box 5. Pivotal points and feeding transitions

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5 Woman: I could feel myself welling up because I had my heart set on getting out [of
6 hospital] that day ...that's why I said we'd go on to the formula. (ID 2203. Interview 3 weeks
7 after birth: formula feeding, introduced at 1 week, breastfeeding stopped at 1 week)

8
9 Woman: I think if it hadn't been for that explanation [from the health visitor], I may well have
10 sort of said, "well I've tried my best, I'm giving up." So I'm glad I didn't, and I didn't because
11 of the health visitor, because she was so reassuring.

12 Partner: Aye. Because we were getting to the stage where we were... because at the end
13 of the day, all what you'd like to do for her [the baby], the number one priority is she's getting
14 food, getting enough goodness in her, irrespective of where it comes from. (ID 2294.
15 Interview 2 weeks after birth: breastfeeding, with formula introduced at 1 week)

16
17 Woman: That first weekend we gave him a bottle. "That's fine" ..., "we call that a crisis
18 bottle," she [health visitor] went, "and there's nothing wrong with that. If it works for you,
19 that's fine, but one bottle a day is not going to do any harm," so if anything she was a bit
20 more encouraging. (ID 2003. Interview 3 weeks after birth: breastfeeding, with formula
21 introduced at 1 week)

22
23 Woman: She was wanting fed like almost every hour on the hour, and - with me having
24 [son] and her dad being, runs about a lot, so I was mainly being home by myself and I found
25 it difficult to try and feed her and deal with him as well.....and I got to a point I just couldn't
26 cope any more, I was too tired, just wanted to sleep all the time. I thought, "No, can't do this,
27 need to stop." (ID 2287. Interview 12 weeks after birth: formula feeding, introduced at 3-4
28 weeks, breastfeeding stopped at 7-8 weeks)

29
30 Woman: I'd said that I was sort of persevering with it, and she [community midwife] said "try
31 this, try the next thing", but they didn't really sort of offer to show me. I just said that I was
32 topping him up with bottles and I was thinking that it wasn't really working very well, but I'd
33 kind of persevered with it, ...but then it was too much. (ID 2255. Interview 3 weeks after
34 birth: formula feeding, introduced at 1 week, breastfeeding stopped at 1 week)

35
36 Woman: He was waking every kind of hour and a half/two hours wanting to feed, so I tried
37 him on the solids after speaking to the health visitor. I just would like to sleep and I just don't
38 know why he's not sleeping at night time, so I just have to see if the food will help. (ID 2295.
39 Interview 19 weeks after birth: breastfeeding, with formula introduced 5-6 weeks and solids
40 <16 weeks)

41
42 Woman: Kind of a joint decision with the doctor because he'd got to four weeks and he still
43 really hadn't put on any weight, so it was really his health was more important I think rather
44 than fully breastfeeding. (ID1010. Interview 8 wks after birth: breastfeeding, formula
45 introduced at 5-6 weeks)

46
47 Woman: After a second bout of mastitis caused me difficulties in finding time to express
48 during the day when my husband had returned to work, I decided effectively last Sunday to
49 stop even trying, and just to focus on the formula feeding. I think, while there's still a part of
50 me that's upset about it, I think generally speaking it's been a relief because I've been able
51 to focus much more on the baby. (ID1173 Interview 6 wks after birth: formula feeding,
52 introduced at 1 week, breastfeeding stopped at 3-4 weeks)

Box 6. Feeding care: what would make a difference?

- Prioritise the immediate period after birth for resources to help women to breastfeed and 3-4 months after birth for the introduction of solids
- Provide opportunities for realistic interactive discussions with appropriately skilled health care providers and peers before and after birth with the option to include significant others
- Offer proactive rather than reactive care and anticipate those at risk of changing feeding behaviour at pivotal points
- Set realistic rather than idealistic goals, at individual, local and national level
- Pay more attention to emotional issues than the technicalities of breastfeeding by communicating in a narrative style which is woman/family-centred and sitting with women through feeds to build confidence and self-efficacy
- Use open questions rather than a check list approach and acknowledge that there are many ways to feed a baby safely
- Consider organisational systems and structures that would provide continuity of highly skilled feeding care from pregnancy through infancy

reasons why women change their feeding behaviour.^{6,9,10} For some in our study, the pivotal points were brief, intense, accompanied by significant emotional distress and feeding behaviour changed promptly. These intense pivotal points mostly occurred with transition from breastfeeding to formula in the early weeks when the mother and baby are learning a new skill at the same time as recovering from the physical and emotional consequences of childbirth. They also occurred at crisis times like illness. For others pivotal points and feeding transitions were a more gradual cognitive process, weighing up the pros and the cons and accompanied by less emotional dissonance. More gradual pivotal points are recounted particularly by parents with older children, those with strong family and social network support and around the introduction of solids. Families provide accounts of timely intervention around pivotal points which enabled them to continue breastfeeding or delay the introduction of solids. There are missed opportunities for help, for example midwife home visits when the baby is asleep or busy ward staff who have other priorities like drug rounds. Distress can increase when care is provided by an unknown person, staff are “too busy”, conflicting advice is encountered, or where help is not available. Our analysis suggests that mothers are particularly likely to stop breastfeeding or to introduce solids early at a pivotal point if they lack health professional support at an important time; lack a readily available network of family and friends to provide emotional support and practical help; or have significant others who formula fed or had negative breastfeeding experiences.

From a new mother’s perspective availability of trusted family, friends or professionals who are able to provide emotional and practical help, are perceived as key contributors to advantage or disadvantage with regard to infant feeding. Yet not all help provided is perceived as beneficial either to breastfeeding, introduction of solids or maternal wellbeing and it can create tension and a conflict in ideals. Pivotal points are common at around 4 months, if babies change their crying, feeding or sleep behaviours. Even parents who have “persevered” with their ideals, may reach a point when they introduce formula or solids

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2
3 earlier than planned in search of the immediate gain of a more settled, contented baby; relief
4 from their anxiety and more sleep. Many parents collect tips and suggestions from a variety
5 of information sources, the media, family and friends, health professionals and try many
6 strategies before introducing formula or solids. Influence depends on the value and trust
7 attached to the source and what fits best with their circumstances.
8

9
10 What would make a difference? Our interpretation is that infant feeding care would improve
11 by providing more proactive rather than reactive care, anticipating mismatches between
12 ideals and reality that underlie pivotal points and providing skilled family-centred help to
13 resolve difficulties.
14

15 DISCUSSION

16
17 In this paper, we describe how the philosophical positions of idealism and realism underpin
18 communication within and between families and health professionals about how to feed
19 infants in the first six months after birth. Idealism underpins the WHO global
20 recommendation of exclusive breastfeeding for 6 months, and the targets or indicators set by
21 governments in many countries. Six months exclusive breastfeeding is considered
22 unrealistic and unachievable by many families and promoting this is perceived as setting
23 parents up to fail. Our data were collected prior to widely publicised and contested research
24 questioning the 6 month guideline.⁴⁸ Conflicts between health and non-health ideals and
25 values for parents create tensions, leading to pivotal points whereby parents change their
26 infant feeding behaviour to restore their ultimate goal of family wellbeing. Discounting future
27 health in favour of immediate gains has been widely described particularly amongst
28 disadvantaged families.^{27,49} The willpower needed to persevere with feeding ideals may be
29 either harder to engage or more readily depleted for those who are disadvantaged either
30 economically or socially and need their willpower to struggle with other adversities.⁵⁰ An
31 argument can be made for shifting the emphasis from antenatal education to postnatal care,
32 with anticipation and prevention of pivotal points where breastfeeding ceases or solids are
33 introduced inappropriately.
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38 The strengths of this study are the serial interviews with women and their significant others,
39 which examine the interactions between individuals and families in health and social
40 contexts. They explored feeding on a continuum, from intentions in pregnancy to how these
41 translated into actions after birth. Unlike many studies our explicit focus was to ask what
42 would have made or would make a difference to breastfeeding experiences at each
43 interview, to inform future intervention studies. It is uncertain how transferable our data is
44 outside the UK, however international qualitative evidence synthesis highlights the need for
45 more realistic infant feeding support.¹⁰ Our study confirms the constructs of intensive
46 mothering⁴⁴; the give it a go breastfeeding culture⁴²; deviance and the discourses around
47 good and bad mothering^{43,44}; the expectation and reality gap¹⁰; getting breastfeeding
48 "right"¹⁰; the medicalisation of breastfeeding⁹; the guilt and failure associated with
49 stopping^{10,44}; gaps in health service provision such as prescriptive rather than individualised
50 care; the challenges of breaking the rules⁴⁷; busy postnatal wards; and lack of effective
51 practical and emotional support from health professionals at significant times.⁹ Our sample
52 was more economically advantaged than we had aimed for. Offering incentives to
53 participate in interviews was originally proposed as a strategy to improve recruitment of
54 "hard to reach" families, but this was not approved by the Ethics Committee. SIMD for
55 postcode of residence seems unreliable for selecting disadvantaged participants particularly
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3 in mixed urban and new build areas and for immigrants who are often highly educated but
4 working in low paid jobs. This is perhaps not surprising as SIMD is not intended for use at
5 an individual level and age at leaving full time education is considered the best proxy
6 measure for assessing socio-economic status.⁵¹ For infant feeding it is debateable how valid
7 it is to assess “advantage” and “disadvantage” for new parents based on traditional socio-
8 demographic characteristics alone. Not having an emotional and practical support network
9 or being surrounded by significant others who have formula fed, had negative breastfeeding
10 experiences, introduced solids early, are unaware that recommendations have changed are
11 also disadvantages which can influence feeding decisions and health inequalities.
12
13

14 The WHO guidance of exclusive breastfeeding for 6 months¹ is intended to inform
15 international government policies, yet it is being widely communicated in written and verbal
16 health service information as an individual feeding goal for parents. Similarly, the pass-fail
17 nature of the BFI accreditation scheme³⁰ may generate a “right-wrong” culture which does
18 not facilitate mothers and health professionals to work in partnership to make individual
19 choices informed by personal values and circumstances. By promoting 6 months exclusive
20 breastfeeding, policy makers are encouraging idealistic expectations and goals in
21 pregnancy, but health services are not providing the skilled help required to establish
22 breastfeeding after birth. This mismatch between idealism and realism is likely to be a
23 mechanism behind the media stories of mothers feeling pressurised to breastfeed.⁵² The
24 theory on changing and sustaining healthy lifestyle behaviours indicates that achievable
25 goals set by individuals themselves, which are mastered and then re-set incrementally,
26 known as smart goal setting is effective and builds self-efficacy.⁵³ Would changing the
27 message to “breastfeed for as long as you can” and “introduce solids as close to 6 months
28 as possible” with more individually tailored goal setting, social support and feedback make a
29 difference to breastfeeding outcomes? Or do we just need to rebalance the health service
30 input to increase the intensity and frequency of support after birth around the pivotal points
31 for ceasing to breastfeed and introducing solids, as indicated by the evidence for weight
32 management and exercise to prevent disease?⁵⁴
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37 The serial narrative interviews employed in this study with open questions and continuity
38 focusing solely on infant feeding are a tool which could be modified for use in clinical
39 encounters to anticipate families most at risk of pivotal points when feeding behaviour
40 changes. We hypothesise that this would assist in the identification of women who are more
41 likely to experience intense pivotal points in the early days with breastfeeding or at around 3-
42 4 months with the introduction of solids and facilitate discussion about any potential or actual
43 mismatch between ideals and reality. The dominant discourse in health service policy,
44 research and practice is “breastfeeding support for women”. Support is an ambiguous word
45 that can infer either a realistic woman centred or a more idealistic breastfeeding centred
46 philosophy. We advocate that this should change to “family centred feeding care” in health
47 service written and oral discourses. The word “care” has an implicit person centred meaning
48 and is less likely to be misconstrued as pressurising; “feeding” embraces solids as well as
49 milk and “family” acknowledges the important role of others in infant care. Realistic
50 information with a facilitative patient-centred style¹¹ should aim to minimise tension and
51 distress and help parents feel more confident, with avoidance of “do-don’t” discourses. More
52 acknowledgement of the importance of emotional wellbeing as an outcome that matters to
53 families is needed. Physiologically this is explained by the association between stress
54 reducing oxytocin levels and milk flow.⁵⁵ Emotional wellbeing is most precarious soon after
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3 birth and to address this the emphasis for professional breastfeeding care should be after
4 rather than before birth. The findings of this study lead us to suggest that it is time to revisit
5 the current ideal of training all health professionals to provide infant feeding care, particularly
6 with shorter hospital stays, reduced routine postnatal contact with families and staff
7 shortages. Certainly more of the same approach to promoting and supporting breastfeeding
8 would seem unlikely to be effective²⁵ and service re-organisation will be needed if care is to
9 anticipate pivotal points.
10

11
12 Almost two decades ago there was a debate around idealism in health promotion which
13 questioned the transformation of health into a political value.⁵⁶ We would argue that it is time
14 to revisit this debate for infant feeding, if we are to design and deliver successful
15 interventions to improve infant feeding outcomes and subsequent health outcomes of future
16 generations. This study is hypothesis generating and several potential changes to policy
17 and practice could arise from the study messages. Increasing feeding care after birth;
18 proactive rather than reactive care; specialisation with dedicated feeding teams; a family
19 centred narrative approach rather than check lists; these changes in health service
20 behaviour would all have considerable implications for health professional training,
21 accreditation schemes and resources. Achieving health service change is likely to be just as
22 challenging as achieving patient behaviour change. ~~However, w~~We would argue that infant
23 feeding is too important and resources too scarce to make changes without robust evidence
24 from randomised controlled trials or other appropriate evaluation strategies.
25
26

27 28 **COMPETING INTERESTS**

29
30 All authors have completed the Unified Competing Interest form at
31 www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and
32 declare that PH, LC, JB and RM have no relationships with companies that might have an
33 interest in the submitted work in the previous 3 years; their spouses, partners, or children
34 have no financial relationships that may be relevant to the submitted work; and PH, LC, JB
35 and RM have no non-financial interests that may be relevant to the submitted work.
36

37 38 **DETAILS OF CONTRIBUTORS**

39
40 All authors were involved in the design of the study, the analysis of data, and the writing and
41 editing of this paper. LC and JB conducted the interviews with participants. All authors had
42 full access to all of the data in the study and can take responsibility for the integrity of the
43 data and the accuracy of the data analysis. PH wrote the first draft of the paper and all
44 authors made important intellectual contributions to the content and approved the final
45 version.
46

47 48 **ETHICS COMMITTEE APPROVAL**

49
50 Approval was obtained from the North of Scotland Research Ethics Committee (reference
51 number 09/S0802/65). All participants provided written informed consent and any details
52 that could allow identification of participants have been changed to protect confidentiality.
53

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2
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6

7 The views expressed are those of the authors and the authors are all independent of the
8 funding body.
9

10 11 12 **DATA SHARING**

13
14 A full study report is available at <http://www.healthscotland.com/documents/4720.aspx>. Data
15 sharing: no additional data is available as consent was not obtained.
16

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Supplementary Files

A longitudinal qualitative interview study of infant feeding experiences: idealism meets realism.

The full final report of this study which includes additional detail on the sample characteristics and the findings is available on the NHS Health Scotland website:

<http://www.healthscotland.com/documents/4720.aspx>

The information presented here is not available in the final report.

S1: Opt-in form sent with the study information leaflet to recruit women to participate**Talking about feeding babies – are you interested in taking part?****About your baby**

What date is your baby due?

How do you plan to feed this baby? (Cross one box only)

Undecided

Breast milk

Formula milk

About you

How many children do you have already?

What is your age?

What is your present or most recent job?

(please tell us if you have never had a job or if you are a student)

How old were you when you left full-time education? School or college, whichever you last attended full-time. (Cross one box only)

16 or under

17

18

19 or over

How would you describe your nationality?.....

What is your postcode?

Who do you live with?.....

About the father of your baby

What is his present or most recent job?

(please tell us if he has never had a job or if he is a student or if you don't know)

How old was he when he left full-time education? School or college, whichever he last attended full-time. (Cross one box only)

16 or under

17

18

19 or over

Don't know

Taking part in this study

If you are interested in taking part in this study please give your name, address and telephone number and a researcher will contact you.

Name

Telephone

Address

Mobile

E mail

THANK YOU

S2 Discussion topics posted on Baby Feeding Talk Website Forum

Who has given you information about what to eat during pregnancy, and what do you think about the information you've been given?

What information have you had about baby feeding? Has there been anything you found particularly helpful, or unhelpful?

How is feeding going? What has been helpful? What has been difficult?

Who (or what) helped you most during the first two or three months of feeding your baby? Did anything make it more difficult?

How old was your baby when you started looking for information about introducing solids - not necessarily doing it. What did you want to know, and who or what did you find most helpful?

S3 Topic guides for semi-structured qualitative interviews and their change over time.

20/08/09 Antenatal topic guide.

Developed before the study started based on the commissioning brief and the research team knowledge of the relevant literature.

- Have you talked to anyone about feeding babies while you have been pregnant (*see if they mention health professionals or family first*). Can you remember what you talked about, when? What stories have you heard?
- Information (written/verbal/internet/adverts) received from health professionals (*or family if only mention health professionals first*) about feeding your baby and the food you eat in pregnancy and views about this. Anything which was particularly helpful/unhelpful. Anything which could have been done differently or at a different time/person.
- Baby feeding decision – has it been made, how and when; influences.
- Views of the partner, family and friends on infant feeding. How have they fed their babies and what experiences have they had, what are their views. Similarities/differences. Is there anyone you look up to and think – I would like to be a mother like you? Or the opposite (I think I will do things differently). This could be anyone including celebrities – see who they mention – no leading questions.
- Where family and friends live and expected help available around the time of birth when come out of hospital. (*Probe: What sort of help?*) Regularity of contacts with family and friends. Who will be the most influential people around you w.r.t. feeding (significant others)?
- For multiples: previous good times and bad times with feeding after birth and the help received – what could have been done differently?
- Expectations, hopes, fears about the first 6 months after birth.
- Anticipated help needs in the first 6 months after the birth of this baby and who is likely to meet these needs.
- What would information and preparation for feeding your baby be like in an ideal world? Who would provide it, how, when and where? Just to you, to other members of your family? One-to-one, groups, internet.
- How important do you think feeding is? (*see if they mention any health benefits*) What about how much babies weigh? How is this likely to influence you?
- If health benefits relating to feeding not mentioned anywhere – raise at end Do you think feeding will affect your baby's health? If so how?
- If childhood obesity not mentioned - raise at end. There has been a lot on the TV and in newspapers about childhood obesity – what are your views about this?
- Follow up anything that is new or different from other interviews. Probes to differentiate where possible between information, emotional, appraisal and instrumental (practical) help/support.

20/08/09 Postnatal topic guide.

Developed before the study started based on the commissioning brief and the research team knowledge of the relevant literature.

- General experiences after birth/since the last interview (good times and bad).
- Baby feeding experiences after birth/since the last interview (good times and bad).

- Decisions made about baby feeding, how these were made and who influenced the decision. Have you made any changes to your feeding from what you planned / since we last met? What triggered the change? (trying to think how to ask about 'decisions').
- Help received (information/emotional/appraisal/practical): who from (professionals, family and friends, the wider community), type of help, whether it did help or hinder, how could the help or support have been provided differently?
- What would be the most helpful thing that could happen now?
- What about the time it takes to feed the baby?
- Any worries, stresses, anxieties re feeding. Have you shared these with anyone? Who?
- Views about returning to work, social life and other influences on feeding decisions.
- Views about the study website and participating in the discussion forum?
- Follow up of specific points raised in previous interviews, in particular any changes in views, attitudes, plans or decisions and how these arose.
- What would help and support be like in an ideal world. Who would provide it, how, when, where? How could health care when you are in hospital, b) health care when you are at home be different, more helpful?

13/10/11 Postnatal topic guide.

Modified following analysis of initial interviews and through research team discussion.

- General experiences after birth/since the last interview (good times and bad).
- Baby feeding experiences after birth/since the last interview (good times and bad).
- Decisions made about baby feeding, how these were made and who influenced the decision. Have you made any changes to your feeding from what you planned / since we last met? What prompted the change?
- Help received (information/emotional/appraisal/practical): who from (professionals, family and friends, the wider community), type of help, whether it did help or hinder, how could the help or support have been provided differently?
- What about the time it takes to feed the baby?
- Any worries, stresses, anxieties re feeding. Have you shared these with anyone? Who?
- Views about partner's return to work / departure of helpers – what difference will this make?
- Views about returning to work, social life and other influences on feeding decisions
- Follow up of specific points raised in previous interviews, in particular any changes in views, attitudes, plans or decisions and how these arose.
- What would help and support be like in an ideal world? Who would provide it, how, when, where. How could health care be different, more helpful a) when you are in hospital, b) when you are at home?
- Thinking back to the information received during pregnancy do you think anything could have been done differently to help you prepare more?
- Views about the study website and participating in the discussion forum?

8/12/09: Postnatal topic guide after stopping breastfeeding and from 8-10 weeks after birth onwards.

Developed following analysis of initial interviews and through research team discussion.

- Baby feeding experiences since the last interview (good times and bad).
- Decisions made about baby feeding:
 - Introducing non-milk fluids – water - what sort (tap, boiled, mineral), juices – what, when and why?
 - Introducing remedies, OTC non-prescribed medicines what, when and why?
 - Introducing solids – already? Plan? What foods will you choose? Who have you talked to about introducing solids? What sort of things have you talked about?
- How were these decisions made and who influenced the decisions. Have you made any changes to your feeding from what you planned / since we last met? What prompted the change?
- Advice and information received about a) introducing non milk fluids, b) remedies, c) solids. Who from (professionals? family and friends? other sources? Probe whichever are not mentioned), whether it helped or hindered.
- How could the help/advice/information or support have been provided differently? What would you have liked?
- Views about information sources? Web? The study website and participating in the discussion forum?
- Views about returning to work, social life and other influences on feeding decisions.
- What about the time it takes to feed the baby now – has it changed compared to the earlier weeks?
- Any worries, stresses, anxieties re feeding. Have you shared these with anyone? Who?
- Follow up of specific points raised in previous interviews, in particular any changes in views, attitudes, plans or decisions and how these arose.

08/03/10: Topic guide for final interview at around 6 months after birth.

Developed following analysis of earlier interviews; review of the literature on the effectiveness of interventions to increase breastfeeding duration and exclusivity; and through research team discussion.

- Read all previous interviews and follow up on key themes.
- How is the feeding going now, anything different?
- Solids – started / progress? How decision made – signs for starting or increasing? When? How much? What? Difference made? Advice and information, who from – health professionals, family, friends. Helped or hindered?
- Milk feeds, any changes? Why?
- Other drinks being given? Prompts as Q3 on solids.
- Anything else - medicines etc? Why? Prompts as Q3 on solids
- Anyone said unhelpful things about feeding? Who? What said?
- Any worries re feeding?
- What are your views about baby feeding and a child's weight later on?
- Have you looked at the study website at all? Any comments?

- Who has been most influential on feeding decisions since we last spoke?

01/03/10: Introduce scenarios

1. Suggested introduction: “We have put together some scenarios about help which might be offered with baby feeding, based on what women / their families have told us, and we’d like to get your comments on them”.
2. Discuss scenarios in order, print on separate pieces of paper, largish print. For multiparous women, offer chance to comment from first baby perspective or for present baby. Start each scenario with general questions, ‘What do you think would be the good things about this sort of help? And the difficult things?’
3. Use prompts as appropriate – some things will have already been covered in interviews, or won’t be appropriate if woman not keen on a particular scenario. NB there are 2 prompts: ‘Continuity’, and ‘Qualities of helper’ which probably don’t need repeating in A, B and C.

Scenarios/vignettes

A

On the postnatal ward in hospital A, someone with special breastfeeding experience sits with you for a whole breastfeed. She helps you to position your baby for breastfeeding and latch the baby on. If your baby has difficulty latching on, she or other experienced colleagues come back for as many feeds as it takes to get the baby feeding comfortably.

Possible prompts

- 1) What about partner - helpful for him to be involved?
- 2) What about the number of different people helping – what would you prefer?
- 3) What would the ideal helper be like? Does it matter if the person helping has breastfed herself? Why? (Qualities of helper)
- 4) What if they said you needed to stay longer to get this help as it would be difficult to give you as much help at home?

B

In hospital B, women who are breastfeeding when they leave hospital receive a phone call at home every day for the first 14 days from a midwife or a breastfeeding support worker. She can arrange for someone with expert breastfeeding skills to visit at home if there are problems or she can suggest coming to the hospital to be seen by a breastfeeding specialist.

Possible prompts

- 1) What would be the good things about talking on the phone? Difficult things?
- 2) If you needed more help, would it be best to be visited at home, or to go to the hospital?
- 3) Would you want it to be the same person phoning or would that not matter? (continuity)

C

In hospital C, there is a specialised baby feeding team, made up of midwives, health visitors, dieticians and feeding assistants. It gives help to families from pregnancy until the baby is 6 months old, on breastfeeding, bottle feeding and introducing solids.

Possible prompts:

- 1) Does it matter which profession provides help?
- 2) What about the number of different people you might see? What if you could see the same 3 or 4 people more frequently, or the same 1-2 people less frequently? (continuity)
- 3) How would it be seeing one team of midwives (or health visitor) for all aspects of pregnancy (baby care), but someone else about baby feeding?
- 4) What would be best way to contact the team? (Phone, text, other?)
- 5) What days / hours should team be available?

D

In area D, breastfeeding and bottle feeding are discussed at an antenatal class with women and their partners, or relatives or friends. Some women from the local breastfeeding group attend and one breastfeeds her baby. Another describes a difficult caesarean section and a baby who did not want to breastfeed. She tells of how painful breastfeeding was for her, but now that the baby is 3 months old, says she is glad she kept going.

Possible prompts

- 1) Is it a good idea to include partners?
- 2) Is a class preferred, or an individual chat with a midwife?
- 3) What do you think about someone describing difficult experiences?
- 4) If you were given the choice between extra information on breastfeeding before the birth, and extra help after the birth, which would you choose?

Y

In area Y, local women who have breastfed are trained to help women at home in the first 2 weeks after birth.

Possible prompts

- 1) What sort of help would you like?
- 2) Pros and cons of local women vs health professionals?
- 3) How would you like to be able to contact them / they you? Visiting at home, by phone, at a breastfeeding group?

Z

In area Z, local women provide home help services for women who are breastfeeding during the first few weeks after birth. This is to help with household chores, shopping or caring for older children.

Possible prompts

- 1) What sort of things would you have liked help with?
- 2) At what stage would help be most useful?
- 3) Would you use a service if you had to pay? How much do you think would be reasonable?
- 4) What about formula feeding women?

T

In area T, when babies are 3 – 4 months old, the health visitor sends a letter offering an individual appointment or a group session to discuss introducing solids. There is a choice of day time or evening group sessions and women are invited to bring their partner or another relative / friend if they wish.

Possible prompts

- 1) Timing of discussion (age of baby) - when preferred?
- 2) Significant others too?
- 3) Pros and cons of group versus individual discussion?
- 4) What would you want to discuss?