A STUDY OF THE EXPERIENCES OF PRIMIPAROUS MOTHERS WHO INITIATED BREASTFEEDING

This thesis is presented in fulfillment of the requirements for the Degree of Master of Women’s Health by research.

Submitted by Patricia Laura Hannigan in the year 2000.
Declaration

This Thesis has been submitted for the Degree of Master of Women's Health by research. In accordance with the rules pertaining to the submission of this thesis at the University of Melbourne, I declare that the material presented here has not been presented for any other degree at any institution. The work is original and was performed totally by the author.

Signed  

[Signature]

Patricia Hannigan.
Acknowledgements

This project could not have been carried out without the help and influence of many people.

Firstly I would like to thank the mothers in Papua New Guinea and Zambia who I had the privilege to care for and to be welcomed into their homes with great warmth and hospitality. It is these mothers who showed me that breastfeeding could be so much different to the ways to which I was accustomed.

Next I must thank the mothers who participated in this study, for their generosity in giving me some of their time and for trusting me with details about the happenings and feelings of their lives in the first weeks after they gave birth to their first child. Also my appreciation to the midwives who took the time from their busy schedules to participate in the project.

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Finally, thank you to my husband Aidan, who, despite being seriously ill and undergoing extensive chemotherapy and radiotherapy for much of the time of my candidature, never wavered in his enthusiasm and support. Without his support this research project could not have been completed.
I dedicate this thesis to my three grandchildren, Joel, Emily and Cameron.
Explanatory Notes

Whilst I attempted to write this thesis using the first person I found, for whatsoever reason, that I was uncomfortable in doing so and consequently reverted to the more traditional third person excepting when describing the researcher bias in chapter two. Here I found the use of the third person out of place and therefore wrote this small part in the first person.

Whilst I had expected some difficulties in definition regarding the difference between fully and partly breastfeeding, this was not the case. All the mothers in this study were either exclusively breastfeeding or exclusively bottle feeding at the time of the interview. Therefore the headings referring to breastfeeding or bottle feeding mothers throughout this thesis can be taken to mean exclusively one or the other at the time of the interview.

When referring to the midwives I have always used the feminine pronouns although it is acknowledged that a small minority of midwives are male.

Finally, when the word doctor is used it refers to medical practitioners. The term does have far wider application, but it is not so in this thesis.
### Abbreviations and Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACMI</td>
<td>Australian College of Midwives</td>
</tr>
<tr>
<td>ALCA</td>
<td>Australian Lactation Consultants Association</td>
</tr>
<tr>
<td>ANF</td>
<td>Australian Nursing Federation</td>
</tr>
<tr>
<td>APMAIF</td>
<td>Advisory Panel for the Marketing in Australia of Infant Formula</td>
</tr>
<tr>
<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
</tr>
<tr>
<td>CINAHL</td>
<td>Cumulative Index to Nursing and Allied Health Literature</td>
</tr>
<tr>
<td>EOA</td>
<td>Equal Opportunities Act</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>IBFAN</td>
<td>International Baby Food Action Network</td>
</tr>
<tr>
<td>IVF</td>
<td>In Vitro Fertilization</td>
</tr>
<tr>
<td>LLL</td>
<td>La Leche League</td>
</tr>
<tr>
<td>M&amp;CH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MAIF</td>
<td>Marketing in Australia of Infant Formula</td>
</tr>
<tr>
<td>MFW</td>
<td>Mother Friendly Workplace</td>
</tr>
<tr>
<td>NH&amp;MRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NMAAA</td>
<td>Nursing Mothers Association of Australia</td>
</tr>
<tr>
<td>PND</td>
<td>Post Natal Depression</td>
</tr>
<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>SCBU</td>
<td>Special Care Baby Unit</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children's Emergency Relief Fund</td>
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<tr>
<td>WABA</td>
<td>World Action for Breastfeeding Alliance</td>
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<tr>
<td>WHA</td>
<td>World Health Assembly</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YPPP</td>
<td>Young Pregnant and Parenting Programme</td>
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A STUDY OF THE EXPERIENCES OF PRIMIPAROUS MOTHERS WHO INITIATED BREASTFEEDING

The present-day almost pandemic decline in breast-feeding...is essentially a twentieth-century phenomenon. In other words, it represents a nanosecond of time in the 200 million years of ancestral lactation history. The strangeness and radicalness of this abrupt and summary discarding of the most fundamental biological aspect of mammalian behaviour has been slow to be appreciated, as have its consequences (Jelliffe and Jelliffe 1978: 366).

INTRODUCTION

Human milk is the ideal food for human babies. One might assume that such a statement could be accepted without further proof considering that the human race has survived for ‘hundreds of millennia’ with human milk being the only food for the young baby (Jelliffe and Jelliffe, 1978: vi), and that the burden of proof should be on any product seeking to replace breastmilk to demonstrate at least its suitability, if not its superiority to breastmilk. Whilst holding to the original tenet that breastmilk is the ideal for human babies, some specific benefits of breastmilk can be set out to reinforce the case. For example, breastmilk contains the correct balance of nutrients for the growth and development of the human baby. This balance changes during the days and weeks and months of breastfeeding (Renfrew et al., 1990: 5). Also, there are immunological advantages (Borgnolo et al., 1996; May, 1999) and evidence that there is a reduced likelihood of allergies in children who are breastfed (Halken et al., 1995).

There are also economic advantages associated with breastfeeding. For the family there are savings on the cost of buying formula and bottles together with the costs
of sterilizing equipment and storing formula (Meershoek, 1993). In a preliminary
economic analysis it was estimated that, in Australia, there would be a saving of
$11.75 million per year if eighty percent of babies were breastfed exclusively for
the first three months (Drane, 1997). More recently Smith, (1999) sets that
estimate much higher stating that if World Health Organization (WHO) and
United Nations International Children’s Emergency Fund (UNICEF) optimal
feeding recommendations were met in Australia this would result in an increase in
the national output by 0.7% of Gross Domestic Product (GDP), a greater benefit
than the anticipated gain of 0.1% of GDP by introducing major tax reform. That is
a per capita saving of $217 based on the 1998-99 GDP of $591,791,000,000
(Australian Bureau of Statistics [ABS], 1999a No. 5206.0) and a population in
Australia of 19,021,400 (ABS, 1999b No. 3101.0).

However in the last seventy years substitutes, manufactured mainly from cow’s
milk and fed to the baby by bottle and teat, were introduced world wide without
proof of their value. In 1976 Jelliffe stated that bottle feeding had ‘come to be
regarded as normal’ (p. 232). And in Australia in 1995, according to the most
recent National Health Survey, fifty percent of babies in Australia were bottle fed
by the age of three months. (ABS, 1995).

This production of breastmilk substitutes was, according to Mead (1979), another
facet in the rise of the technological age. The change to bottle feeding was just
one more marvellous thing and likened to the change from candles to electric light
(p.3). Technological/scientific changes which take place can have positive or
negative effects, and care needs to be taken to ensure that our lives are enhanced
rather than diminished by these actions, as noted by Mumford (1961):
Much of the thought about the prospective development of cities today has been based upon the currently fashionable ideological assumptions about the nature and destiny of man. Beneath its superficial regard for life and health lies a deep contempt for organic processes that involve maintaining the complex partnership of all organic forms, in an environment favorable to life in all its manifestations. Instead of regarding man's relation to air, water, soil, and all his organic partners as the oldest and most fundamental of all his relations—not to be constricted or effaced, but rather to be deepened and extended in both thought and act—the popular technology of our time devotes itself to contriving means to displace autonomous organic forms with ingenious mechanical (controllable? profitable?) substitutes (p. 527).

There has been a parallel development in the thinking of the scientific, technological age and the medical practices from the time of the industrial revolution. This is *linear westernism*: it is man-made, technological, provable and new, and it downgrades the biological and traditional, including breastfeeding (Jelliffe, 1976: 223).

Breastfeeding rates in Australia reached an all time low in the early 1970's with approximately twenty percent of babies attending the Maternal and Child Health (M&CH) clinics being breastfed at three months (Lund-Adams and Heywood, 1995). These breastfeeding rates steadily increased from the 1970's until levelling out in the mid 1980's (1995). They have not, however, improved in the 1990's and the 1995 Australian National Health Survey revealed a slight decrease in breastfeeding rates overall.

Internationally, breastfeeding is supported by organizations such as WHO, UNICEF and The World Alliance for Breastfeeding Action (WABA). In Australia targets to improve breastfeeding rates have been set and one of these is to increase the number of babies who are exclusively breastfed for the first three months to
eighty per cent by the year 2000 (Mathers, 1990). It would appear that this target has not been met.

The researcher spent a total of five years working as a midwife in Papua New Guinea (PNG) and Zambia, and in both these areas breastfeeding was universal and appeared to be largely trouble free. Infant feeding bottles were not used in either place, and in PNG the use of infant feeding bottles was prohibited by law. Few problems in establishing lactation arose during the mothers' hospitalization and those women who did have difficulties were helped by their friends and families rather than the health care personnel. Midwives did not appear to have any role in these matters. The researcher then pondered about the difficulties experienced in breastfeeding in Australia as well as the role of the midwife in regard to these difficulties.

A review of the literature in Western countries and Australia in particular suggests that there are many factors that influence breastfeeding, both within and without the health care system, and that changes being implemented are largely, although not entirely, within the health care system. For example, The Ten Steps to Successful Breastfeeding recommended by the WHO (1998) sought changes in practices in the health care system. On the local scene, publications by the Victorian Government, the Final Report of the Ministerial Review of Birthing Services in Victoria (1990) and more recently, Promoting Breastfeeding also deal with recommendations for changes in the health care system. (Victorian Department of Human Services (1998).

Publications such as the above indicate the importance of health services in furthering breastfeeding and taking this into account, this thesis will examine the
experiences of breastfeeding mothers having regard to the health care system followed by such socio-cultural factors breastfeeding experiences that were considered important by the mothers. As well midwives, who are at the forefront of the implementation of the changes already made, will be interviewed to examine their perspectives of their role in supporting breastfeeding and compare these to the mothers' experiences. It is hoped that such an examination will contribute to an understanding of more effective ways to promote breastfeeding in Australia.

Aims of the Project

The aims of this study were:

- identify breastfeeding problems mothers have experienced
- formulate theories about what could be done to improve breastfeeding outcomes
- consider if it is practicable for the health care system to implement these changes
- explore what strategies might be developed to improve breastfeeding outcomes beyond the health care system.

In the Chapter One the literature relating to the topic is reviewed. In Chapter Two the study plan and methods to explore the research topic are presented. The findings of the research are described in Chapter Three and these are integrated with discussions of these findings. Chapter Four is the final chapter and here conclusions are drawn and recommendations are made.
CHAPTER ONE: LITERATURE REVIEW

Given the study objectives, this review has included books, journal articles, magazine articles, and current affairs items from newspapers. Searches were made of the Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Public Medline (PubMed) and Cochrane data bases. The review also covers a range of fields including history, anthropology, sociology, economics, medical and women's studies.

The literature review covers not only the material on hospitals and health professionals in regard to breastfeeding but also socio-cultural issues associated with breastfeeding. Although acknowledging that hospitals and health professionals are not independent of socio-cultural influences, the material has been presented under the separate headings of hospitals and health professionals and socio-cultural factors for clearer identification of the issues. Whilst many socio-cultural factors are identified as being relevant to breastfeeding and, in particular, to breastfeeding outcomes, the changes, as has been stated, that are being made in attempting to improve this situation have been largely implemented in the health care system. In setting out the topics of this literature review these are ordered to correspond with those in Chapter Three for easy reference.
1.1 Hospitals and Health Professionals

Despite approximately ninety percent of mothers initiating breastfeeding in Australian hospitals, these rates drop substantially after the mothers return home and by the age of three months the rate has dropped to approximately fifty percent of babies in Australia being exclusively breastfed (ABS, 1995). This is consistent with a study conducted over each of four years at the Royal Women’s Hospital, Victoria which showed that 88% of mothers initiated breastfeeding in hospital, 80% were still breastfeeding on discharge but at three months the rate had dropped to between 51% and 57% with the variation being between the different years. (Nicholson and Yuen, 1995).

This section examines the literature about hospital practices in relation to breastfeeding from the 1950’s to the present day and considers criticisms that have been directed at these practices, who is responsible for breastfeeding promotion, changes that have taken place and changes that are recommended as well as overall criticisms of the hospitalization of breastfeeding mothers.

1.1.1 Past Practices of Hospital Care for Breastfeeding Mothers

Historically health professionals have stated that they are in favour of breastfeeding but some of their practices have been detrimental to the establishment of lactation. A New Zealand obstetrician Truby King, as early as the 1920’s, in the Australian edition of his book, which was sold nation wide through newsagents, stated babies should be fed at four hourly intervals during the day and not fed at all during the night (King, 1923: 37). The most commonly used midwifery textbook in the 1960’s in Australia was by Scottish midwife Margaret
Myles (1964) who recommended that a baby should not be put to the breast until six to twelve hours after the birth, and that four hourly feeding, 

...gives the mother more time between feeds for housework and shopping, and it is easier to run a hospital nursery on that regime (p.526).

As well, Myles advocated the mother should be sedated on the first night after the birth to ensure a good night’s sleep (1964: 472). Rigid timing of feeds was also advocated by the medical profession (Wilson-Clyne, 1963: 896). These three factors, delaying the first feed, timed feeds and no breastfeeding overnight were later described as being detrimental to lactation (WHO, 1998).

In the Royal Women’s Hospital in Melbourne in the late 1950’s, breastfeeding was described as a battleground between staff and mothers, with mothers feeling that they had to initiate breastfeeding although they had no intention of continuing. It was stated by the mothers that this was due to either fear of the midwives or a desire not to cause them any trouble (McCalman, 1998: 299-300). Despite changing practices such as the introduction of the Ten Steps the attitude of midwives in the 1990’s continued to attract criticisms and Brown et al. (1994) said,

*When reflecting on the complaints that women made 20 to 30 years ago about postnatal care, and those that are heard today, we came to see that what they had in common was the lack of flexibility and the insensitivity to individual preferences and needs (p. 109).*

The accusation that health professionals have contributed to poor breastfeeding outcomes continued throughout the 1970’s, and 1980’s. Smibert (1975), for example, considered that the rules of lactation were imposed by male obstetricians and childless nurses who had no firsthand experience of breastfeeding.
1.1.2 Changes and Recommendations From the 1970’s Onwards

The return to breastfeeding in the 1970’s was instigated by mothers from higher socio-economic groups and not the health professionals (Lund-Adams and Heywood, 1995: 94). Such mothers have led the move which has then promoted change in other groups. One outcome of this movement was the establishment of woman to woman support groups such as the Nursing Mothers’ Association of Australia (NMAA) (Smibert, 1975). During the 1980’s, in response to consumer demand, hospital practices were then modified and now it is normal for babies to breastfeed early, room-in, and not be given complementary feeds, particularly by bottle (Lund-Adams and Heywood, 1995).

Further changes have been made in the health care system with the view to improving breastfeeding outcomes. For example the Ten Steps to Breastfeeding recommended by WHO and UNICEF in 1989 were designed to improve breastfeeding rates (Minchin 1998, p. 262). Among others the Ten Steps include informing all pregnant women about the benefits and management of breastfeeding, giving newborn infants no food or drink other than breastmilk unless medically indicated, encouraging breastfeeding on demand, and giving no artificial teats or pacifiers to breastfeeding infants (Saadeh and Akre, 1996).

Adoption of these steps answers many of the criticisms described above. Hospital assessments in Australia began in 1993 and up to June 1999 fourteen hospitals in Australia, including ten in Victoria, have been accredited and more are awaiting accreditation (Blackburn, 1998). Those hospitals which meet the quality assurance standards of these strategies receive the Baby Friendly Hospital Initiative (BFHI) award.
The long term goal of the Initiative is to protect, promote and support breastfeeding. (Victorian Government Department of Human Services 1998: 82).

As Minchin states,

*Perhaps BFHI’s greatest impact has been through getting hospitals to consider submitting to an external assessment...[and]...BFHI has lent credibility and authority to those many voices calling for change within; it has empowered midwives and breastfeeding mothers alike* (1998: 264).

Suggestions have also been made about the present practice of the shorter postnatal stays in hospital. One suggestion made, with some reservations, is that a shorter stay in hospital may be associated with higher breastfeeding rates (Brown and Lumley, 1997). This is supported to some degree in the Final Report of the Ministerial Review of Birthing Services in Victoria called Having a Baby in Victoria, (1990) which cites the Monash Birth Centre experience that stays of 24 to 48 hours after birth are compatible with higher rates of breastfeeding (p.121).

The Review weighs the advantages and disadvantages of shorter hospital stays, which in 1990 were five to seven days (p. 112). From some mothers’ viewpoints the advantages for a longer stay were that it gave them a chance to rest (p. 115) and a time to gain confidence. However contrary arguments given by other mothers for a shorter stay was that the last place to rest was the hospital. Those who supported a shorter stay stress the familiarity of the home where they had control over the child and the environment (p. 117). They did, however, feel that if hospital stays were shorter there was a need for daily midwifery visits and home help. The providers favoured the longer period in order to establish breastfeeding and to give the mother the time to learn to cope with a new baby (p. 118). The Review was ambivalent on this issue of shorter stays and suggested that more
research was necessary (p. 129) and, in Recommendation Number Fifty, that early discharge should only occur when there was appropriate support services, including domiciliary midwifery services and home help, available. The Report was also ambivalent as to whether such domiciliary midwifery care should be linked to the hospital care or should be community based. In the Report continuity of care (p. 36) and midwives giving conflicting advice (p. 127) was also discussed.

Bernard-Bonnin et al. (1989) state that, because hospital stays are becoming shorter, hospital studies are becoming less meaningful and that there should be greater focus on hospital outreach and community programs.

1.1.3 Breastfeeding: Who is Responsible?

Health carers themselves disagree which profession is the most important with regard to encouraging breastfeeding. In a survey of health professionals most named midwives as the most influential, but approximately 30% of midwives and 40% of doctors said doctors had this role (Lowe, 1990). However Renfrew in the introduction to Minchin’s book Breastfeeding Matters (1998) believes that midwives are the professionals most involved with mothers’ success in breastfeeding, although fathers, doctors and others are involved in the process. In 1994 Llewellyn-Jones, former associate professor of Obstetrics and Gynaecology at the University of Sydney, saw the midwife as the health professional, along with ‘rigid hospital routines’ as being responsible for the decline in breastfeeding rates and recommended changes that are necessary to reverse this trend (pp. 271 and 275). But it has been suggested by Summers even in the late 1990’s that doctors must carry overall responsibility because,
... midwives still are the assistants of the obstetrician and do not have autonomy in their practice (1998.2).

Hastie (1998) believes that this subservient position of the midwives in the health care system mirrors 'the submissive position of women in society generally' (p.3).

No matter where the responsibility lies, the belief that breastfeeding problems are caused, to a degree, by poor practices and lack of knowledge by health care professionals is summed up in the following:

...[T]he sad fact is that some cases of lactation failure are iatrogenic (Dawson et al. 1993: 10).

1.1.4 Social and Psychological Aspects of the Training of Health Workers

It has been suggested that antenatally health professionals could help mothers to revise a decision not to breastfeed if that decision was based on misconceptions or if the mother was ambivalent (Vnuk, 1995). On the other hand, an Australian study shows that the influence of health professionals on the attitudes to and the choice of infant feeding methods are minimal and mothers across the social spectrum were said to be 'equally dissatisfied' with regard to the help and support for breastfeeding from hospital midwives (Brown et al., 1994: 107).

Whether or not health professionals can influence mothers about breastfeeding Raphael and Martinke (1994) state the need for a broadening of the training of health care workers to include social and psychological assessment and that the management of these aspects should be as significant as the biological management so that health care enhances rather than devalues women's views of themselves. The 1990 Final Report of the Ministerial Review of Birthing Services in Victoria also recommends that midwifery curriculum content should include an
overview of women's health issues in their social, political and economic context (p. 155). This is in line with the criticism of Barclay et al. (1997) who believe the training of midwives concentrates on the biological aspects and ignores the social.

As well, Morrow (1995) maintains that,

...it is essential that we go beyond giving women more information about the benefits of breastfeeding with the assumption that this will offer them an informed choice. We cannot be successful if we blame or moralise. Instead, we must look with compassion and insight (p. 6).

1.1.5 The Medicalization of Breastfeeding

On the broader scene, Van Esterik (1989), considers the promotion of breastfeeding by the health care system as part of the process of which she calls medicalization. This is a process in which the definition and treatment of a condition shifts from lay persons to health professionals and the judgement of those professionals is regarded as superior, so that the management of these conditions becomes the responsibility of those health personnel. Treatment subsequently takes place in hospitals and clinics. Health professionals are, according to Van Esterik, pressured to seek new treatments for conditions which were previously considered 'normal'; medicalized problems are removed from their social and economic contexts and patients are given rules with which they are expected to comply (1989: 114-115).

The concept of medicalization being isolated from the socio-economic influences this process of medicalization and could reduce the ability of the mother to carry out the natural function of breastfeeding. As Cornwall says,

Essentially, medicalization is a process through which people come to lose faith in their own knowledge and information...and in their powers of judgement. They lose it at different speeds, and in relation to different areas of expertise, but the process is defined as
medicalization because the tendency is for medical rather than commonsense views to dominate (Cornwall, 1984: 22).

Kitzinger (1987) carries the matter further and contends that the hospital is the last place that a new mother and baby should be (p. 59) and believes that the mother finds herself either,

... fighting the system or becoming passive and institutionalized within a few hours of admission (p. 67).

Whilst in 1989 Rothman wrote in regard to childbirth,

... [T]here are inherent problems in limiting our vision of childbirth to its technical, medical dimension. That vision of childbirth enables us to think only in terms of morbidity and mortality rates, and not the often wrenching social and personal implications involved in childbirth management programs and technology (p.171).

But, as late as 1994, Llewellyn-Jones continued to see obstetric care in these terms stating,

... [T]he quality of obstetric care in a country can be measured by the maternal and perinatal mortality rates (p.195).

In conclusion, the approach that concentrates on the benefits of breastfeeding, the technique of breastfeeding, modifying various hospital practices and providing more training to health care professionals, is according to Van Esterik (1989), a mere tinkering with a part of a larger problem (p.193). The need for wide based changes is embodied in the following quotation by Minchin (1998):

National campaigns to promote breastfeeding serve no useful purpose unless they are integrated campaigns, which alter the medical, social, cultural and economic realities which truly discourage breastfeeding (p. 68).

What these other socio-cultural factors are is discussed in the following section.
1.2 Socio-Cultural Factors Influencing Breastfeeding

The word culture has been defined in many ways, but for the purpose of this thesis Williams’ definition of the word appears appropriate because of its breadth of meaning. Williams (1976) considers culture to mean,

... a whole way of life, material, intellectual and spiritual (p. 16).

Hertz (1909) states that the importance of culture cannot be stressed enough in considering attitudes to breastfeeding because,

... the facts of nature are always transformed by culture (cited in Maher 1992 p. 91).

The process of acculturation begins at birth and the way we see life, including child rearing practices, is likened by Williams et al. (1994) to how a fish believes swimming in water is normal and cannot understand that other species live outside of water. In fact, it requires considerable insight to realize that the customs and practices of one’s own group are neither the only, nor necessarily the best, methods but merely some of the many alternatives possible.

Socio-cultural associations with breastfeeding are identified in the literature and include, amongst other topics, the influence of international and government bodies, the influences of the media, the attitude of partners and demographic indicators such as smoking, education and maternal employment. To begin with, differing historical cultural perceptions of breasts, breastmilk and breastfeeding are reviewed.
1.2.1 Some Cultural Perceptions of the Breast and its Functions Through History

Yalom (1997) describes how breastfeeding, along with breastmilk and breasts have been viewed in differing ways in various cultures throughout history.

In Egyptian mythology the Pharaoh drank milk from the breasts of the goddess Isis in order to achieve immortality (p. 11). Similarly, in Greek mythology Zeus wanted his son Hercules to become immortal by drinking from the breasts of the queen of goddesses, Hera. Then, when Hera pushed Hercules away from her breasts the milk spurted into the heavens forming the milky way (20-21).

Yalom describes how in Christian medieval times breastfeeding,

...was decidedly more than a simple matter of alimentation: the mother transmitted with her milk a whole religio-ethical belief system (p. 38).

In France, before the revolution, royal women’s milk was regarded as superior to that of the peasants, whereas after the revolution the strong milk of peasant women was promoted (p. 116). Delacroix’s portrayal of the topless ‘Liberty Leading the People’, an early 19th French century painting, represents, according to Yalom,

...a defiance as urgent and as aggressive as the revolution itself (p. 122).

As a more recent example of another cultural attitude, Yalom interprets the election of the bare breasted La Cicciolina to the Italian parliament in 1987 as a ‘message of sexual liberation’ (p. 246).
1.2.2 Attitude of Partners

In an Australian study of 556 completed questionnaires from a possible 717 new mothers, it was found that the most important factor for initiating breastfeeding was the perceived attitude of the father (Scott et al., 1997). In another Australian study the majority of women believed the choice of infant feeding methods was their own, although almost half felt they had been assisted in their decision making by their partners (Cox and Turnbull, 1994). The NMAA (1991) advocates that fathers need to be aware of the advantages of breastfeeding, because their support has a positive impact on the outcomes.

In another Australian study the mothers rated highly the importance of their partner's attitude to the continuing, although not the initiation, of breastfeeding and concluded that partners should be included in all the aspects of antenatal education and the postnatal care of the baby (Fetherston, 1995). However in a longitudinal American study in which the fathers were interviewed it was shown that the fathers' increased knowledge did not necessarily lead to better support of their breastfeeding partners (Giugliani et al., 1994).

In putting forward another view, Germaine Greer, an expatriate Australian, argues that the mother and the child are the primary couple, whose relationship is erotic in nature and the father is supernumerary. She suggests that this type of eroticism is attacked by the consumer society in order that the breasts be reserved entirely for the 'husband's fetishistic deflection' (1984: 209-210). This is supported by an American longitudinal study by Jordan (1986) which found that fathers dislike their partners breastfeeding when the breasts have hitherto been a major source of his sexual pleasure (p. 95). A permanent solution to this alleged problem,
according to Dettwyler (1995), is to change what sons are taught about the purpose of female breasts (p. 191).

1.2.3 The Perceptions of Breasts

According to Dettwyler (1995), in Western culture,

...[T]he female breast as an erotic sexual organ has become pervasive, to the extent that some people would deny that the breast has any function in child rearing (pp. 168-169).

Dettwyler goes on to say that this is a cultural belief with limited global distribution and is concentrated in mainly Western industrialized nations (p. 177).

There are many ways in which the perceived distortion of the natural function of the breast is maintained. One of these, according to Dettwyler (1995), is by the construct of when breasts may be shown. Part exposure of the cleavage and sides, although never the nipple, is acceptable in an evening dress, but not to teach in primary school; fully exposed breasts, especially large breasts, are grist for the massive pornography mill; and scantily clad women are used in advertisements to sell all manner of products (1995: 175). Morrow (1995) states that it is no wonder women feel awkward about breastfeeding considering the links between breasts and pornography.

Another cultural aspect indicating the erotic nature of the breasts is the type of words which are used to refer to women’s breasts. Greer (1999) lists the following terms which appear to refer to anything other than the physiological function of the breasts; 'tits, jugs, boobs, norks, bazookas, hozooms, knockers, bristols, pops, chugs, titties [and] bobbies' (p. 47). Further, breasts can be referred to as 'erotic toys,' as in an article that appeared in Woman's Day by sex therapist Rosie King (October, 1998: 47). And, according to Yalom (1997).
For most of us, and especially for men, breasts are sexual ornaments... (p. 3).

A more drastic way to emphasize the erotic function of the breasts is, Dettwyler (1995) maintains, in the procedure of breast augmentation or, as she prefers to call it, 'female mammmary mutilation', which is performed without any regard for the lactational function of the breast (p. 178).

Finally, in considering attitudes towards breasts, Scott et al. (1997) surveyed the attitudes of five groups towards breastfeeding in public. The five included a group of mothers of infants and small children and a group from the NMAAA. The topics discussed included breastfeeding in public, which was considered by most to be routine, necessary and often unavoidable and, because of lack of facilities, resulted in some mothers having to resort to breastfeeding in the toilet. Also, whilst they accepted that women could breastfeed in public the two groups under discussion felt that it should be performed 'discreetly', that is to say, with a minimum of the breast showing.

1.2.4 Mass Media and Advertising

In the publication Evidence for the Ten Steps to Successful Breastfeeding (WHO 1998: 1) the elements considered necessary for the implementation of breastfeeding policy are set out. Amongst these elements is not only a commitment to breastfeeding by parents and health professionals, but also a commitment by the media (p. 6). However the media, and especially the print media, which has the potential to further breastfeeding, may be restricted in scope according to Bowman (1988) who said,
Freedom of the press was won by a generation of martyrs who fought authoritarian governments, but now the danger is that proprietors of the press now have that same power; they limit information, opinion and ideas, and act to the detriment of a democratic society (p.69).

Pilger suggests that media self-censorship happens because the primary purpose of the media is to make money (1998: 79) and to do so needs to attract readers and advertisers. In doing this, it will not usually act outside the norm and is conservative in its approach (Moore et al. 1996: 116; Pilger, 1998: 79). Sponsors can choose which programs they will support and programs that do not attract sponsorship will not be viable as the following statement indicates,

...[A]dvertizers can choose selectively among programs on the basis of their own principles. With rare exceptions these are culturally and politically conservative (Herman and Chomsky 1988: 17).

A stronger statement about the situation is made by Bowman (1988), a former journalist who says,

...[I]n the [advertising] industry that it will do things it is ashamed to confess (p.79).

New journalists, he maintains, are soon compromised by the system and cites as an example what he views as the tardiness of the press to embrace the connection between smoking and ill health as 'cherchez l'avertissement' (p. 80).

In the media, life is presented in a form that promotes certain consumption patterns. Reality is therefore not reflected accurately in the media according to Douglas (1995: 15–16), but the reflection is more like those of the mirrors at a fun-fair where some facets are exaggerated and others diminished (Gitlin 1980:29).
The media in Australia may be similarly susceptible to such distortions as that stated above. John Laws, a Sydney talk back radio commentator, is alleged to have accepted $1.2 million from the Australian Banking Association to refrain from making adverse comments against the banks (The Age 17th July 1999).

Thus the need to satisfy advertisers and to attract readers could be a reason why breastfeeding, which is not a marketable commodity, appear to be rarely mentioned in the media in other than a negative light. A possible exception, however, took place in Australia in 1998. The Victorian Equal Opportunities Act (EOA) 1995 prohibits discrimination on the basis of parental status and sex in the provision of goods and services (Hansard 1995). In The Age (9/1/1998) the case was reported of Ms. Gately who was asked to leave a public area of the Crown Casino when she was breastfeeding. She then contacted Ms. Campbell MP, who called for specific legislation to make it clear that women can breastfeed wherever they are legally entitled to be. In reply the Attorney General stated that the Act already protected rights to breastfeed, and subsequently, in the parliament, Ms. Campbell was refused leave to introduce an amendment to the Act to add a special inclusion specifically referring to breastfeeding. In justifying the opposition to the tabling of the amendment the then Premier, Mr. Jeffrey Kennett, said breastfeeding in public could be offensive to some people (The Age 9/4/1998)\(^1\).

These efforts by Ms Campbell to strengthen the rights of breastfeeding mothers are in line with Irigaray's belief that laws are needed to support the differences between the sexes and not just to support gender equality (1993: 11).

\(^1\) In The Age 3.4.2000 it was reported that Ms. Campbell, now the Minister for Community Services, planned to re-introduce this amendment to the parliament and it was expected that the amendment would be passed.
Turning to magazines directed particularly at women, an examination was made to identify what was said about infant feeding by taking two surveys. Firstly by examining a cross section of magazines in one randomly chosen week to assess the concentration of advertisements and for any references to infant feeding and secondly, by examining four and a half years of copies of the magazine Women's Weekly with regard to the leading articles for references to infant feeding.

Firstly, on examining six women's magazines bought on the 25th August 1998, a high concentration of full page advertisements was found ranging from 34% in Women's Weekly to 74% in Cleo. As there were smaller advertisements on other pages, the percentage of advertisements quoted here is conservative. On examining the main articles for any references to breastfeeding, only one was found. This was an article in the Woman's Day about a twelve year old English girl, who was bottle feeding her baby because she had been disgusted by the sight of milk coming out of her breast. There were three other allusions to motherhood in general, although not with regard to breastfeeding or, indeed, infant feeding at all. The view of motherhood in general presented in this cross section of magazines was sensational rather than mundane, with the only mention of breastfeeding being negative and, to some degree, supporting bottle feeding.

The second survey, a search of each edition of Women's Weekly from January 1994 to June 1998 inclusive, showed a similar trend. Again leading articles were examined. The leading articles regarding motherhood were, without exception, about the rich and famous and the emphasis was on the type of birth with only some articles mentioning infant feeding, both breast and bottle, in passing.
Therefore in these editions of Women's Weekly breastfeeding would appear to be a peripheral issue with at least equal emphasis being placed on formula feeding. Because there is little evidence of the promotion of breastfeeding these magazine articles appear to support the views of Moore et al. (1996) and Pilger (1998) that the media furthers the social and political status quo. Therefore, if the content of the magazines reviewed is an accurate reflection of overall policy, then women would not be able to obtain accurate information about breastfeeding from popular magazines.

1.2.5 The Effect of a ‘Bottle Feeding Culture’ on Breastfeeding

The function of breasts is determined in two ways: biologically, stemming from our status as mammals who suckle their young; and culturally, which can obscure the biological function in such a way that it can become unrecognizable. These cultural patterns are absorbed subconsciously by observing the behaviour of relatives and close friends (Williams et al. 1994).

As an example, before the advent of formula nearly all women breastfed, lived in closer family groups and seeing women breastfeeding was a normal part of a girl's growing up (Thomson, 1989: 219; Lawrence, 1995: 397). Today, although approximately fifty percent of women in Australia continue to breastfeed after three months (ABS, 1995; Lund-Adams and Heywood, 1995), they do so mainly in private and, as a study made in Perth, Western Australia shows the adolescent girls was the group out the five groups that was studied which was most offended by breastfeeding in public (Scott et al., 1997).

Beasley and Heritage (1998-99) support the contention that we live in a bottle feeding culture by their findings. Also, a baby being bottle fed in a television
programme continues to reinforce the cultural norm according to Minchin (1985: 307) and, Wendy Brodribb (1991) for the NMAA states,

> There are many subtle and not so subtle influences on children and adults through advertising, TV, films and books which portray bottle feeding as the norm, and breastfeeding as difficult and of little importance to the mother and baby (p. 223).

Morrow (1995) also discusses the normalcy of bottle feeding in our society. Hence the relative absence of public breastfeeding together with the presence of public bottle feeding both reinforce bottle feeding as the norm. This is ironic given that the vast majority of women choose to initiate breastfeeding in Australia.

Previous feeding experience has also been shown to powerfully influence whether an infant is breastfed or not. Most mothers who breastfeed their first child will repeat this decision with subsequent children, while those who artificially feed will repeat that decision (Righard, 1998). Although, according to Lawson and Tulloch (1995), this decision may be modified if the mother has been educated beyond secondary level, this continuity in feeding behaviour suggests the importance of distinguishing primiparae from other mothers in developing predictors of feeding success.

There is also evidence that, in other primates, breastfeeding is not necessarily instinctive and, without natural contact with breastfeeding in the formative years, future lactation is impaired (Jelliffe and Jelliffe 1973: 128). Thomson believes that smaller families and greater mobility may mean that a new mother may never have seen a baby being breastfed (Thomson, 1989: 219-220). Jelliffe and Jelliffe (1973) describe how chimpanzees, raised in captivity without the opportunity of seeing breastfeeding were unable to do so themselves (p.128). Recently Heidi
Weak, Senior Primate Keeper at the Melbourne Zoo discussed the matter of primates, in this case gorillas, further. She said that gorillas who are not raised by their own mothers or in a gorilla troupe are likely to become 'poor mothers'. However gorillas can also learn mothering behaviour if they are raised in groups where they see other gorilla mothers raising their offspring. Breastfeeding, while essential, is only a part of the problem. The first problem is whether the infant has been accepted by the mother and if so then two further factors are necessary for breastfeeding to be initiated. Firstly the mother must hold the baby correctly so that the baby can reach the nipple. Secondly the mother must accept the baby suckling (Personal communication 1999).

It seems, therefore perhaps not too outrageous to suggest, that as other primates with no direct experience of mothering have difficulty with breastfeeding, new human mothers with similar lack of experience may, as has been suggested by Jelliffe and Jelliffe (1973: 128), be unable to do so for themselves without help and advice.

1.2.6 Education

Better educated women have been the leaders in infant feeding fashion, firstly in turning to bottle feeding and then leading the return to breastfeeding in the early 1970's (Lund-Adams and Heywood, 1995: 92). A similar correlation between continuing breastfeeding and maternal occupation was described by Williams and Carmichael in 1983, who also referred to lesser educated women as a 'major problem' who needed to be educated and supported by professional and lay organizations like the Nursing Mothers Association of Australia (p. 77).
In 1992 Redman et al. found that women who had tertiary education were seventeen times more likely to be breastfeeding when the infants were four months old than those mothers who had not completed secondary school, and that better education was positively associated with assistance seeking if problems arose.

1.2.7 Smoking

Breastfeeding mothers who smoke are less likely to initiate and continue breastfeeding (Lee, 1997; Scott and Binns, 1998). Whilst some believed this mirrored the associated lower socio-economic status and maternal education status (Redman et al. 1995), recent studies have shown that smoking in itself is also directly related to breastfeeding outcomes and the impact is dose related (Redman et al. 1995). Smoking is adversely associated with the rates of both initiation and duration of breastfeeding and women who are single, unmarried or separated were more likely to smoke (Brown et al., 1994: 106-107). Smokers also report a higher incidence of problems related to inadequate milk supply. One theory is that higher somatostatin in the human milk leads to lower prolactin levels (Widstrom et al., 1991), and another, in an experiment with rats exposed to cigarette smoke, is that smoking causes increased dopamine secretion in the hypothalamus gland, which leads to lowered prolactin levels (Jansson et al., 1992, cited in Scott and Binns 1998).

1.2.8 Maternal Employment

In discussing the position of working mothers and breastfeeding it would be well to begin with a quote from an Australian article by Tan and Jeffrey (1995) who state that,
Work and time are crucial factors influencing the choice and duration of breast feeding. Many mothers now work and this often means low paid unskilled employment where facilities to breast feed are often insufficient or do not exist. A multitude of work, home and physical pressures lead to early weaning (p. 375).

And, according to Minchin (1998),

Breastfeeding is always going to be a struggle in societies where women of reproductive age cannot expect a living unless actively participating in the extra-domestic labour market (p. 286).

The NMAA (2000) states that women make up 42% of the workforce and 27% of women return to their jobs in the first twelve months of their baby’s life and returning to the workforce is a reason women give for weaning their babies (Lowe, 1990; Cox and Turnbull, 1994). Lund-Adams and Heywood (1995) believe that the large numbers of women in the workforce shows the need for facilities and support for breastfeeding mothers in the paid work force.

In the 1993, in the Breastfeeding Awareness Week promotional pamphlet, WABA highlighted the need for environments suitable for breastfeeding. To begin to achieve this aim the Mother-Friendly Workplace (MFW) Initiative was introduced. In Australia the NMAA has taken a lead role in the implementation of the MFW.

While these are useful initiatives, they are far from being universally implemented and, as Minchin says,

Sacrificing breast feeding to the demands of the work place is bad policy, bad economics, bad psychology (1998: 287).

Such a statement, however, may reflect ‘middle class’ attitudes. Some women may not have the financial luxury of being able to stay away from work, or probably may not work where such initiatives are implemented.
1.2.9 Lower Socio-Economic Groups and Assistance Seeking

Another cultural factor that may arise, particularly among lower socio-economic groups of women, is that they are less likely to ask for help even they may know of the availability of support for breastfeeding (Bailey and Sherriff, 1992). This may be, Manderson (1985) suggests, because they are intimidated not only by institutions but also by voluntary groups of middle-class women. If this is so it may be an inhibiting factor to the work of such bodies as the NMAA.

1.2.10 Dummies or Pacifiers

Studies by Richard and Alade (1998) show that there is a correlation between the use of dummies and breastfeeding outcomes and that breastfeeding problems may be prevented if dummies are not used extensively. However, Victora et al. (1993) believe that the use of dummies is an indication of breastfeeding difficulties but in a later study (1997) conclude that it is not clear whether the relationship is causal, reverse causal or confounding. According to Victora et al. (1997) dummies can be used to extend the time between feeds reducing stimulation and thereby reducing supply, which confirms the mother’s belief that her milk supply is inadequate.

1.2.11 The Culture of Technology

According to Crouch and Manderson (1993), in our technologically based society a further problem is that of the unpredictability of the caring for and nurturing of a newborn baby. Pregnancy is usually an ordered, controllable and predictable state in which women can remain autonomous. Caring for a new baby, on the other hand, is not only continuous, ever present and never ending, but also
unpredictable (pp. 135-136). The burden of the nursing mother is described by Crouch and Manderson:

*It is laden with responsibility and, in most cases, socially isolating and lacking adequate supports [causing mothers to] feel vulnerable, lonely and confused* (p. 139).

Following interviews with women, Crouch and Manderson linked the problems with regard to adapting to breastfeeding on demand to our Western society which is inclined to measure and quantify everything. One mother described determining hunger and satisfaction as stressful and longed for an ordered life in which she could plan her activities. Woolridge (1995) agrees and maintains that people are uncomfortable with *‘flexible patterns of management’* (p. 218).

1.2.12 Cultural Influences on Health Professionals

Everyone, including health workers, is moulded by the norms of their society, which contains both rational and irrational elements and according to Williams et al. (1994) there is a lack of awareness of cultural influences by health workers (Williams et al. 1994), which was suggested when discussing the social and psychological aspects of the training of health professionals.

An example of cultural influences on health workers can be taken from the growth charts used by health workers to measure weight gains of babies. Currently used growth charts were developed during the time the majority of babies were bottle fed. Using these charts it appears that a breastfed baby is falling behind when in fact their development is normal (The Australian College of Paediatrics, 1997). This can worry mothers who make the comparison to the *‘ideal’* weight that is, in fact, based on the data from bottle fed babies (Lund-Adams and Heywood, 1995: 95 and 98). As part of the bottle feeding society, health workers have, it is
suggested, not recognized that it could be the chart, rather than the baby's progress, that is in error, and to support this WHO is investigating the feasibility of introducing growth charts where the rates are based on those of breastfed babies (National Health and Medical Research Council [NH&MRC] 1996: 19).

1.2.13 The Cultural Norm of Sleep Patterns

Both professional and lay people offer advice how to 'train a baby to go through the night' (Kitzinger, 1995: 388). But the interpretation of 'night waking' as a problem is culturally determined according to Merrick (1997: 1). Merrick also suggests that the problem is not about sleep itself but about the expectations and anxieties of our culture about sleep (p. 5). Babies in Western culture wake less frequently at night than in other cultures, but this is interpreted as a greater problem by parents (Elias et al., 1986: 327). This cultural view of the physiologic norm may have come about because of early weaning and separate sleeping practiced in western cultures (p. 322).

In another approach, a study of the sleep patterns in normal children in Queensland found that normal Circadian rhythm is not well established until four months. In this study it was found that 88.3% of babies less than one month old woke between one and four times a night and only 6.5% did not wake at all and, by one year, 60% of infants woke between one to four times and 38.4% slept through. Infants' broken sleeping patterns can lead to maternal sleep deprivation, marital disharmony, post-natal depression and child abuse (Armstrong et al. 1994). According to Elias et al.,

*Breastfed infants slept in shorter bouts than did weaned infants and slept less overall* (1986: 328).
Elias et al. also conclude that societal norms of sleeping and waking patterns will need to be revised as prolonged breastfeeding increases.

1.2.14 Local and International Support Groups

On the international scene there was a drastic drop in breastfeeding in Western countries in the 1950’s and 1960’s (Brodribb, 1998: 362; Minchin, 1998: 224). From 1977, public awareness began to grow about the problems involved in formula feeding, the most serious of which were in the non-western countries (Minchin, 1998: p. 227).

This awareness was followed by international action by WHO to limit the sale of formula (Minchin, 1998: 228). A non-governmental organization was formed, the International Baby Food Action Network (IBFAN) to represent views to the WHO and in 1981 the WHA adopted an International Code of Marketing on Breast Milk Substitutes (Brodribb, 1998: 369-372; Minchin, 1998: 235-236). This Code, whilst it does not call for a ban on the sale of formula, asks governments to halt the advertising and promotion of formula, bottles and teats as well as other restrictions regarding formula.

To turn to the Marketing Code and its effects in Australia, the Code, whilst it recognizes that there is a legitimate market for formula, seeks to ensure that products are not marketed or distributed to mothers or to health care workers in ways that may interfere with breastfeeding (Brodribb, 1998: 369). To achieve this aim it calls on governments to halt the advertising and promotion of breast milk substitutes, bottles and teats to the public as well as halting the free distribution of formula samples (Minchin, 1998: 235).
Official monitoring of the Code in Australia only began in 1992 when the manufacturers of infant formula agreed to the Marketing in Australia of Infant Formula (MAIF) Agreement, which set up the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) to monitor breaches of the agreement (Minchin, 1998: 245). Minchin considers that in recent years there has been a deterioration in the infant formula industry’s compliance (1998: 247). Minchin (1988) also questions the degree of conformity to the Agreement by the formula companies and states,

...[at] the time of writing there were few signs that government will enforce the Agreement strictly (p. 252).

The problem is, as Brodribb (1998) states, that it is almost impossible to target marketing so that it only impacts on mothers using formula (p. 271), and whilst direct advertising is not used, advertising takes place via displays in chemists, as well as in literature disseminated by such means as the Bounty Bags2 (Minchin, 1998: 248). In 1996 infant formula sales in Australia were reported as worth $100 million and new companies were coming on to the market (Brodribb, 1998: 371).

The other thrust of the international scene has been that of actively promoting breastfeeding. At a meeting in Florence, the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding was formulated and then adopted by the WHA in May, 1992. This resulted in the formation of WABA, an international body set up to support the right of all mothers to breastfeed. The second aim of the Innocenti Declaration was to ensure that every facility providing maternity services fully practices all of the Ten Steps to Successful

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2 Bounty Bags, distributed by Bounty Australia (Minchin 1998: 267-268) are given to most new mothers in Australia and contain information and samples of various baby care products.
Breastfeeding, which was achieved by the foundation of the WHO/UNICEF Baby Friendly Hospital Initiative (BFHI) (WHO, 1998: 1).

As well as international groups there has been a growth of mother-to-mother support groups but such groups were met with resistance or lack of support from the medical profession. In Australia the NMAA was founded in Melbourne Victoria in 1964 (NMAA, 1998) and Smibert (1975) recounts that the initial reaction of the medical and nursing professions was antagonistic and members of the NMAA were described as, ‘interfering busy-bodies’, ‘suburban crackpots’ [and] ‘dangerous fanatics’ (p. 17).

Two further professional bodies that have been active in the field of breastfeeding may also be mentioned. These are the Australian College of Midwives Incorporated (ACMI) which is the group charged with the responsibility of overseeing the implementation of the BFHI in Australia and The Australian Lactation Consultants Association (ALCA) which was founded in 1987.3

1.2.15 Women’s Self Image and Attitudes

Burgum (1994), in an Australian study suggests that a positive self image is the most important factor associated with good breastfeeding outcomes. One factor which adversely affects self image is the immaturity of adolescence, where a young woman in Western society, who is struggling to adapt to her new body image, and her breasts becoming sexual objects (Dix, 1991; Vnuk, 1995). As well, it has been demonstrated by linear regression calculations that body image may be a predictor of breastfeeding outcomes in its own right, regardless of socio-

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3 For details of ALCA see Minchin 1998: 276-281.
economic class and this is independent of actual body mass index (Foster et al., 1996).

The consequences of a negative self image might include the theory put forward by Jelliffe and Jelliffe as far back as 1973, that failed lactation is due to the failure of the let down reflex, which has been impaired by lack of maternal confidence, by anxiety and by uncertainty (p. 127).

Uncertainty, if present, may lead to inappropriate breastfeeding decisions as was shown in an Australian study which attributes the lack of breast milk to the attitude of the mother:

*Breast milk insufficiency was often self diagnosed by the mother on the basis of a child crying more frequently, not sleeping at night, or having changed its feeding patterns* (Scott et al., 1997).

Anxiety over milk supply was given as a reason for ceasing breastfeeding in 51% of the mothers in a survey conducted in Melbourne by Lowe (1988) and lack of confidence is given as a reason by Hill (1992). According to Carter and Altemus (1997), this anxiety of the mother can interfere with both birth and lactation, and also suggest that lactation can be inhibited by stress.

Further study on the question of anxiety and stress in relation to insufficient milk supply is indicated in an article by Bailey and Sherriff (1993) who highlighted the need for a prospective study of the many complex factors which determine the duration of breastfeeding in lower socio-economic groups. And, in an American article by Ueda et al. (1994) it is stated that,

*Further studies are necessary to determine the mechanism by which psychological stress inhibits oxytocin release...*
Another area where self image may be relevant is that of child sexual abuse which can impact on self esteem and is therefore probably associated with reduced breastfeeding outcomes (Raphael and Martinek, 1994; Buist and Barnett, 1995). Such abuse impacts on motherhood in general and breastfeeding in particular, for example, by dissociative techniques during breastfeeding. The skin to skin contact and the milk ejection reflex may remind an abused woman of ejaculation, and their impaired view of themselves may make it difficult for them to establish a network of support (Kendall-Tackett, 1998).

1.2.16 The Feminist Movement and Breastfeeding

In this section definitions of patriarchy, the two strands of feminism, how breastfeeding has not been adequately addressed by the feminist movement, and why it ought to be considered, are discussed.

In the feminist movement one of the main obstacles to women’s self realization is that of patriarchy. This has been interpreted in various ways in the feminist literature, ranging from patriarchy defined as male domination over women (Millett, 1969) to patriarchy defined in terms of power relations within the family (Ehrenreich and English, 1979). Furthermore, Birke (1986) has defined patriarchy to mean the form of male power over women existing within contemporary capitalism (p. 172-173). It has also been suggested that while men live mainly in the public and women in the private dimensions of society, it is to be remembered that both are dominated by patriarchy (Gordon, 1990: 12). Feminism challenges this dominance. (Van Esterik, 1994: S41-S42).

Further, Stuart-Macadam (1995) argues that biology and culture are inextricably linked with an alteration in the one having an effect on the other. A change in
attitudes to breastfeeding would therefore require a significant change in the
culture, one of such a dimension that patriarchal dominance might be further
challenged by bringing reproduction into the public, rather than the private, sphere
(p. 7).

In the feminist approach to this problem of male dominance two differing points
of view are put forward. Simone de Beauvoir’s concept of biological determinism
and the seeking of women to achieve equality with men (1988) can be contrasted
with the idea that by aspiring to absolute equality with men, women’s biological
differences are undermined. The second view maintains that,

Liberation struggles are not about assimilation but about asserting
difference, endowing that difference with dignity and prestige, and
insisting on it as a condition of self-definition and self-determination
(Greer 1999: 1).

Breastfeeding, according to Van Esterik (1995), is about asserting the concept of
difference and, as such, should be a feminist issue because: breastfeeding requires
structural changes in society to improve the position and condition of women; and
breastfeeding confirms a woman’s control of her own body, challenges the model
of the woman as consumer, challenges the predominant view of the breast as
primarily an erotic organ and requires that women’s work be redefined to
integrate women’s productive and reproductive capacities. As these changes
would involve health, profits and the empowerment of women, Van Esterik
(1995) believes these changes must therefore be political in nature (p. 145).

Putting breastfeeding as part of a woman’s reproductive activity into its true
context therefore requires more than just changing hospital routines. This is
because,
...[B]reastfeeding as a process is strongly affected by emotional and cognitive states, and thus is very sensitive to social context...[and] There is no way to transform a bottle-feeding culture into a breastfeeding culture without engaging in politics (Van Esterik 1994: S47).

However Van Esterik (1994) says that breast-feeding is absent from many feminist works (p. S42). Consistent with this is the statement by Crowley and Himmelweit (1994) that,

*Motherhood has always posed a problem for feminism* (p. 30).

A possible explanation to this scarcity of reference to breastfeeding in feminist literature is put forward by Van Esterik who states,

*In their efforts to be inclusive, feminists have avoided privileging mothers over other women or breastfeeding mothers over mothers’* (1994: S43).

In conclusion, in the 1960’s and 1970’s the capacity for women to earn money in the public sphere has increased and the reproductive, or private role has become less visible. These changes began with the industrial revolution and the consequent cash economy and the earning capacity of the family (Jelliffe and Jelliffe, 1976: 233-234). The challenge in the 1990’s and beyond is to integrate breastfeeding, traditionally part of the private sphere, into all other aspects of women’s lives (Tan and Jeffrey, 1995).

This struggle to bring the private into the public arena is a difficult one as it challenges the patriarchal system, but perhaps this is necessary if breastfeeding practices are to change. If the feminist movement were to openly support breastfeeding it would assist in the struggle for change.
1.3 Conclusion

In reviewing the literature there were many studies that examined the socio-demographic factors and their relationship to breastfeeding as well as articles examining the role of the health services and health professionals. Whilst these studies are invaluable in furthering understanding of factors related to breastfeeding two elements are largely absent, that is the attitude of the mothers and the viewpoint of the midwives who assist the mothers. So far as qualitative studies are concerned two recent Australian studies have examined motherhood in general from the woman's point of view, but with only small reference to breastfeeding. These were by Brown et al. (1994) and Barclay et al. (1997) and the findings in both showed that the mothers' experiences of motherhood in general were largely negative. Also, on the cultural side, only one recent Australian article, that by Scott et al. (1997) was found which dealt with the approach of the mothers to cultural issues, in this case to breastfeeding in public.

In the light of the fact that breastfeeding rates have levelled out in the 1990's (ABS, 1995) despite the changes that have been made in the health system by such actions as the Ten Steps the researcher hopes a study to examine experiences of breastfeeding mothers from their point of view and the role of the midwives from their viewpoint will be helpful in returning to improved breastfeeding outcomes.

Having examined the themes concerned with breastfeeding covered in the literature the researcher sets out the study plan and methods for the research project in the next chapter.
CHAPTER TWO: STUDY PLAN AND METHODS

A review of the relevant literature has revealed a number of recent Australian studies in which the relationship between breastfeeding and such demographic variables as smoking, education and socio-economic status has been evaluated by quantitative means (Lowe, 1990; Fetherston, 1995; Lawson and Tulloch, 1995; Nicholson and Yuen, 1995; Cox and Turnbull, 1998). The researcher in this project has adopted a qualitative approach in order to facilitate further understanding of the experiences of the mothers, as well as to examine how these perceptions compare with those of a group of health professionals, in this case the midwives. The title of the project has been defined as:

A Study of the Experiences of Primiparous Mothers Who Initiated Breastfeeding.

As has been discussed in Chapter One, breastfeeding outcomes in Australia have improved since they reached their lowest point in the 1970's until late in the 1980's (Lund-Adams and Heywood, 1995), but have remained largely static in the 1990's (Australian Bureau of Statistics, 1995). It is hoped that the findings of this research project will contribute to better breastfeeding outcomes in Australia by improving the supports for, as well as identifying possible deterrents to, breastfeeding.

2.1 Researcher Bias

Greenberg (1993) stated that ‘No study is immune from bias’ (p. 117). I have tried to discern and declare such biases as I might have, so that those who read this thesis may assess for themselves what impact these could have had on the research project.
I am both a mother and a midwife. As a mother I believe that I weaned my babies earlier than I would have done otherwise, because of misinformation I was given by health care professionals.

Although there have been significant changes in the care of breastfeeding mothers in the health care systems, criticisms of midwifery practices continue. As a midwife, I find myself defensive at times. However, my experiences as a midwife in both PNG and Zambia, where health professionals appeared to have little or no role in assisting mothers to breastfeed, yet where breastfeeding is universal, have raised many questions for me as to the efficacy of the practices in Australia.

These experiences have been the major factors in my electing to undertake this research project. I have tried to prevent my biases from influencing the design and analysis of the project by careful adherence to recommended and systematic procedures.

2.2 Study Design

Qualitative methods have been chosen because these facilitate explorations, without preconceptions, of women's views in their complexity. Use of such methods in this way is supported in the following statement by Minichiello et al. (1990) who said,

*Therefore, if we believe (as most researchers using qualitative methods do) that social reality exists as meaningful interaction between individuals then it can only be known through others' point of view, interpretations and meanings (p.100).*

Semi-structured interviews were used to obtain the data from the mothers, who were invited to participate in the study during their postnatal stay in the hospital. It was proposed that the interviews would take place approximately twelve weeks
after the birth in order to examine the mothers’ perspectives of their experiences in those preceding weeks (Lund-Adams and Heywood, 1995). A retrospective design was selected in order to minimize the possibility that the actual participation in the study might have influenced in any way the mothers’ perspectives of breastfeeding or the actual breastfeeding outcomes, a possibility known as the Hawthorne effect (Polgar and Thomas, 1995: 78).

A focus group discussion (FGD) with the hospital midwives was also conducted in order to assess similarities or differences in perspectives between mothers and midwives. Using more than one method is called ‘triangulation’ and, according to Minichiello et al. (1990), helps corroborate the findings when examined from a different viewpoint (p. 11).

2.2.1 The Format and Content of the Interviews

2.2.1.1 Semi-Structured Interviews with the Mothers

Semi structured or focussed interviews were chosen as the preferred method of obtaining the data from the mothers. Minichiello et al. (1990) describe such interviews as follows.

Semi structured or focussed interviewing  Refers to interviews in which there are no fixed wordings of questions or ordering of questions. Rather the content of the interview is focussed on the issues that are central to the research question. Interview schedules are often employed to aid the interviewer in maintaining this focus (p. 104).

In order to direct the content of the interview themes were identified from the review of the literature. These themes were expanded as relevant information was acquired during the interviews. As well, it was hoped that new themes would develop during the interviews. The interviews commenced with ‘ice breaking’
questions designed to facilitate an environment in which the mother relaxed and felt comfortable to discuss her experiences as a mother in general and her breastfeeding experiences in particular. As the interviews became more free flowing the planned themes were introduced as seemed appropriate. In all the interviews in the main study this strategy appeared to be successful.

The following themes were developed prior to the pilot study:

- the reasons why the mother chose to breastfeed
- the mothers’ perceptions of the support for breastfeeding in the antenatal period
- the mothers’ perceptions of their experiences in the hospital and during the immediate post discharge period with particular regard to the health care system
- the mothers’ perceptions of the support and difficulties they experienced from their partners as well as their families and friends
- any other themes the mothers wished to discuss.

On the basis of the pilot interviews (see below) another theme, the mothers’ experiences of breastfeeding in public, was added. These themes were used during the fieldwork interviews with the mothers.

The interviewer had a copy of the themes and marked each off as it was introduced. At the conclusion of each interview some socio-demographic information was obtained in order to provide a context for the qualitative data. Field notes recording additional factors observed during the interview were
written as soon as the interviewer returned to her car after having taken leave of the mother.

2.2.1.2 The Focus Group Discussion with the Midwives

A FGD was chosen as the most appropriate and efficient method for investigating the perspectives of the midwives. The FGD has several advantages. According to the recommendations of Morgan and Kreuger (1993) the topic was familiar to the participants and the interaction was made more comfortable by ensuring there were few, if any, power differentials in the group (p. 12). With time and money being a restricting factor in this project the FGD also was preferred, because it is less costly and faster than individual interviews. Thus, advantages described by Albrecht et al. (1993) that opinions can be developed within group dynamics rather than in social isolation could be utilized.

In the interviews with the midwives three themes were explored. These were,

- what do you do to assist mothers to breastfeed?
- what else, if anything, would you like to do to assist mothers to breastfeed?
- what problems if any, do you have with what you do or what you would like to do?

2.3 The Pilot Study

The pilot study was carried out as per the planned protocol and two factors emerged that required modifications to the main study: privacy for the interview, and an additional theme, breastfeeding in public to discuss.
At one interview the mother's partner, an interstate transport driver, was unexpectedly at home and, whilst he made the interviewer welcome, he tended to dominate the interview with his views of the hospital and the birth. The interview with the mother was not free flowing as the interviewer had hoped and the themes, though introduced, were not explored as had been planned.

On the day of an appointment with another mother, the interviewer needed to telephone the mother to check a detail about the address. The partner answered the telephone and was very abusive telling the interviewer to 'piss off you f..... c... we don't want nobody sticky beakin' into our business.' The conversation concluded and no further contact was made with the mother.

At another interview the mother was eager to discuss her breastfeeding experiences and the themes were explored as planned. The mother discussed at length her experiences of breastfeeding in public places as well as stating, without any prompting, how wrong she thought it was that breastfeeding in public places was illegal.

As a result, modifications were made to the main study. Firstly, considering the difficulties encountered with the partners, greater emphasis was placed on the need for privacy between the interviewer and the mother. To help ensure this care was taken to stress the need for privacy when discussing the venue for the interviews with the mothers during the telephone contact. Secondly, the question of breastfeeding in public was added to the theme list.
2.4 Recording the Data

Both the semi-structured interviews and the FGD were recorded using an audio cassette recorder and the data was later transcribed. Polgar and Thomas (1995) advise that audio taping has some disadvantages such as an increased refusal rate, as well as the taping interfering with the normal flow of the conversation during the interview (p. 140). After consideration of these factors it was decided that, for this research project, the benefits of taping the interviews outweighed the disadvantages in order for the interviewer to concentrate on the interview as well as to obtain a full record of the interview. This was, in fact, borne out by the interviews.

2.5 Ethical Considerations

2.5.1 Ethics Approval

Ethics approval for the research project was obtained firstly from the Human Research Ethics Committee at The University of Melbourne. Approval for the main study to take place was obtained from the Ethics and Research Committee of the Bendigo Health Care Group. For the pilot study ethics approval was obtained from the Ethics Committee of the Yarra Ranges Health Services.

2.5.2 Confidentiality and Storage of the Data

An explanation was given verbally and in writing to the mothers and the midwives in both the pilot and the main study regarding the strategies that would be used in order to maintain confidentiality and proper storage of the data. It was explained that although the interviews were to be taped, their names would not be used during the interview and in each transcript a pseudonym would be used, and
that after analysis of the data the information on the tapes would be erased and the transcripts would be kept in a safe place by the researcher.

2.6 Research Setting

It was noted in the literature that there had been little research related to breastfeeding carried out in the provincial regions in Victoria. While the feasibility for carrying out the research in such a setting was being considered it was found that Bendigo is a city with little ethnic diversity, with only 4,677 out of a total population of 81,338 (approximately five percent) being born outside of Australia (ABS, 1996). Bendigo was therefore chosen for the study because of the relative ease with which a more ethnically homogeneous sample might be obtained rather than in the larger maternity hospitals in multi-ethnic Melbourne, the capital city of Victoria. This was an advantage as it eliminated the potential for variability with regard to ethnicity as found previously in relation to breastfeeding. (Lund-Adams and Heywood, 1995). Because the Bendigo Base Hospital is a public hospital it was also anticipated that mothers who chose to give birth there would be more likely to be in the lower socio-economic group, thus increasing the probability of obtaining a sample of mothers in the group most likely to discontinue breastfeeding at an earlier time (ABS, 1995; Lund-Adams and Heywood, 1995).

Further, the interviewer was not a resident of Bendigo and therefore unlikely to be known to either the mothers or the midwives.
2.7 Populations and Samples

The population of mothers sampled comprised primiparous mothers who gave birth at the Bendigo Base Hospital. A sample was recruited in one calendar month from the mothers who gave birth in the hospital over that period of time in 1999. The population of midwives was those who worked in the Bendigo Health services in both the acute and the domiciliary services, but did not include those in administrative positions. The sample who participated in the FGD was self-selecting.

2.7.1 Sample Size

Due to limitations of time and budget, and the choice of qualitative methods, a small sample was selected.

2.7.2 Criteria for the Selection of the Samples

The following criteria were applied to identify prospective study participants among the mothers:

- primiparous mothers who had initiated breastfeeding. As mothers tended to repeat the infant feeding method they used with their first baby with subsequent children based on their first time feeding experiences (Lund-Adams and Heywood, 1995) primiparous mothers therefore had no ‘baggage’ from previous breastfeeding experiences.

- at least eighteen years old and therefore able to give informed consent.
in order to ensure that the babies could suck normally at the breast in
the first days, three criteria were required. These were to exclude:

a) babies delivered at less than 37 weeks gestation

b) those who had congenital difficulties affecting the baby’s ability to
suck

c) those babies who were admitted to a Special Care Baby Unit
(SCBU).

- there should be no maternal contraindication to breastfeeding as set

- the mothers should be fluent English speakers to ensure that a depth of
information could be obtained.

The criteria for the selection of the midwives who participated in the FGD were
that they were employed to work in either the acute or the domiciliary services of
the Bendigo Health Services in the case of the main study and in the Yarra Ranges
Health Services in the pilot study. As well, these midwives should be employed as
grade two midwives, that is, not in an administrative position.

2.7.3 Recruitment of the Samples

2.7.3.1 Recruitment of the Sample of the Mothers

The staff in the postnatal wards of the hospital were informed that the research
was taking place and the sample selection criteria. Each day during the selected
month the researcher visited the unit several times and discussed the eligibility of
each of the newly delivered mothers to participate in the project.
After allowing a short time for the mother to rest after the birth, six hours after a normal vaginal delivery and twelve hours after an instrumental delivery or a Caesarian Section, the mothers were approached by the researcher who briefly described the project and gave them a written information sheet which restated the information. If the mothers were agreeable to consider participating in the project the researcher returned either later that day or the following morning to answer any questions that the mothers might have. If the mothers then agreed, they signed the informed consent form and also gave their address and contact telephone number.

2.7.3.2 Recruitment of the Sample of the Midwives

To recruit the sample of the midwives for the FGD a notice was placed on the appropriate notice boards together with copies of the information sheets. Those midwives wishing to participate in the study were invited to write their names and telephone numbers in the space provided as well as to take an information sheet to read. Those who responded were contacted by telephone and a mutually convenient time for the FGD was arranged.

The informed consent forms were signed immediately prior to the interview.

2.8 The Main Study

2.8.1 The Semi-Structured Interviews with the Mothers

2.8.1.1 Recruiting the Sample of the Mothers

During the month in which the sample was obtained thirty five primiparous mothers gave birth at the Bendigo Base Hospital. Of these seven were ineligible to participate, one because of the baby’s prematurity, one because breastfeeding was
not initiated and five because the babies were admitted to SCBU. For two others there was insufficient time for them to be approached between the birth and their discharge from the hospital, as both gave birth during the night and had chosen to leave the hospital by ten o’clock the following morning.

Five mothers declined to participate after reading the information sheet and discussing the matter with their partners. One of the partners spoke directly and brusquely to the interviewer saying ‘We don’t want nobody tellin’ us what to do.’ The other four mothers gave similar reasons, (that they didn’t want other people ‘interfering’ in their lives). The remaining twenty-one mothers consented to participate in the project.

2.8.1.2 Problems Encountered in Recruiting the Sample of the Mothers

A problem in recruiting the sample of the mothers for the project was that it was difficult in the hospital setting to find a time that was convenient for the mothers and of sufficient length for the interviewer to even briefly explain the project. In the mornings many activities were taking place in the hospital including treatments, caring for the baby and visits from various other health personnel. In the afternoons and evenings the mothers had visitors for most of the time.

After visiting at various times of the day the researcher chose to come just before the mothers were served their lunch. Although the explanation regarding the project may have impinged on the mothers’ meals this was thought to be preferable to interrupting other activities or disturbing a mother’s rest.
2.8.1.3 Arranging the Interviews with the Mothers

Each mother was sent a letter ten weeks after the birth of her baby to remind her of the project and to inform her that the interviewer would contact her by telephone within a few days to arrange a suitable time and venue for the planned interview.

During the follow-up contacts interviews were arranged with all but one of the mothers. This mother said during the brief discussion in the hospital that she was living in refuge accommodation because of domestic violence and was hoping to be placed in emergency housing soon after her discharge from the hospital. When contact was attempted she had moved from the address that she gave in the hospital and the interviewer made no further attempt to contact her.

Arrangements were made with each mother in regard to the location of the interview so as to find a place which would be both comfortable and private. Seventeen interviews were thus arranged in the homes of the mothers and three in cafes that were deemed more convenient for the mothers. The three mothers who chose to be interviewed in cafes gave the following reasons for the decisions. One mother’s partner worked on night shift and was therefore sleeping, one said it would more convenient because she lived over an hour’s drive from Bendigo and came into town once a week, and the third mother said she thought it would be good to have a change from staying at home all the time.

Nineteen of the twenty arranged interviews proceeded as planned. In regard to the twentieth mother, on arriving at the house it was found that the mother and her baby had just been evicted because, according to the landlady, she had not paid the rent. The landlady did give the interviewer a contact address and telephone
number, but this was not followed up as it was felt that the mother's situation was
too distressing for the interviewer to intrude at such a time.

But on another occasion, when the interviewer was looking at the facilities for
breastfeeding mothers at a modern shopping complex in the centre of Bendigo,
she met the mother who had been in refuge accommodation at the time the sample
was recruited. The mother appeared glad to see her, gave her new address and
telephone and an interview time was arranged. Therefore a total of twenty mothers
out of the twenty-one who consented to participate in the project were
interviewed.

However during one of the interviews it was found that the baby had been
admitted to SCBU after informed consent had been obtained in the hospital. It was
alleged by the mother that the baby had been admitted to SCBU because of
dehydration caused by the staff's refusal to acknowledge her difficulties while
trying to initiate breastfeeding. Whilst the findings from this interview were most
interesting, they were not used in the analysis of the data because the mother did
not meet the criteria for selection to the sample.

Therefore the data obtained from nineteen of the twenty mothers who were
interviewed was used for the analysis.

2.8.2 The Focus Group Discussion with the Midwives

The FGD with the midwives was arranged and proceeded as anticipated with six
midwives participating. As in the pilot study, both the acute and domiciliary
services were represented as were both day and night staff. The discussion was of
a ninety minute duration. Despite one member of the group being overly verbose,
the themes to be explored were discussed in detail with little prompting required from the facilitator. Some clarifications were also sought and obtained.

2.9 Transcription of the Data

A new micro cassette was used to record each interview and the information on the tapes was transcribed as soon as possible, and always within 72 hours after the interviews took place. In this way the information was fresh in the interviewer's mind so that any explanatory notes about such things as shades of meaning and body language could be added to the transcript for clarification.

2.10 Data Analysis

Thematic analysis of all the themes was used to analyse the transcripts. From the transcripts, themes from the original list, as well as emerging themes, were identified and the data obtained were copied to separate files using the Microsoft Word 97 software. From this information emergent themes were identified and grouped together. Similarities, differences and patterns were sought in order to develop interpretations of the findings which were then compared with the issues discussed in the literature review.

2.11 Limitations of the Research Project

The study design had several limitations. Firstly, as previously stated, there are the limitations that are imposed because of the time and economic constraints that were placed on the project, as it was carried out by a single researcher and at her own expense. Also, although a saturation sampling method might have yielded more insights, the above constraints prevented using this approach. To overcome or minimise this potential limitation the participants in the sample were
interviewed in great depth and the researcher read widely in the available literature.

Another limitation was that as this is a small, non-random study, generalizations cannot be made from the findings, but it is hoped theories may be developed from which further research can be undertaken. One example of the limitations on the generalizing of the findings to the broader population is that while ethnic homogeneity reduces variability in the sample, the theories that may be generated do not necessarily apply to the many ethnic groups in Australian society.

Lund-Adams and Heywood (1995) advise caution when carrying out research in a particular area because of the possibility of confounding factors, and this needed to be considered when the findings were examined.

Whilst it was recommended that there should be a good match between the facilitator and the participants in the focus group discussion, care had to be exercised to ensure that members of the group did not know the views of the facilitator and therefore give responses that were designed to please. As well there could be reluctance within a group of people who know each other to express what they may perceive as controversial views, but the spontaneity and range of the responses suggest this was not the case in the FGD undertaken here. In order to reduce limitations, care was taken to use inclusive facilitation, and to emphasize to the need for confidentiality within the group.

The findings from these interviews and FGD are set out and discussed in the next chapter.
CHAPTER THREE: FINDINGS AND DISCUSSION

In order to achieve the aims of the study, the objective is to present the views of the experiences of breastfeeding mothers and triangulate these experiences where appropriate with the views of the midwives with regard to hospitals and health professionals. This chapter also covers a range of themes which were discussed both by the mothers and the midwives about the hospitals and health personnel in general and how these might relate to breastfeeding in particular. As well, socio-cultural themes that were only discussed by the mothers are also considered. The socio-demographic data that was obtained to provide context for these themes is presented first.

As this is a qualitative research project it emphasizes what the participants consider to be of importance, based on the themes identified in the literature review and other themes that emerged in the interviewing sessions. Firstly will be discussed the experiences of the mothers about their stay in the hospital, their experiences in regard to initiating breastfeeding and their perceptions towards the midwives and, in turn, the midwives perceptions of the care they offered. This is followed by the socio-cultural themes dealt with by the mothers ranging from such issues as breastfeeding in public to maternal employment.

Findings and discussion are presented together to facilitate the flow of the writing and avoid repetition, a format that is appropriate to qualitative research. Some themes were considered of more importance than others to the mothers and the findings on such themes are set out in proportionately greater detail, so as not only to show the degree of the mothers' feelings and the importance of these issues to them, but also because the mothers' words speak for themselves in a manner that
no paraphrasing could do. The discussion of the findings in this study will be developed during the course of this chapter and in the concluding chapter.

The themes, both those which were first identified together with those which emerged during the interviews, have been arranged so that they are encompassed by the broader sub-headings of each section of this chapter. These sub-headings are as follows:

3.1 Demographic Data
3.2 Reasons Given Why the Mothers Initiated and Discontinued Breastfeeding
3.3 Hospitals and Health Professionals
3.4 Socio-Cultural Factors Influencing Breastfeeding
3.5 Thoughts and Feelings Described by the Mothers

3.1 Socio-Demographic Data

An overview of the socio-demographic data is presented firstly in a brief summary form and then in a table. The table uses the mothers’ pseudonyms so that the reader can consider the findings of this study in their socio-demographic context. At the time of the interviews ten mothers were exclusively breastfeeding and nine were exclusively bottle feeding.

3.1.1 The Mothers’ Ages

The mothers’ ages ranged from eighteen to forty years with nine of the mothers being under 25 years and ten being older than 25. In this study the two age groups had some distinct contrasting characteristics. In household income, for example, the difference between the groups was absolute in that all of the younger mothers’ household income was less than that of all the older mothers. Five of the younger mothers said that their only income was from social security payments.
As well, all of the mothers in the older age range had a continuing relationship with their partners, while only four of the nine younger mothers were in a relationship with a partner at the time of the interview. The age of the partners in both groups approximately mirrored that of the mothers.

3.1.2 Smoking Status

Eight out of nineteen mothers (42%) said they smoked at the time they became pregnant. Of this eight, six quit in early pregnancy because they said, they did not want to harm the baby, and two were smoking at the time of the interview and both had weaned their babies. Whilst these figures are probably explained by the small sample they are considerably different to those of the national average which shows that 30% of women in Australia smoke prior to pregnancy and 23% of mothers continuing to smoke during pregnancy (Panjari et al. 1999). The figures are in line with the findings reported by Lee (1997) and Scott and Binns (1998) that smoking mothers are less likely to continue breastfeeding.

3.1.3 Ethnicity

As expected, there was little ethnic diversity in the sample. Eighteen of the mothers were born in Australia, with the remaining one being born in Scotland and coming to Australia with her parents at the age of three. Of the partners, all but one was born in Australia, with that one being born in England and also migrating to Australia as a young child.
3.1.4 Education Level

The education level the mothers had achieved was divided into three categories: those who did not complete year twelve at secondary school; those who completed year twelve; and those who had studied at a tertiary institution. The education levels achieved by the older and the younger mothers was approximately the same. Although the sample is too small to draw any definite conclusions, perhaps the fact that there is a university campus in Bendigo may have skewed these findings, because four of the younger mothers had some tertiary education, having commenced but then deferred their university courses because of the birth of their babies. The findings in this study are consistent with those of Redman et al. (1992) with the better educated mothers in this study being more likely to continue breastfeeding while the mothers who completed a lower level of education were less likely to breastfeed.

3.1.5 Type of Delivery

Fourteen of the mothers had a spontaneous vaginal delivery, one had a ventouse extraction and four had emergency Caesarian Sections.

The demographic information is set out below in a table together with the pseudonyms that are used throughout the remainder of this thesis.
Table 1: Demographic data

<table>
<thead>
<tr>
<th>Name</th>
<th>Breast or Bottle at 12 Weeks</th>
<th>Age Self</th>
<th>Age Partner</th>
<th>Type of Birth*</th>
<th>Education (Self)</th>
<th>Education (Partner)</th>
<th>Smoking</th>
<th>Country of Birth</th>
<th>Partner's Country of Birth</th>
<th>Annual Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne</td>
<td>breast</td>
<td>20</td>
<td>21</td>
<td>NVD</td>
<td>Tertiary</td>
<td>&lt; year 12</td>
<td>No</td>
<td>Australia</td>
<td>Australia</td>
<td>15 - 20,000</td>
</tr>
<tr>
<td>Bella</td>
<td>bottle</td>
<td>20</td>
<td>22</td>
<td>CS</td>
<td>&lt; year 12</td>
<td>&lt; year 12</td>
<td>No</td>
<td>Australia</td>
<td>Australia</td>
<td>10 - 20,000</td>
</tr>
<tr>
<td>Carol</td>
<td>breast</td>
<td>30</td>
<td>34</td>
<td>NVD</td>
<td>Year 12</td>
<td>&lt; year 12</td>
<td>No</td>
<td>Australia</td>
<td>Australia</td>
<td>30 - 40,000</td>
</tr>
<tr>
<td>Dido</td>
<td>breast</td>
<td>40</td>
<td>37</td>
<td>NVD</td>
<td>Tertiary</td>
<td>Tertiary</td>
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*(NVD) Normal Vaginal Delivery, (CS) Cesarian Section, (Vent) Ventouse

3.2 Reasons Given Why the Mothers Initiated and Discontinued Breastfeeding

Of the sample of nineteen mothers in this study ten were exclusively breastfeeding their babies and nine were exclusively bottle feeding their babies at the time of the interview. None of the mothers were partly breast and partly bottle feeding and no mother had introduced other foods into her baby’s diet. The reasons why the mothers chose to initiate breastfeeding were explored as well as the reasons for those who discontinued breastfeeding. The findings and discussion of these matters are presented in this section.
a) Reasons Given Why the Mothers Chose to Breastfeed

In the Victorian Breastfeeding Guidelines (1998) it is recommended that expectant mothers be taught the 'principles, techniques and benefits of breastfeeding' (p. 4) in the antenatal period. In this study all excepting one of the mothers had decided before they became pregnant to 'try' and breastfeed because they said they knew that it was the best thing to do for the baby. Sue, Marie and Pam, three of the younger mothers who had deferred their tertiary education because of their pregnancies, also borrowed books from libraries to learn more about breastfeeding. After Becky became pregnant she said she decided to attempt to breastfeed and also obtained information from books that she had borrowed. Her decision to 'try' and breastfeed was reinforced by the information that she was given in the antenatal classes. Tanya and Anne said that they remembered their own mothers breastfeeding their younger sisters and said they believed that this influenced their decisions to breastfeed. Deidre, a science graduate, spoke of some specific benefits to the baby of breastfeeding such as better health, increased immunity to disease and less likelihood of allergies.

Only two of the mothers spoke of any benefits that they anticipated for themselves. Wendy thought that breastfeeding might be better for her, and Pam, who subsequently weaned her baby after two weeks, thought breastfeeding would be,

...something special, something that no-one else could do for the baby.

Apart from these two comments no other mother said that they thought that they might enjoy breastfeeding or that they considered that breastfeeding would be easier than bottle feeding. On this point, Deidre went so far as to say that she
would prefer to bottle feed her baby if formula was as good as breastmilk.

Breastfeeding she said was a 'sacrifice' that she had decided to make for her baby. This is a different finding to that of Stamp and Crowther (1995) who found that one of the main reasons the mothers continued breastfeeding was because they found it 'enjoyable' (p. 15).

Despite the very low incomes of some of the mothers, including five who said that their only income was the social security benefits, no-one mentioned the day to day savings of not having to buy formula, bottles and other equipment.

b) Reasons Given Why Mothers Discontinued Breastfeeding

Of the nineteen mothers in the sample nine had changed to formula feeding by the time of the interview. Six had weaned their babies within the two weeks after leaving the hospital, and three had weaned after approximately six weeks.

In an Australian study by Bailey and Sherriff (1992) a number of reasons are given by the mothers for ceasing to breastfeed. These include poor milk supply, embarrassment, sore nipples, baby demanding too many feeds, inverted nipples and the baby not gaining enough weight. This study had similar findings. Two further reasons for discontinuing breastfeeding were also discussed by the mothers. Firstly, a mother said she weaned on the advice of a paediatrician because the baby was said to have problems with reflux; and secondly, some of the mothers said they disliked breastfeeding, with one mother saying that she didn’t like it at all and the other that she hated her breasts being touched. Kendall and Tackett (1998) have speculated that child sexual abuse could give rise to such feelings of revulsion and further study is indicated to determine the underlying causes of such feelings.
Of the mothers who weaned shortly after returning home from the hospital, three of the younger mothers were those who expressed a degree of revulsion with breastfeeding. One of these mothers was Becky, who had not considered breastfeeding before she became pregnant. She said her pre-pregnant cup size in a brassiere was size D and during the pregnancy her breasts became so large that she could not buy a brassiere to fit her. This became even more pronounced during the first days of lactation and this is how she described the situation:

...[W]hen the milk came down it was worse, they were just huge, they could hit me in the face...I just hated it...

Despite this hatred, Becky said she breastfed most of the time throughout the day and the night while she was in the hospital. She described it as follows:

...[B]reastfeeding was terrible, I hated it 'cos...she was never full, never content and she'd feed for two hours and then she'd stop for five to fifteen minutes and then she'd be hungry again and she'd feed for another two hours and that'd happen all day and all night...

When she returned home she said that, at the domiciliary midwives' insistence, she continued with a similar feeding regime with her sitting and breastfeeding for about two hours out of every three around the clock. This was in spite of increasingly damaged nipples and exhaustion. After two weeks she described what happened when she visited the Health Centre as follows:

...I went to the Health Centre and something I should have recognized when I walked in the door I didn't even see, it was a truck or something and she [the MC&H nurse] said to me 'oh did you see the truck outside?' and I said 'what truck?' She said 'what's wrong haven't you had any sleep?' and I said 'no' and I told her what had happened and we put her on to formula that day...since then she's been fine...

Bella, the second younger mother who also expressed a dislike for breastfeeding said,
...[O]h it drove me mad... I was so happy to go on the bottle... they [her breasts] were just big and hard and cos I play basketball too... oh just touching them annoyed me, I didn’t like it at all.

Pam said she found that the reality was different to what she had read about breastfeeding in that she also fed for most of the day and night. At home she said she had more to do than sit in a chair all day feeding a baby, she liked to be more active and described breastfeeding as follows,

...[I]t’s the best thing to do for our baby, but once I had him things weren’t going the way that... the book said... I felt like a cow...

As well as dislike other reasons for ceasing to breastfeed given by Bailey and Sherriff (1992) were also mentioned by the mothers in this study. Liz, aged 29 and in the older age group, said she weaned her baby twenty four hours after her discharge from the hospital. She believed that the baby was not getting enough milk and she said that the baby had been given formula supplements in the hospital for the same reason. As well, she said her nipples were very painful. This pain was subsequently diagnosed as thrush when the baby’s mouth became infected. Whether the baby was receiving adequate milk or not is not possible to determine at this point.

Kylie, a mother who weaned two weeks after discharge from the hospital, was the only mother in the sample who had flat nipples. She said that despite following the advice of the hospital and domiciliary midwives regarding attachment and feeding by breast and bottle and expressing every three hours, twenty-four hours a day, the baby was crying constantly and when there was no improvement in how the baby attached to the breast after two weeks, Kylie said she decided to change to bottle feeding.
Lesley was another mother who said she fed by breast and bottle and expressed three hourly around the clock in an effort to build up her milk supply. Despite her stated determination to breastfeed Lesley too said that she did not find breastfeeding the pleasant experience that she had expected. But in an effort to continue breastfeeding, Lesley said that she attended the lactation clinic at the hospital before deciding to bottle feed her baby and finally, after two weeks said, 'no, this is not for me'.

On the issue of the mothers needing to breastfeed most of the time two possibilities might be considered. Firstly that breastfeeding technique was not being effectively taught and therefore there was not adequate milk transfer. Or secondly, as these mothers also expressed a revulsion to breastfeeding, the question arises as to whether the babies were receiving insufficient milk as a result of impaired let down reflex as suggested by Ueda et al. (1994). Further research is indicated on these points. If the former is the case then more effective breastfeeding education would eliminate the need for formula supplements, a practice contrary to WHO (1998) recommendations. However if the second explanation is correct then it must be argued that the supplementary feeding given, for example to Liz’s baby, was necessary in order to adequately hydrate and nourish the baby.

Jessica, Helen and Nellie were mothers who said they weaned their babies at approximately six to eight weeks after giving birth. Jessica believed that her supply had become insufficient because the baby became increasingly discontented, although the weight gain appeared to be satisfactory. She said that it wasn’t until after she changed to formula that she learned about growth spurs
from some other mothers and said that she wished she had been better informed. These mothers were part of the younger group who had a greater tendency to be alienated from the health care professionals, and therefore less likely to seek assistance.

Helen said she also believed that her milk supply had become inadequate prior to weaning and thought it was odd that this had happened just when her long standing wound infection had healed. However, she did see benefits in bottle feeding and also described how her husband was now able to help her saying,

...the bottle was easier, I get a good night's sleep every night, I've got a wonderful husband who feeds her every second night in the middle of the night, so there's a bonus, definitely.

Nellie said that she had no problems with the adequacy of her milk supply, but her very discontented baby was diagnosed as having reflux and she said that she was advised by a paediatrician to wean the baby on to a specially thickened formula. Why this regime was prescribed rather than an alternative used in conjunction with continued breastfeeding is not possible to determine.

Reasons given by the mothers for insufficiency of milk in this study were because the baby was discontented and demanding frequent feeds. On this point, in an article by Scott and Binns (1998), a suggestion is made that the mother may be susceptible to the influence of her family and friends about the quantity or the quality of her milk. Also, Thomson (1998) suggests a psychological reason for these perceptions when she said that breastfeeding 'occurs above the eyebrows' as much or more than it does in the mammary glands.

Perhaps the reasons for discontinuing breastfeeding, including insufficiency of milk supply, cannot be divided into the separate categories of psychological and
physiological but are a combination of the two. Anxiety on the part of the mother as to her ability to breastfeed or her lack of confidence to do so or feelings of revulsion at doing so may, for instance, be a possible cause for a poor milk supply or the discontinuing of breastfeeding. This is consistent with the view put forward by Carter and Altemus (1997) in the literature and this subject will be discussed in Chapter Four.

3.3 Hospitals and Health Professionals

In the literature it has been shown that health professionals’ previous practices were detrimental to mothers initiating breastfeeding. While changes have been made, criticisms continue to be made. Kitzinger (1987), for example, has, as has been stated, discussed the disempowering effect of hospitals on new mothers (p. 57). This section, therefore, takes into account the circumstances of being in hospital and also the attitudes of the mothers and the perception of the midwives. Llewellyn-Jones (1994) blamed ‘rigid hospital regimes’ such as timed feeds as being largely responsible for low breastfeeding rates (p. 271). But, as the literature has shown, many of the routines of which Llewellyn-Jones was critical have now been replaced, particularly by the Ten Steps recommended by the WHO. As is outlined in the literature, the Ten Steps have been adopted by a number of hospitals in Victoria under the Baby Friendly Hospital scheme and the Bendigo Base Hospital in preparing to seek the status of a Baby Friendly Hospital is implementing the Ten Steps recommended by WHO. While the benefits of the BFHI are not being questioned nor is it questioned that certain guidelines might need to be implemented for the better running of the hospital and the welfare of the patients, these benefits may not be considered in the same light by the
mothers. For example, while overall hospital practices have changed, there was evidence of one case in this study of some rigidity in the implementation of at least one of these steps, that is to ‘help mothers initiate breastfeeding within a half hour of birth’ (Victorian Department of Human Services, 1998: 82). This occurred when Bella described how she wished she did not have to breastfeed very shortly after a prolonged labour which culminated in a Caesarian Section, but she was told that she must do so. Many of the mothers in this study described difficulties with aspects of being in hospital. These ranged from a general uneasiness because of being in a strange environment and being away from their homes, to maintenance problems that caused some inconvenience and other difficulties that caused considerable distress.

Mothers discussed how they found the care given by the midwives with particular emphasis on the subject of breastfeeding. The midwives spoke of what they perceived as difficulties they had in helping the new mothers to learn how to breastfeed. Some of these problems were discussed by both the midwives and the mothers, some only by the mothers and some only by the midwives.
3.3.1 Perceptions of the Hospital

The mothers discussed several difficulties with being in the hospital which are presented under two headings, divided into those that were considered to be lesser and greater difficulties by the mothers.

3.3.1.1 Lesser Difficulties

a) General Uneasiness

Anne, who described herself as a 'real outside person' and stayed in the hospital for four days, said she found being in hospital strange and she spoke of being particularly uncomfortable with not being able to readily go out in the fresh air. Lesley, who also stayed for four days but after a Caesarian Section, described how she felt uneasy with being in a hospital bed and believed that this was a contributing factor to her being unable to sleep in the hospital.

This feeling of strangeness at being in a hospital was more apparent amongst the younger mothers, but it was ameliorated for them, to some degree, by the presence of their visitors. Marie said that she had many visitors and always wished that they could stay longer. She said she cried when her mother left even though she later described how they had some stormy moments after her discharge from the hospital. Becky said she was glad that her visitors stayed until eleven o'clock at night even though she was exhausted. She said that she dreaded being without her friends at night, because of all the problems she said she was having with breastfeeding the baby and, what she described as, the 'long, lonely nights.'

In contrast two of the mothers, who were trained nurses, said that they were very comfortable with the surroundings. They said, however, that they believed they
had been given some preferential treatment with regard to the postnatal ward to which they were allocated. One said she was in a private room and 'enjoyed' her stay, and the second nurse said she was in a two bed ward by herself and maintained that she had 'no complaints at all.'

b) Hospital Maintenance Problems

Two of the mothers complained of maintenance problems that caused them some difficulties. Bella was in labour when the hot water system broke down. She described it as 'ridiculous' when she sought pain relief by having a warm bath that the nurses had to use kettles of hot water to maintain the temperature of the water. Lesley found it particularly annoying that her call bell was out of order and that it buzzed continuously instead of the usual shorter ring.

3.3.1.2 Greater Difficulties

The overall noise in the ward, the particular difficulties with being in a shared ward, and lack of sleep were described as the most distressing problems. Although the three are interrelated they are considered under separate headings for greater clarity.

a) General Noise

Many of the mothers spoke of the noisiness in the ward. For example, Carol said,

"...If you think it’d be quiet up there, but the staff are so noisy, there are happy buckets getting thrown around, doors getting shut and doors getting opened...as well as listening for your baby and the baby opposite and all the other babies in the rooms, you can just hear everything...it was as noisy at two o'clock in the morning as it was at two o'clock in the afternoon."
Carol, who was advised to rest more because of high blood pressure, went on to say how the one time she could rest was a Sunday afternoon when the ward was not so busy, because several mothers had gone home. She settled down to try and sleep but said she couldn’t rest even then because,

...the cleaners came in, they were in and out of your room cleaning the room and vacuuming and cleaning toilets and everything...

It seemed that the sound of the call bells in one ward could be heard in other wards and several mothers spoke of how they found this noise disturbing. Lesley, for example, described how she thought she could hear most of the bells when they rang and said,

I could hear the buzzers going off left, right and centre when I was there...I was amazed how much people buzzed...

b) The Two Bed Wards

The maternity unit consisted of one and two bed wards, with the majority of the mothers being accommodated in two bed wards postnatally. Each ward had its own ensuite facilities. Problems arose because of the layout of the double wards and there were also conflicts at times with the second mother in the room or with her visitors.

Carol described the difficulties of the ward itself as follows:

I was up the other end and I had to pass through the next lady’s curtains and interrupt her to go to the toilet or the bathroom or something...if she had visitors...you had to actually walk through her area where everyone else was and, getting up in the middle of the night and you’re tripping over things to go to the toilet...I didn’t like that.
Leonie, who was in the bed opposite the one occupied by Carol, but at a different time, had been advised to expose her nipples to the air and she described how embarrassed she was when trying to do this, as well as cope with the problems she was experiencing with breastfeeding, when her neighbour's visitors had to pass through her curtains to get to the next bed. She described the difficulties thus,

"It was purely because the way the curtains were... I think it was really awful... I was just sick of it, I couldn't stand it any longer... you just didn't get any privacy... I'd had it all afternoon and evening of people going in and out and opening up my curtain..."

Regarding the other mother in her room Helen spoke of how her companion kept the television and the light on all night and she was too reluctant to ask her to turn them off. Lesley complained that her neighbour's husband stayed until 1:30 in the morning and, as well, Lesley also described how her room-mate's visitors skate-boarded around the ward as follows,

"I mean their visitors came on skate boards and skated around the ward with skate boards, I kept thinking 'I can't believe this is happening'..."

For Pam the other mother's baby in her ward 'cried twenty-four hours a day' and it was because of this that Pam chose to go home after two days. And Sue said her sleep was disturbed when a new mother was admitted to her ward at one o'clock in the morning following a Caesarian Section.

On the other hand there was one positive comment about the two bed wards. This was made by Tanya who appreciated that her room mate was an experienced mother who gave her a lot of assistance.
A consequence of the general strangeness, the overall noise and the problems inherent with being in the two wards was that of lack of sleep which, although linked to these problems, is discussed next under a separate heading.

c) Lack of sleep

Pam, when asked how she slept replied simply ‘I didn’t’ and Liz who said that she ‘hardly slept at all’ stated,

...[M]idwives are no different during the day than they are at night...noise wise just except for the food trolleys and things that wasn’t coming around...

Lesley, who also said that she ‘didn’t sleep’ described her viewpoint as follows,

...[T]he first three days I had a lady in with me and we didn’t really get on that well and her husband used to stay until 1:30 at night and I couldn’t sleep knowing this man was there so in the end I just said ‘you will have to do something, this is ridiculous, this has gone on for three nights’ so they came and they asked him to leave, ‘oh yeah, in a minute, in a minute’.

It would probably be universally agreed that breastfeeding a new baby means that a mother’s sleep will be disturbed. This is confirmed by the findings by Armstrong et al. (1994) who state that over ninety per cent of babies under the age of one month wake at least once during the night. The findings in this study indicate that there were additional factors, discussed above, that caused even further interruptions to the mothers’ sleeping in the hospital. Armstrong et al. (1994) maintained that there are also potentially serious consequences for a mother deprived of sleep and these included Post Natal Depression (PND) and the likelihood of committing child abuse. The longer term effects of this lack of sleep on breastfeeding are not possible to assess in this study, but it is difficult to see
how a milieu such as that described by the mothers in the hospital could be
conducive to their learning the new skill of breastfeeding.

3.3.2 Factors Associated with Early Discharge from Hospital

In the Final Report of the Ministerial Review (1990) postnatal hospital stays were
given as five to seven days and in considering shorter stays it was suggested that
there would be a greater need for more domiciliary midwifery services and home
help. In this study in 1999 the midwives stated that the average postnatal stay of a
primiparous mother was approximately four days. Sue was the only mother in the
study who stayed longer than the average due to a wound infection following a
Caesarian Section and she stayed in hospital for nine days. But some of the
mothers chose to leave the hospital earlier than the four days. For example Pam,
as stated above, said she went home after two days despite the hospital advising
her to stay because she said the other baby in the ward ‘cried twenty four hours a
day’. Bella stayed in hospital for three days after a Caesarian Section, because she
said she believed that her mother would be better able to care for her. None of the
mothers interviewed said that they regretted when they left the hospital nor did
they consider that it would have been beneficial if they had stayed longer.

Contrary to what Bernard-Bonnin et al. (1989) state therefore, perhaps hospital
studies might be more, rather than less meaningful, because of shorter postnatal
stays. Breastfeeding still continues to be initiated in hospital and, because the time
is short, it is necessary that problems such as those mentioned above still need to
be accurately and quickly identified in order that they may be dealt with in the
more concentrated time span. Further review appears to be indicated in regard to
support services that are available for the recently discharged postnatal mother. At
the time of the FGD the midwives said that they were funded for one postnatal visit per mother and, according to the mothers, there was no home help offered.

3.3.3 Perceptions of the Midwives’ Overall Support for Breastfeeding

During the mothers’ postnatal stay in hospital the midwives were the health personnel who assisted with the establishment of breastfeeding. The comments in this regard were wide ranging from a statement that the midwives ‘were fantastic’ to one that ‘they were just horrible,’ although the number of positive comments was far fewer than the number of negative comments.

3.3.3.1 Positive Comments

By and large the positive comments were made by older mothers who continued to breastfeed. These statements were brief and of a general nature such as ‘they were good,’ although there were three instances where an individual midwife was singled out for attention. Liz described the help she received from that particular midwife as follows,

...[T]here was one midwife that came on and she was really good, she sat down with me for ages and every feed she’d say call me and come and she got me doing it right and after that it was fine... I found there was only one midwife who was really willing or maybe had the time or took the time to sit down and actually sit there while I fed her...

Lesley also said she appreciated how the same midwife spent many hours with her and how she looked forward to that midwife’s shifts,

There was a midwife up there who was just a treasure... she was so patient, she didn’t walk out and say ‘oh look I’ll be back later’... but she was the only one that really offered any support or any help or any advice.
Deidre appreciated the advice this midwife gave. She found the advice 'logical', and said she preferred that approach to what she saw as the assumption that breastfeeding ought to come naturally saying,

...[s]he was quite good because, to her, it was sort of a logical step A, B, C ...it's a procedure that you follow...

3.3.3.2 Negative Comments

The majority of the mothers' comments were critical of the midwives. These included giving conflicting advice together with lack of continuity of care, rough handling of the babies, perceptions of being over aggressive in promoting breastfeeding and a negative attitude towards the mothers who chose to bottle feed.

a) Perceptions of Conflicting Advice and Lack of Continuity of Care

Conflicting advice on breastfeeding was commented upon in the 1990 Final Report of the Ministerial Review of Birthing Services in Victoria by the mothers (p.127) and this was borne out in this study and would appear to be unchanged in the nine years since the Review.

Midwives' alleged conflicting advice was frequently spoken of during the interviews with the mothers. This, along with lack of continuity of staff, was summarized by Liz saying,

...[T]here was always someone different and they'd tell you something different every time...

Wendy said that she became confused by all the different opinions and, whilst Anne thought some mothers might benefit from being shown several different breastfeeding techniques, she only wanted to learn one at that stage. But Lesley
appeared even more distressed by the conflicting advice and was tempted to give up altogether in the hospital when she said,

...Oh God get me a bottle, get me some formula...everyone would tell me that I was doing it the wrong way, so the way that this person taught me, the next person would say it was the wrong way and the way that person taught me the next person would say that was the wrong way...

Not only did the mothers comment on the conflicting advice they were given, but two of the mothers indicated that the advice they were given was, in their opinion, also incorrect. This was summarized by Liz with regard to her belief that the baby was not getting enough milk, contrary to belief of the midwives,

They were supportive, but they were wrong...

Jessica, who said she had been breastfeeding without any trouble during the first 24 hours post partum, said that the advice to then lay the baby on a pillow while she fed only 'led to troubles,' which were finally resolved when she decided not to continue using the pillow.

The midwives in the FGD also appeared to support the mothers’ statements that there was conflicting advice when they discussed the various ways in which they said they taught the mothers how to breastfeed. These methods ranged from the midwife being active and mothers passive with the midwife holding the baby’s head and the mother’s breast, to a method where the midwife was passive and explained to the mother what to do. There was a very lively discussion about the merits of each method. There was a wide range of opinions on this subject in such a small group.
Regardless of the pros and cons of each method some of the midwives appeared to use their own particular method of teaching to the exclusion of any other, although to achieve the best results optimum educational strategies would probably need to vary from one mother to another. From the findings in this study, even though a variety of teaching methods might be appropriate overall, each mother needed continuity of a particular method. Also there did not appear to be any plan that was followed by successive midwives. Finally, only one mother spoke of being ‘involved’ in the decision as to which strategy she preferred.

Lack of continuity of care during both the antenatal and the postnatal periods was also spoken of by the midwives, a factor, they said, which contributed to the problem of mothers being given conflicting advice. In the antenatal period two systems of care were used: firstly shared care, where the mother was cared for by the local general practitioners and a clinic run by the midwives and secondly a clinic for the high risk mothers who visited a clinic at the hospital each week and saw a doctor at each visit. With shared care the midwives said that the general practitioners were unlikely to even mention breastfeeding and when these mothers came to the midwives’ clinic at the hospital they would see several different midwives throughout the antenatal period. In the clinic for the high risk mothers the midwives said an attempt was made for the mothers to see the same doctor at each visit, but there is no such strategy in place for continuity of care by the midwives. By the time the women had been through either system the midwives considered that the mothers had ‘already seen a truck load of midwives.’ The midwives also said that they had no input to these clinics and referred to themselves as being ‘just lackeys,’ which supports the statements by Summers
(1998) and Hastie (1998) that midwives are in a subservient position to the doctors.

Postnatally, lack of continuity of care, was identified as a problem in the Final Report of the Ministerial Review of Birthing Services in Victoria (p. 127).

However, this problem would appear to have continued. The midwives said they believed this was because there was a large number of midwives on the staff, most of whom worked part-time, and also because continuity of care was not a priority for the more senior staff who were responsible for patient allocation. The mothers were attended by different midwives on most of the shifts and even by two or three midwives on the one shift. Although each mother was allocated a particular midwife on a shift it often happened that she might be busy elsewhere when a mother required help and, in such a case, the mother would be attended by whoever was available at the time. In this way a mother could be attended by as many as ten or more midwives during a three day stay in hospital. The midwives also said they found it frustrating that they were unable to follow through and assess the effect of breastfeeding education strategies they had implemented.

However the midwives did say that there had been some improvement in regard to continuity of postnatal care now that a lactation consultant worked on the ward each week day and also said that there were fewer breastfeeding problems being encountered by the domiciliary midwives in the first days after leaving the hospital, again because of the presence of the lactation consultant. This improvement was in spite of the fact that, at times, the presence of the lactation consultant created some tension with the midwives, which they said, was because they were unsure of the role that each was expected to play. It was also suggested
in the FGD that some of the midwives were wary about the introduction of the lactation consultant, and one said that they were 'guarding their territory,' because they feared that their role in breastfeeding education might be usurped by the better trained lactation consultant.

b) Perceptions of the Rough Handling of the Babies

Alleged rough handling of the babies by the midwives was another theme that kept recurring during the interviews with the mothers. Mothers complained about the way the midwives would 'grab' the baby's head and 'jam' him on the breast. Nellie, for example, said that when this was being done,

...they weren't gentle at all...they were really, really, really rough...

It was agreed by both the mothers and the midwives that some of the midwives held a mother's breast and her baby's head and 'put the baby to the breast.' Some of the midwives said that they believed that this practice was necessary when a mother 'did not even know how to hold her baby' let alone how to facilitate attachment to the breast. This view was possibly confirmed by one of the mothers when she described how the other first time mother in her shared ward had just sat and looked at the baby and had rung the bell every time the baby moved because she said she didn't know what to do. Perhaps this might be in line with the statement mentioned in the literature review by Heidi Wenk (personal communication 1999), the senior primate keeper at the Melbourne Zoo, when she described how the problems of another primate, a mother gorilla, who had not been reared with other gorillas and had therefore not seen mothering, were two fold. Firstly the mother had to understand how to handle her baby and then she
had to accept the infant suckling. If this comparison is valid then some human
mothers, who have had little contact with child rearing, could also need assistance
with such basics of how to hold a baby before learning how to breastfeed.

Lack of basic mothering skills, as described above might therefore be one
explanation as to why the midwives found it necessary to hold both the baby and
the mother’s breast in order to facilitate the baby’s attachment to the nipple. But
despite the possible need to teach the mothers how to hold their baby, the mothers
in this study said they were distressed by this manoeuvre which, some of the
mothers said was carried out in an overly rough manner. Even if the mothers
needed this degree of assistance then the procedure should be modified so that it is
performed in a way that does not cause the mothers distress.

The rough handling of a baby was carried further by Kylie who alleged that a
midwife picked her baby up by the blanket and ‘sort of threw him.’ But the most
serious complaint was made by Deidre who said,

...[S]he was sort of shaking his head from side to side and that really
upset me... I told her that and she got really defensive and she yanked
the [bell] cord out of the wall...

Deidre went on to say that the staff said that she had misinterpreted the events
because of ‘third day blues’, something which she strenuously denied. This
incident, as described by Deidre, went beyond normal handling of a baby.

Whether the midwives’ explanation for the mother’s interpretation of the event
was adequate or not Deidre said that she felt powerless to act and that the staff had
‘closed ranks’ against her. In circumstances such as this the mothers need to be
informed of what processes are open to them in order to pursue any grievances,
and such information could be given in the antenatal classes.
c) Perceptions of Over Aggressive Promotion of Breastfeeding

McCalman (1998) said that in the 1950's 'Breastfeeding often became a battleground' (p. 299) between the midwives and the mothers, and Brown et al. (1994) said of present day practices that there is 'inflexibility and intransigence' (p. 109) on the part of the midwives. Both these statements are consistent with the findings in this study with the mothers using such words as 'bossy', 'forced', 'pressured', 'pushy', 'don't let up' when describing how they viewed the midwives' attitude to breastfeeding. Marie, who said that she wanted to breastfeed, and was doing so at the time of the interview, was critical of the way mothers were expected to breastfeed saying, 'you had no choice.'

But the most colourful description of what she perceived to be an over zealous promotion of breastfeeding was given by Pam when she said,

*Oh no way, there wouldn't have been a hope in haggery that I was going to put that baby on to formula...*

Only one mother spoke of being involved in the decision making process and this lack of consultation is consistent with a statement by Brown et al. (1994) when they said,

*Advice, it seems, is rarely offered in the form of suggestions – 'try this' – but as a confusing series of solutions, given with inappropriate certainty by the parade of passing experts* (p. 109).

As well as some of the midwives being seen as over enthusiastic in their promotion of breastfeeding, there was also the belief that the mothers who chose to bottle feed were discriminated against. Lesley said she felt that she was being watched when she got a bottle out of the refrigerator in the nursery during the night, and she believed that the staff would have chatted to her had she been
breastfeeding. Also, Jessica believed that the staff were nice to her only because she was trying to breastfeed. Liz believed that her room-mate, a primiparous mother, who had elected to suppress lactation, was in some ways discriminated against. Liz said,

_There was a young girl who chose not to breastfeed...right from the start and they didn't help her at all...they'd be in and out of her room, they didn't sit, they didn't talk to her...they just completely shut her off and ignored her and I think it was because she chose to bottle feed._

Such alleged discrimination is consistent with the findings of Brown et al. (1994) that midwives lacked flexibility and were insensitive to individual preferences and needs (p. 109).

d) Perceptions That The Midwives Were Too Busy

The mothers frequently spoke of how they believed that the midwives were too busy to spend sufficient time with them. They all believed that the staff/patient ratio was inadequate given that some of the mothers, especially first time mothers, required assistance for the duration of several feeds. Anne, for example, said,

...[[It's not that they didn't want to help you...there's obviously not that many of them...to go around a lot of patients.]

And Jessica said that she

...supposed they did their best but they were just run off their feet...

Carol said she was reluctant to ring her bell for help because the midwives seemed to be overworked. Whilst Deidre agreed that someone always came, it was not always the person that she wanted, and she said that the wait may be up to ten minutes, which she thought was an overly long time. She said that it was
...stressful for me at the time with the baby crying and you can't keep him quiet...they were tied up with other people or not enough staff, I don't know...

Liz also agreed that the midwives were too busy, but she felt that they were selective about which mothers they spent more time with, tending to ignore her because she was having so many difficulties with breastfeeding. She explained it as follows:

I just don't think anybody wanted the hassle of me and my upset baby, they just wanted to go with the other girls and their easy to feed babies...

In the FGD the midwives also agreed that there was simply not enough time to teach the mothers how to breastfeed and spoke of how frustrated they felt at not being able to spend more time with the breastfeeding mothers. The following statements describe how the midwives viewed the situation.

It is appallingly bad at the moment because we've been so full and so busy and I found myself feeling guilty that I would have been quite happy if a woman decided to bottle feed because I knew I didn't have the time to be there for half an hour or an hour...

...[I]f you've got ten other things to do that you've been running around doing, it's hard to walk into a room and be very calm and relaxed and give the aura that you've got all the time in the world to deal with what is going on for that woman and you're the only person I have to deal with when you know the buzzers are all going and stuff...

Whilst mothers spoke highly of a midwife who spent 'as long as was necessary' and at times this was for an entire shift in helping a mother to breastfeed, the midwives viewed the consequences of one midwife spending such a prolonged time with one mother in a different light. They maintained that this increased the workload on the other staff and, while one or two mothers could benefit, others received even less help. The system, they said, just could 'not cope' with the
midwives giving extended time to a few mothers. But they also said that they were frustrated that they were unable to give what they saw as adequate time to each mother. An increase in the staff-to-patient ratio which would help to alleviate the problem would add to the cost of the care given and would require political lobbying for increases in funding through the state health budget.

e) Perceived Lack of Appreciation of the Mothers’ Needs

Whilst breastfeeding soon after the birth and rooming in have been shown by the WHO (1998: pp. 31 and 62) to improve breastfeeding outcomes, some of the younger mothers who had had a difficult labour and/or delivery described how they were not ready to begin caring for their babies or to learn how to breastfeed in the first hours after the birth. As already mentioned briefly Bella, who had a prolonged labour which culminated in a Caesarian Section, said,

...Then about two o’clock that night I’d had medication after just having him, I was so tired because I was awake all night...the nurse comes in and was trying to pull me to the side so I could try and breastfeed him...I knew he needed it but I was just about bugged and needed a bit of space...

This alleged incident, although in keeping with the wording of the fourth of the Ten Steps it is contrary to a further statement that ‘after a Caesarian section initiation of breastfeeding may be delayed’ (WHO, 1998: 31).

Also, whether the mother is experienced in handling a baby or not, it would seem reasonable that help with such tasks as nappy changing and comforting the baby should be available, particularly after an operative delivery, if not by the staff, then by a family member or friend. By contrast, at the time the researcher lived in PNG from 1988 to 1991, where breastfeeding was universal, all mothers had a friend or relative as a carer who attended to both the needs of the mother and the
baby during their stay in the hospital. In fact, it was required that all hospital 
patients have such a carer who was called a 'guardian.' This policy gave the 
mothers more time to rest and, in fact, the mothers insisted on their 'big sleep' 
immediately after the birth. This apparent lack of attention to the mothers' wider 
needs is consistent with the following statement by Brown et al. (1994),

*However, we did end up with concerns about the need for mothers' 
recuperation after birth and with a sense that this is not given a high 
enough priority* (p. 110).

3.3.4 Midwives and Breastfeeding Education

3.3.4.1 Whose Role is it?

In the literature there were differing opinions about whose role it was to teach 
mothers how to breastfeed. Lowe (1990) discussed whether this was the role of 
the midwives or the doctor. Minchin (1998) and Clark (1995) maintained that the 
responsibility lay with the midwives, while Summers (1998) claimed that the 
overall responsibility must be carried by the doctors, because midwives do not 
have professional autonomy. In this study, both the mothers and the midwives 
believed that the task of assisting mothers initiate breastfeeding was that of the 
midwives. Deidre was the only mother in the study who mentioned her 
breastfeeding problems to the doctor while she was in the hospital and described 
his response thus,

> *I told him I was having problems with breastfeeding...[the doctor] 
wasn't contributing any advice, he kept well out of that, I suppose it's 
not his area, I think the midwives have the expertise in that...*

The midwives said that their role regarding breastfeeding was to teach the mothers 
both why breastfeeding was best for the babies and how to breastfeed. However, 
this study found that the mothers were, in all but one instance, aware of the fact
that breastfeeding is better for babies and wanted to try to breastfeed in order to do
the best they could for their babies. Therefore, it is suggested that what is needed
is not so much information about the benefits of breastfeeding, but education on
actually how to breastfeed. That role was carried out by the midwives in Bendigo
mainly in the first days post partum as well as by some demonstration and
discussion in the ante natal classes.

3.3.4.2 Difficulties in Teaching Breastfeeding

The midwives discussed problems that they had in helping mothers initiate
breastfeeding. These were insufficient time, lack of continuity with the mothers,
problems with some of the mothers having few skills in caring for a baby and
some midwives stating that their colleagues were not up-dating their skills in this
area. The first three of these difficulties have already been discussed and the last
subject, the midwives not up-grading their skills will be presented here.

The midwives said that some of their colleagues were not updating their
knowledge sufficiently and that these same midwives were resistant to, and even
hostile, to change. Two reasons were given for this. Firstly, many of the midwives
had their own children to care for and the time needed to fulfill their family
responsibilities together with the time at work meant they were unable to
undertake any further obligations. Presently there is little scope for paid study

The second reason given by the midwives was that some of their colleagues were
'just not interested' in upgrading their skills. One reason for this alleged attitude
might be that their family responsibilities, together with their employment
obligations and the lack of time to up-grade their skills may be overwhelming and
result in an apparent ‘don’t care’ attitude and the following suggestion would be helpful. In order that midwives could upgrade their skills annual paid study leave could be considered together with assistance with the fees for some courses undertaken.

3.3.5 Suggestions for Changes

Discussion also took place between the midwives about the problems of implementing any new initiatives because of lack of funding. Although some said the difficulty was more to do with management’s allocation of the money rather than the actual level of funding, the midwives believed that when savings had been made in their department the monies that became available went to other, less cost efficient, areas in the hospital. They also said that any suggested initiatives were assessed on the cost rather than the likely benefits saying, for example,

...[T]he first time you suggest anything, it’s what’s it going to cost?

Two of the mothers also put forward suggestions for change. Deidre, who held a diploma in business management, said the staff-to-mother ratio was inadequate and should be increased although she also said it would be difficult to improve the situation to the optimum of one-on-one without ‘over capitalizing.’

A way to overcome some of the problems mentioned, and without increasing funding needs, was put forward by another mother Lesley, who suggested a way that might improve the time that the midwives had to spend with each mother. That is, to have a comfortable lounge room where the mothers could go if they needed help with breastfeeding. Here one or two midwives could be working
throughout the day. This would help eliminate the time spent moving from mother to mother and it would ensure greater continuity of care if the same midwives were allocated to that room on their successive shifts. Lesley also thought that such a communal room would increase the potential for mother-to-mother help and, as well, the mothers would not have to worry about visitors going through the curtains if they were breastfeeding in a two bed ward when there were visitors to the other mother.

3.3.6 Perceptions of the Domiciliary Midwives

Visits by the domiciliary midwives are arranged for all the mothers who live within a twenty five kilometer radius of the hospital. The service is offered to mothers for approximately four days after discharge from the hospital. Three of the mothers in the sample lived beyond the twenty five kilometre boundary and therefore did not receive this service, although one of those, Helen, who had a persistent wound infection, said she was visited daily by the district nursing service for several weeks for dressings. These district nurses were also said to have responded to Helen’s concerns regarding breastfeeding.

Most of the mothers who were visited described the domiciliary midwives in positive terms such as ‘good’, ‘nice’, ‘supportive’ and ‘fantastic’ and Bella was glad that the midwife who visited her ‘wasn’t a breastfeeding-is-better midwife.’ The mothers said that the domiciliary midwives answered questions, helped attach the babies to the breast, weighed the babies and checked wounds. One mother, Tanya, referred to tests that were carried out to exclude the possibility that her distressed baby might be suffering from a urinary tract infection. As well, the
domiciliary midwives were said to have organized the borrowing of breast pumps from the hospital when it was considered necessary.

Although Pam and Liz said they were encouraged to continue breastfeeding by the domiciliary midwife they stated that they felt that they were not being actually 'forced' to do so as has been previously described when the mothers were in the hospital. As well, the domiciliary midwife may have had more time to spend with the mothers as is suggested by Carol's statement that 'she had a cup of tea and a chat...'

But there were also some difficulties expressed in regard to the domiciliary midwives. Jessica was apparently not aware that the domiciliary service was only available for a short time after discharge, and believed she was being discriminated against for not breastfeeding when she was referred to the M&CH clinic after she telephoned the service for advice regarding weaning the baby at two months of age. Pam, who weaned her baby two days after discharge from the hospital, said the domiciliary midwife advised her 'not to put the baby on formula because it was bad for them,' but she also went on to say that 'they were really good' when she decided to bottle feed.

There were also two cases where the mothers said problems were not identified by the domiciliary midwives, Liz's alleged undiagnosed nipple thrush may have contributed to her decision to wean the baby at nine days old and Tanya's baby was later found to have a silent oesophageal reflux rather than a urinary tract infection.

The findings in this study show that the mothers were, on the whole, a great deal more positive about the support that they received from the domiciliary midwives
in comparison to that given by the hospital based midwives. Mothers who wished to continue breastfeeding said that they felt that they received the help that they needed. As well, those mothers who wished to wean their babies felt that they could do so without censure. Possible changes to the present model of care to one that increases the role of the domiciliary midwife are given in Chapter Four.

3.3.7 Empowerment, Disempowerment and Medicalization

In this section the question of whether the mothers believed they were able to make their own decisions, that is to say they felt self-empowered, particularly about breastfeeding, is considered.

The two mothers who were satisfied with the help they received were the two who were trained nurses. Two other mothers, Tanya and Anne, who were still breastfeeding at the time of the interview, also appreciated the help they received, although they wished that there had been more assistance available.

But, on the other hand, there are a number of examples indicating that the mothers did not feel free to discuss options for possibly changing to formula feeding and therefore felt coerced into following advice with which they said they were not comfortable. Even mothers who wished to breastfeed and continued to do so were critical of what was perceived as over aggressive promotion of breastfeeding.

Examples have already been given demonstrating that the mothers felt that they were not in control and where they said they were 'pressured' and 'forced' to breastfeed when they were in the hospital. Lesley spoke of trying to assert herself but was unable to do so, saying
...[W]hen that woman had a go at me, when she said 'dear we're only trying to help you, we're giving you all the information', I stood up for myself and she shot me down... I burst into tears, when she left that was... I sort of did at the start [stand up for myself] and then they got the better of me and just from tiredness and everything I just gave up and thought I'm getting out of here now...

Liz said that when she had another baby in that she would probably breastfeed in the hospital and change to the bottle as soon as she returned home to avoid conflict with the midwives. She described her intentions thus,

...I might do the hospital thing and when I come home put it straight on the bottle... anything to keep them quiet...

In turning to the literature on this issue of empowerment and disempowerment of the mothers in hospitals, the statement of Kitzinger (1987) that the hospital is the last place where a mother and her new baby should be may be too extreme on the evidence of this study, which would appear to support the view of Van Esterik (1989) that breastfeeding is part of the process of medicalization, under which the definition and treatment shifts from the lay persons to the professionals.

In the hospital situation it is to some degree inevitable that a mother has to rely on the expertise of the professional staff and this imbalance in knowledge may result in an imbalance in power. But, notwithstanding, the professionals should use their additional knowledge in such a way as to facilitate the mothers becoming active participants in the decision making process. In this study, however, it would appear that the mothers were more passive than active participants in the care they received, and thus were, to some considerable degree, disempowered. This, however, was more the case when they were in hospital than when they were at home, a matter which is discussed under the next heading.
3.3.8 Differing Dynamics Between the Hospital and the Mothers’ Homes

On returning to their homes the mothers appeared to feel freer to make their own decisions about feeding their babies even though, at times, this was counter to the advice given by the health professionals. For example, the mothers who wished to change to formula feeding, but felt that they were unable to do so while they were in the hospital, weaned their babies shortly after they returned home. It would seem that this change in attitude, which, quite literally, took place overnight, was in large part due to the changing dynamics between a mother being in the hospital and being in her own home. Perhaps these feelings might be best summed up by Carol who said,

...[T]his is my house, I can do what I like...

The findings of the FGD supported that such a change in dynamics took place when the mothers returned home. The midwives in the FGD, for instance, spoke of preferring to work in the hospital, saying that they were not comfortable working in the mothers’ homes, because in the hospital the mothers were in your ‘area of control.’ This can be seen from a response to the following suggestion made by one of the focus group members that a hospital midwife, known to the mother, could visit the home with the idea of improving continuity of care.

Although some in the group said they liked the concept others believed it would not be successful because it would involve a change in the relationship between the mother and the midwife, with the mother being in control rather than the midwife. As one midwife said,

*I think it can be very challenging because you’re in their [the mothers’] area of control rather in your area...*
Also one midwife, who described her experiences in changing from working in
the hospital to the domiciliary services, said her 'whole attitude' had changed.

In summary the hospital is not the same to the mother as her own home. Therefore
it is necessary that the benefits of being in the hospital should outweigh the
disadvantages, such as lack of control, and that the mothers should be encouraged
to participate as much as possible in the decision making process.

3.3.9 Other Health Professionals

While midwives are the health professionals that are the main focus of this study,
the role of two other health care workers, M&CH nurses and doctors, will be
considered briefly.

3.3.9.1 Maternal and Child Health Nurses

All the mothers interviewed attended the (M&CH) clinic. Seventeen of these
spoke well of the service although three of these had had problems which, with
the wisdom of hindsight, they felt might have been dealt with differently. Two of
the younger mothers were critical in their comments. However the generally
positive words to describe the M&CH nurses were 'helpful', 'wonderful',
'available', 'great', 'tremendous' and 'marvellous.'

Some mothers said the advice they were given for particular difficulties was
appropriate. For example Tanya's baby continued to be distressed after the visits
from the domiciliary midwife and the M&CH nurse's assessment of the problem
as being silent reflux was correct. Tanya said that giving her baby medication, as
the nurse recommended, provided almost instant relief for the baby and they both
had a much needed sleep. Wendy received help from the M&CH nurse with
problems of attaching the baby to the breast. The M&CH nurses were also helpful in giving explanations to the mothers. One mother, Jenny, was reassured when she was told that the reason her milk was slow to come in was due to her problems with retained products of conception and Bella was comforted by the fact that she was told that she could ‘give them a call any time.’

Three mothers believed some advice that they were given was not helpful. Anne said she was worried when told that her contented baby was not gaining enough weight. As a result she even considered introducing formula to the child, but her own mother counselled against this and the weight gain soon returned to what the M&CH nurse regarded as normal. The Australian College of Paediatrics (1997) has cautioned against the setting of rigid pre-determined weight gains. Whilst not knowing the reason why this particular weight gain was said to be insufficient, the setting of an ‘ideal’ gain in the absence of any other difficulties, it is suggested, may have the effect of undermining a mother’s confidence and lead to early weaning.

Liz, who had nipple thrush, stated that the delayed diagnosis meant ongoing pain, however she did not blame the clinic nurse and in fact believed that ‘she was only trying to help.’ And, although Jessica, the third mother in this group, felt that the advice she received when she believed that her milk supply was dwindling was inappropriate, she still believed that she had been given ‘all the pros and cons’ of the situation and that she was free to make her own decision about continuing breastfeeding.

Becky and Nellie, two of the younger mothers, said they did not find the service helpful and were critical in their comments. Becky said she did not like the fact
that the M&CH nurse arrived some two hours late for her initial visit to the home. Nellie, who said her baby suffered from reflux and had a rash, did not find the nurse supportive. She said there was ‘just talking and talking, no help.’

In summary, the findings about how the mothers viewed the support that was offered by the M&CH nurses were largely positive as was the case with the domiciliary midwives, and even those who chose not to breastfeed said they did not feel in any way criticized.

3.3.9.2 Doctors

When the mothers were asked who influenced them with regard to breastfeeding no one spoke of the doctors. In response to specific questioning it appeared that the mothers, in the main, did not expect the doctors to promote or assist with breastfeeding. Deidre was the only mother who spoke with the doctor of breastfeeding difficulties which has already been considered under the heading of breastfeeding education.

Nellie consulted a paediatrician when her baby was six weeks old because her baby was very unsettled throughout the day and night. After the problem had been diagnosed as reflux the doctor recommended that the baby be weaned on to a thickened formula. He did not, according to Nellie, recommend the use of Gaviscon, the treatment advised for Tanya’s baby who was also diagnosed as having reflux. Although one cannot conclude from this one instance that the medical profession may be more likely to recommend formula, there was no evidence from the other mothers of the doctors promoting breastfeeding.
There was however some mention about the doctors' role in promoting breastfeeding put forward by the midwives during the FGD when they said that a small minority of the local general practitioners might raise issues relating to breastfeeding during the mothers’ antenatal consultations. But, from the information gained in this study, it would appear that the role of the medical profession in regard to promoting breastfeeding was, at best, peripheral.

Contrary therefore to the statement by Summers (1998) that the medical profession should carry the overall responsibility for breastfeeding outcomes, in this study midwives were solely responsible for assisting new mothers to initiate breastfeeding in the immediate postnatal period. This lack of participation of the doctors in breastfeeding education could perhaps be for one of two reasons. The doctors might believe that the midwives are carrying out an important facet of care so well that they need not take any further part, or the issue of breastfeeding might not be regarded as part of their responsibility.

3.3.10 Medical Problems Described by the Mothers

As has been shown, the mothers experienced many problems in trying to breastfeed and further socio-cultural issues, such as that of breastfeeding in public, will be discussed later. This section aims to summarize the medical problems the mothers said they experienced.

Bella said she had a prolonged labour and twelve hours after labour was established she asked for an epidural anaesthetic, but waited a further twelve hours before this form of pain relief was administered. After yet another twelve hours an emergency Caesarian Section was performed.
Although Becky had a faster labour, she too had a difficult birth and one which she also believed had been avoidable. She said she had been referred to the hospital by a local medical officer because he thought that the baby was big. Although Becky was a well built woman she had expected that there would have been some formal assessment of the size of the baby, given the reason for the referral to the clinic. At birth Becky said the baby weighed ten pound four ounces and there were difficulties in delivering the baby’s shoulders. Becky said,

...[T]hey grabbed her head and ripped her out...

This resulted, Becky said, in her being badly torn and requiring extensive stitching, all of which caused considerable pain in the first days after the birth. As has already been discussed, Becky hated the size of her breasts and, as well as this revulsion, was in some pain as she sat hour after hour trying to breastfeed.

Lesley, a thirty-eight year old woman who said she had a history of several years of infertility including a failed attempt to become pregnant through an in vitro fertilization (IVF) programme, also had a prolonged labour culminating in a Caesarian section.

Wendy spoke of how she suffered from anaemia because of heavy blood loss at the birth, and described how she felt when she first returned home saying,

...[I]t was hard...I think I was tired enough as it was with the low haemoglobin, then to have to cope with getting up at night...

Sue, a younger mother, said she had an emergency Caesarian Section for fetal distress. She stayed in hospital for nine days after the birth, a comparatively long time, because of a wound infection. She described how she felt about the Caesarian Section and how it made breastfeeding more difficult.
...[I was] in a state of shock really, you’re very sore and you feel someone’s kind of hit you with a freight train and you feel sorry for yourself and wonder if the baby’s OK...I wanted to know if it was a boy...and getting breastfeeding started while you are trying to cope with the pain and having to be on all the drugs...

Jenny said part of her placenta was retained in utero and she haemorrhaged shortly after giving birth. She described how, without the benefits of any pain relief, the doctor made several attempts to remove the retained piece of the placenta as follows,

...[T]he doctor did twenty to thirty internal[s] after I had him [the baby] so, virtually, would you call that a curette on the bed? ...I had four sisters in with me and I felt sorry for them, they had to listen to me [screaming] he just kept going in and scooping out...

The following day Jenny had an operation for the removal of the retained products of conception under a general anaesthetic. Jenny said she was anaemic when she left the hospital and felt ‘disgusted.’ She went on to recall how she responded when people would inquire about her health saying,

People would ask how I was and so I’d just spill the beans and tell them exactly what happened, that was my way of dealing with it...

Helen said she had a Caesarian section because the baby ‘was stuck’ and her wound later became infected. This necessitated four courses of antibiotics, several trips to the doctor, thirty-eight daily visits by the district nurse and ten weeks to completely heal. In describing the discharge from her wound Helen said,

...[I]t was just mucky and green and gooey and smelly...I wasn’t happy at all...

It should be noted that some of the mothers who had operative deliveries mentioned the fact that they had little or no help after returning home, but did not appear to see this as a problem. It seemed to be accepted as normal that one just
had to cope as best one could. This lack of home help is contrary to a view expressed in the Final Report of the Ministerial Review of Birthing Services in Victoria (1990: 118).

It is of interest to contrast this situation with that of Leonie who said she underwent emergency surgery because of a bowel obstruction seven days after she gave birth. Leonie said that the hospital arranged household help for her for some weeks after she was discharged because she had had major surgery. Just why mothers who had undergone a Caesarian Section did not receive similar assistance was not possible to determine. In fact there was no evidence to show that mothers who delivered by Caesarian Section were cared for any differently from those who had a normal vaginal delivery.

3.4 Socio-Cultural Factors Influencing Breastfeeding

As stated in the literature, (Hertz 1909, cited in Maher 1992) suggests that ‘the facts of nature are always transformed by culture’ (p. 91), a statement which is supported in regard to breastfeeding by the findings in this study. These socio-cultural themes will be divided into four groups. Firstly are the cultural aspects which were found to be of considerable significance by the mothers which are: the support of partners and family as well as peer and support groups, followed by the cultural perceptions of breasts and lastly the apparent influence of a bottle feeding culture. This will be followed by aspects which were of lesser significance to the mothers in this study. These are the areas of the media, employment, and dummies as well as education and smoking (both of which have been dealt with in the demographic section). The third group consists of areas that are built into other aspects of this study such as the culture of technology, socio-economic
groupings and the cultural influences on health professionals and lack of sleep.

The fourth group consists of those cultural areas which were barely of issue to the mothers in this study and consist of the international and national bodies involved with furthering breastfeeding. It is not to suggest that these bodies are not of importance, as can be seen by the literature, but as they were not mentioned by the mothers they will not be considered further in this study.

3.4.1 Perceptions of the Support From Partners, Family and Peer and Support Groups

The mothers reported that they received support not only from health professionals, but also from their partners, families and peer and support groups. The findings relating to these groups will be presented and discussed divided into two groups: mothers under the age of 25 and those over 25 years old, because there are differences of perceptions between the two groups.

3.4.1.1 Partners

Scott et al. (1997) found the mothers’ perceived attitude of their partners to breastfeeding was an important factor in breastfeeding outcomes. Other studies have ranged from the fathers being unsure of their role in this regard (Freed et al. 1992) to the argument put forward by Greer (1984) that the consumer society discourages breastfeeding because the partners are jealous because of the erotic nature of the relationship between the mother and the breastfed baby (pp. 209-210). Further suggestions on this matter have been put forward including that of the NMAA (1991) which recommends that the fathers be informed of the benefits of breastfeeding and Fetherston (1995) who considers that fathers should be included in the antenatal classes.
In this study all the mothers who had partners and attended antenatal classes did so with their partners except in one case where, it was said, the partner’s work commitments were such that he could not attend. However it was not possible to evaluate the impact of these classes on the fathers’ attitude to breastfeeding. One of the fathers was said to promote breastfeeding, but in all but one instance the mothers said that they believed that the decisions about how the babies were fed was theirs and not that of their partners who, they said, were supportive of whatever decision they made.

For some of the fathers it was said that they accepted none of the responsibilities of parenthood and therefore their attitude to breastfeeding did not seem to be an issue. There was an exception in the case of a father who was described as having tried to dissuade his partner from breastfeeding in the hospital and who later insisted that she breastfeed in her bedroom when his ‘mates’ visited. One month after the baby was born the mother said he ended the relationship and she continued to breastfeed for a further four weeks. This alleged lack of influence in regard to breastfeeding by the partners is borne out by the statements of the mothers which are set out below beginning with the younger mothers.

a) Younger Mothers

Six of the nine mothers in this group were without partners and therefore received no support with the general day to day responsibilities of parenthood. Marie’s former partner said that he regarded himself as being too young to be a father and Sue, who had left her partner because of domestic violence, was going to considerable lengths not to have any contact with him. Anne was in an ongoing
relationship with her partner and he appeared to be supportive of whatever
decision Anne made about how the baby was fed.

Nellie discussed her former partner's attitude to breastfeeding. She said they
argued in the hospital when he tried to persuade her not to breastfeed despite the
fact that she had said she would like to do so saying,

...[U]ntil I had a go at the father, he's supposed to be supporting me
[breastfeeding] not going against me...

After their discharge from the hospital she said her partner and some of his
'mates' visited her at her parents' home and she explained how he insisted she go
into the bedroom to breastfeed the baby:

...I couldn't feed in front of, like while he was here, in front of anyone
so...um...I always had to go into my bedroom while he [the baby] was
feeding and he'd feed for an hour or something like that
and...um...I'd just sit in there doing nothing while I was feeding...that
was annoying and boring...

Nellie said her partner then broke off the relationship when the baby was about
four weeks old. The remaining three mothers who were without partners, Becky,
Pam and Kylie, said that the fathers did not influence their infant feeding
decisions.

Jessica, who was also in this group, said that her partner was supportive of
whatever decision she made.

b) Older Mothers

All the mothers who were in the older age group were in continuing relationships
with their partners (husbands). The husbands, they said, seemed supportive of
whatever decision their wives made and all excepting one seemed to be equally
happy whether the mothers breast or bottle fed the babies. Tanya’s husband, who
was said to be ‘a bit of a tear away’ as a youth, was the exception to this. Tanya
said that he was definitely in favour of breastfeeding and even extolled its benefits
at a family party, much to the surprise of his aunts.

Therefore, all but one of the partners appeared to be ambivalent about whether
their babies were bottle or breast fed despite having attended the antenatal classes
where the benefits of breastfeeding had been discussed and appeared to leave the
decision to the mother. It would have been interesting to have interviewed the
partners/husbands as their views were only given from the mothers’ point of view.
Such a study was, however, outside the scope of this research project.

3.4.1.2 Family

In discussing family support the mothers spoke of their sisters, one grandmother,
one sister-in-law and two mothers-in-law, but the family member most frequently
referred to by the mothers was their own mother who, in their own words, was
always referred to as ‘mum’, a term which will be used frequently to designate the
maternal grandmother in this thesis. The findings in this study about the role of
the maternal grandmother in helping the new mothers are presented here in some
detail to highlight her overall importance. Whilst this help was not usually
directed at supporting breastfeeding, the potential is there for the ‘mums’ to be
more active in supporting their daughters’ breastfeeding endeavours.

a) Younger Mothers

Anne, who could remember her mother breastfeeding her younger sister, said her
‘mum’,
...was always at the end of the phone, she says, you know, it doesn’t matter what hour of the day or night it is like, I can always ring her, I mean she knows more than me...

‘Mum’ was her confidante when she was confused by what she understood to be conflicting advice in the hospital. As well, Anne said ‘mum’ offered to help her with the housework and gave support when Anne was told that the baby was not gaining sufficient weight by the maternal and child health (M&CH) nurse, and also when the baby developed a white coating on her tongue ‘mum’ accurately diagnosed this as thrush and recommended the appropriate treatment.

Marie said she also looked to her mother for help although their relationship was a little more turbulent. Marie appreciated how her mother had scrubbed and vacuumed the shared communal house which Marie described as a ‘pig-sty’.

Bella, Kylie and Nellie were living at home with ‘mum’ at the time of the interview and all three preferred their mum’s support to that offered by the health care system as the following quotations indicate,

...I didn’t receive any help, just ‘mum’...[and] she helps with the washing as I was supposed to rest for six weeks...[after a caesarian section] Bella.

...I wanted to come home with ‘mum’ and I thought that she’d be able to help me probably better than them...Kylie

...‘Mum’ helped me out a lot and really... ‘mum’ did a lot, yeah that’s about it...Nellie.

Pam, who lived independently had said she turned to ‘mum’ for help while she was pregnant, having gone ‘home’ for four months because of severe morning sickness. ‘Mum’ also helped when Pam first come from hospital, after the
breakdown of her relationship with her partner and was supportive of the decision to bottle-feed the baby when she said,

...[W]ell whatever suits you basically just do it...

Jessica said her ‘mum’ had helped out generally with the housework when she came home from hospital.

b) Older Mothers

With the older mothers ‘mum’ was again the main family support person, although in this case it was more through being available to give advice in most cases as well as some practical help in the first days after discharge from the hospital.

Wendy said she appreciated having her mother live with her for the first week after she returned from the hospital. Carol could always ring her ‘mum’, and Deidre could ring both her ‘mum’ and her sister. Leonie was grateful for the help she received from both her ‘mum’ and her mother-in-law. Both Carol and Deidre said that they knew they could always ring their mothers, and Jenny believed that her decision to breastfeed was influenced by the fact that her mother had told her that she had breastfed.

Tanya, who at twenty six years old was the youngest in this group, and who could remember her mother breastfeeding her younger sister, received the most help. ‘Mum’, who lived an hour’s drive away and worked full time, would ‘drop everything’ and come and help, either with the housework or with helping care for the distressed baby. Tanya described it as follows,
I’d be crying and say ‘mum’ and she’d be... cos they live over an hour away... she’d be in the car, she’d be here ‘til ten o’clock at night... she’d get back in the car and go home and get up and go to work the next day and about two days later... ‘mum’... she’d do my ironing and bits and pieces, let me get a break, oh just take him and bath him and go home again, she was really good... and then I went home and stayed for four days when he had his first sleep, eight hours straight after the first Cavision I gave him, she stayed on the couch with him until three o’clock in the morning so that he wasn’t in my room and someone was watching him... she was great.

Liz, who said she found the first days at home very difficult and therefore decided to wean the baby, described her ‘mum’s’ support as follows,

I was prone to breaking down and crying... ‘mum’ was really good... she probably got me through it more than anyone...

Helen described how she appreciated the help she received from both her mother and her mother-in-law when she said,

...[T]hey’d wash the floors and vacuum the floors and all that sort of stuff for me and anything that needed doing they’d do... I don’t know how people do it by themselves...

For most of the mothers in this study their own mother was therefore their key support person. As discussed, two of the mothers, Anne and Tanya, remembered their own mothers breastfeeding and this, together with the support that these ‘mums’ gave, they said, was a positive factor in their decision to initiate and persist with breastfeeding. The breastfeeding history of most of the other maternal grandmothers was unclear, with the mothers sometimes not knowing if their mothers had initiated breastfeeding or how long they might have breastfed. These ‘mums’ had had their children in the late seventies and the early eighties when breastfeeding rates were near their lowest, and when such regimes as timed feeds and babies being kept in the nursery so that the mother might get a good night’s sleep were practiced, and they are possibly not familiar with the changed regimes
that are recommended today. Therefore even with their daughters’ and grandchildren’s best interests as their paramount concern they were unlikely to be able to give appropriate support for the continuing of breastfeeding.

Recommendations how this substantial support given by the ‘mums’ can be incorporated into improving breastfeeding outcomes, are discussed in the concluding chapter.

3.4.1.3 Peer and Support Groups

There were a number of groups in the Bendigo area which supported new mothers and which encouraged breastfeeding. As well, some of the mothers in this study formed their own groups from amongst their peers.

Antenatal classes are recommended in the Victorian Breastfeeding Guidelines (1998) in order to help the mothers to be informed about breastfeeding. As well as teaching about this and other matters related to the birth the antenatal classes were also shown to fulfill another function in this study, that is they went on to become a support group for some of the mothers. Other mother-to-mother support groups were formed through the M&CH clinics, and the mothers also said they knew of the NMAA, because a member of that group had demonstrated breastfeeding in the antenatal classes. However such groups were mainly attended by the older mothers, with the younger mothers saying they felt uncomfortable, or even somewhat hostile, in such groups. In considering the mothers’ own peer groups the position of the older mothers appeared to be enhanced in the group, while the younger mothers described how they felt distanced from their peers and some described a poignant isolation.
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somewhat hostile, in such groups. In considering the mothers’ own peer groups
the position of the older mothers appeared to be enhanced in the group, while the
younger mothers described how they felt distanced from their peers and some
described a poignant isolation.
a) Younger Mothers

Of the younger mothers who continued to breastfeed Anne, who said that her main income was from social security, was the only one who attended an organized mothers’ group. She went to the Young Pregnant and Parenting Program (YPPP) while she was pregnant and after the baby was born went to a group organized by the M&CH nurse, despite feeling a little out of place as the following statement suggests:

...I’m like way younger than all of them there and you know it was interesting going along and all their kids’ve got all the brand name clothes and ‘oh I went down to Melbourne shopping and got this little top’ and stuff and I thought...I said to mum ‘you know you sort of you feel a bit like the odd one out’...

Marie, a deferred university student, lived in a house she shared with several other people her own age. She said that her former partner and the father of the child lived in the same house and that the break-down of the relationship had caused some tensions within the household. Marie said that she had lost her other friends after the birth and described herself as being ‘pretty lonely.’ Marie knew of the YPPP group and had intended to go but hadn’t made contact at the time of the interview, but said she would do so following some encouragement from the interviewer.

Sue said she had friends who were having babies at the same time, but she had lost contact with them because of all the moves she had been forced to make for her own protection. She, like Anne, had made contact with the YPPP group while she was pregnant, but found it too difficult to continue as the following shows:

...[W]ith all the moving and stuff it’s just too much...
This was in spite of the fact that the YPPP was willing to provide transport.

The mothers in the younger group who were bottle feeding not only tended to be
distanced from their peer group, but also did not want to join the organized
groups. Kylie, who continued to live at home with her mother and who therefore
had a live in baby sitter, chose not to join her friends at parties and this is how she
described her feeling with regard to one invitation:

...[M]y closest girlfriend um...I s'pose she wants to go out all the
time, well I'm only twenty so I should be going out all the time...she
goes out all the time and sort of drinks and says to me do you want to
come...get your Mum to baby sit or get someone else to look after
him...but I don't think I would have a good time cos I'd sort of be
thinking about him all night...

Kylie also chose not to go to a mothers' group because she described herself as,

'not a very sociable sort of person.'

Becky was adamant that she would not even try a mothers' group as the following
statement clearly states

NO...no, no, no, no, no, no, and I won't go in one...I hate the idea of
them...they tried to suck me in at Eaglehawk when I first found I was
pregnant...they're always trying to suck me into these groups, but no
it'd be as bad as the one at the hospital for antenatal classes...

Pam, who did attend the antenatal classes, and, whose partner terminated the
relationship while she was still in the labour ward, found she had little in common
with her former peer group and again was one who found herself out of place in
the mothers' groups. She said she

...found them boring and...it depressed me...I don't want to come
here once a week and whinge how my baby doesn't sleep, how my
baby doesn't feed [and] how my husband doesn't do this or that or
whatever...I just didn't get along well in that scene and there was a
lot of bitchiness and I didn't like that...I thought no I'm not going to
be part of this select group.
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whatever... I just didn't get along well in that scene and there was a
lot of bitchiness and I didn't like that... I thought no I'm not going to
be part of this select group.
However, she said she had met up with two other single mothers and said that she enjoyed their company.

Nellie also said she found she was isolated from her peer group in spite of the fact that her mother, who had also been a young single mother, encouraged her to go out so that Nellie was not disadvantaged as her mother believed she had been. After the breakdown in the relationship with the baby’s father Nellie said she felt uneasy in her former group as he continued to participate in all their activities. Nellie also said that she felt ‘lonely.’

Jessica, who was in a stable relationship with her partner, also would not join organized groups and was, to some degree, distanced from her peer group. She stated that when her friends came to visit they ‘couldn’t get rid of them.’ To overcome this Jessica said,

I like to go out now if I think someone is coming round just to prove we are not home, just because they expect we are going to be home, they don’t ring and say are you busy or is he awake or are you ready to go out, they just come and think well they’re going to be home, so I go out so I’m no here.

She also said she did not want to join organized groups because, as she said,

No... up at the hospital they really wanted me to go to a young mothers’ group but I know that they were pretty much a lot of sixteen and seventeen year olds and I just wasn’t interested... people who didn’t have much support in their family and we’ve got plenty of support...

b) Older Mothers

Carol and Jenny are examples of the mothers in the older group who were more likely to participate in both the formal and informal groups. Carol said she was telephoned by the M&CH nurse and invited to join a mothers’ group. This group
ran for seven weeks and after that the mothers continued to meet for coffee and a walk. This was in spite of the fact that Carol described herself as not being,

...into these groups where women go and all they do is complain about their husbands or their lives and everything...

As well many of her friends were having babies and Carol believed this had increased her bond with them.

Jenny kept in touch with the group she met in the antenatal classes, but found the group formed through the health centre comprised of mothers who had older children and, because of this, she stopped attending.

Leonie tended to be more distanced from her peer group who were still in the full time work force, and she hadn’t been able to find a group through her health centre. She therefore joined the NMAA, the only mother in the sample to do so.

Because Lesley had an adopted four year old son she had established a network of friends through the local kindergarten and child care centre and, in this respect, could therefore be considered as a multiparous mother, and indeed she said she felt supported by her friends in her decision to change to bottle feeding.

Liz’s peer group had older children and after she weaned her baby on to formula, her friends told her that they too had bottle fed and that breastfeeding was something that was only done in the hospital.

Helen said she had recently moved to a property out of Bendigo and was isolated from her peer group, and therefore had no contact with either pre-existing or newly formed peer groups. Her sole social contact was at the ‘pub’ on Friday and
Saturday evenings, where she was the only one who had a young baby and where she was also in predominantly male company.

The younger mothers were, therefore, likely to be distanced from their own peer groups and were less likely to attend the groups that, among other things, supported breastfeeding such as those formed through the health care system.

Manderson (1985) states mothers in lower socio-economic groups may be intimidated by voluntary groups and middle class women, and Bailey and Sherriff (1992) say that they are less likely to seek help. In this study three of the younger mothers aged twenty to 21, all of whom were tertiary educated, expressed their reluctance to participate in groups that might be considered to be middle class. Of the three Becky, who said she felt pressured to join a mothers’ group and who refused said,

...[Y]eah, they were a lot older and a lot snootier...

and Anne, who attended a mothers’ group said, ‘you sort of feel like the odd one out.’

The third one of this group, Pam appeared antagonistic to joining groups as described earlier in this section.

That this antipathy towards joining the groups may be due to youth and a dislike of organization, rather than that of belonging to a particular class as suggested by Manderson (1985) is supported by the case of Jessica. Jessica not only disliked joining groups, but also objected to what she considered to being ‘labelled’ because of her youth by the staff in the antenatal clinic.
This alienation from the organized groups as well as from their own peer groups is, therefore, probably more associated with factors related to being a younger mother, rather than with breastfeeding itself. But it is difficult to see how the feelings of loneliness and alienation experienced by these mothers could enhance breastfeeding outcomes. How groups that would support breastfeeding in a way that is acceptable to these mothers as well as how to address the issues of loneliness are problems that need further consideration.

The older mothers, on the other hand, were more likely to join those groups formed through the health care system, and access help if breastfeeding problems arose. As well, their relationship with their peer groups was often enhanced because many of their friends were also having babies around the same time.

3.4.2 Cultural Perceptions of Breasts

Under this heading breastfeeding in public, which will include breastfeeding at home with relatives and acquaintances present, will be considered. The erotic function of breasts as discussed by Dettwyler (1995) has been set out in the literature. This erotic perception of the breasts is part of the cultural norm where a breast is regarded as a sexual organ with little regard to its biological function is endorsed by Morrow (1995). To support this in the examination of women’s magazines described in Chapter One, the biological function of the breasts is barely mentioned. Similar magazines to these were seen by the interviewer in most of the mothers’ homes.

So far as this study is concerned the erotic function of the breast was also supported by a display in the Market Place, a large new shopping complex in the central business district of Bendigo. Here a large advertisement for brassieres
depicting a woman in an opened button through blouse and showing most of her breasts overlooked the food court, at a time when the mothers in this study said they felt they had to go into a less than satisfactory parenting room in the same shopping complex to breastfeed (See picture one at the end of this section).

That this cultural aspect of breasts as being erotic has been absorbed by the mothers, who feel unease in breastfeeding in public, is indicated by such statements by the mothers as 'it is like stripping naked in public' and not liking to 'flash' their nipples. The mothers employed various strategies in attempting to overcome the problems which they anticipated about breastfeeding in public. These included feeding the babies in cars, fitting rooms and deserted corridors as well as parenting rooms which the mothers believed were unsuitable for the purpose. One mother bottle fed her baby expressed breastmilk to avoid using these parenting rooms. They fed their babies before they left home and rushed to do their shopping in the hope that they would be back home before the baby needed another feed. When they breastfed in public this was usually in a restaurant seated at the back where they could not be seen and maybe covered with a rug or something similar. They wore T-shirts that could be lifted up rather than a button through blouse because the T-shirts, they said, were less revealing. They worried about being stared at, being asked to leave the café and the possibility of people being abusive. Mothers, who did not have a car and who could not afford to patronize a café, had fewer options to deal with the difficulties that the mothers identified with breastfeeding in public.

In describing their feelings about breastfeeding in public all the mothers in the sample said they experienced, or expected to experience, a degree of ill ease. This
was the case whether the breastfeeding was in the mothers’ homes with guests present, breastfeeding in other people’s homes, breastfeeding in the public domain, in restaurants and hotels as well as breastfeeding in parenting rooms. The following selection of statements by the mothers illustrates vividly the problems faced, to a greater or lesser degree, by all the mothers who were interviewed.

Anne said she felt comfortable breastfeeding at home in front of guests, and that she could do as she pleased in her own home, but described how she felt when she and her partner visited their landlord’s house for a meal as follows:

...[Y]eah we took Chloe around there the other night and we were in the kitchen and she was in her capsule just on the floor and she woke up...I pushed the chair against the wall and I said do you mind if I feed her here or would you like me to, you know, go into another room and she says ‘oh no you can feed her here’ and as quick as a flash her husband said ‘oh I want to go and watch the news now I’ll leave’ and I said look I said ‘it doesn’t worry me you know’...it wasn’t like I was gonna flop my boob out in front of him or anything...next time I go there I’ll make sure she’s had a feed so we don’t like...do that again...

In contrast to Anne, Marie, who lived in a house which she shared with other students, breastfed in the communal lounge room, but found that the male members of the household would not come into the room.

At a newly opened five star hotel which had widely advertised on the television that it had all facilities, Anne fed in

...a little passageway that was blocked off and had a chair in it...

In another hotel Anne said the only place she said she felt she could go to breastfeed was the toilets, and therefore she chose to feed the baby in the dining room with a rug over her so that other diners could not see what she was doing.
Marie went to the Myer feeding room when she was shopping in Bendigo and the only time she had breastfed in public was at a twenty-first birthday party. On this occasion she describes how she

...just put a blanket over...when I fed her...

When she was asked why she felt the need to cover herself Marie replied that she was embarrassed because of the stretch marks on her breasts, and, to a lesser degree showing her nipples.

Sue didn’t feel comfortable with breastfeeding in public and chose to use the parenting room in the recently opened shopping complex called The Market Place, although she found the room distasteful. This is her description of why she chose to use this room rather than breastfeed in the public areas of the complex:

...I’ve only done it [breastfed in public] a couple of times and, yeah you don’t feel comfortable at all...like you’re stripping off naked and I dunno how I ended up going to those rooms, I guess it’s the changing facilities...it’s just easier to do it there...you can wash your hands afterwards and, no, no most of them really aren’t all that nice to feed in...yeah pretty disgusted...it’s not nice...I mean you wouldn’t want to eat your food in there so you shouldn’t expect your baby to...

Another parenting room at the Myer department store was frequently praised as being clean, comfortable and where the mother could breastfeed in privacy.

However this facility was some distance away from the types of shops that the mothers would use for day to day shopping, and this problem was further exacerbated if the mother did not have a car.

Jessica said she tried to avoid feeding the baby in public because she said that she ‘heard’ people might be offended and described how she avoided such difficulties saying,
I thought if I did breastfeed down there I was certain to have...someone come up and say you shouldn't be doing that in public, it's disgusting, so I actually had to go to a change room in Target one day because he was hungry and I had to feed him...you sort of don't want to take a chance if you go into a café or something that they're gonna say you can't do that in here so I pretty much wouldn't go out until he was fed as much as he could be and then I'd rush to do everything...

Jessica also said she worried that some café owners might be annoyed if people spent a long time feeding the baby and only bought a cup of coffee, and suggested that shops might display some sort of sign on the door if they were happy to allow mothers to breastfeed on their premises. Nellie who, as has already been described under the heading of partners, had to feed her baby in her bedroom when her partner bought his friends around to visit, said of breastfeeding in public:

*I dunno, I'd be a bit embarrassed to do it in front of everyone...*

When she visited Bendigo while still breastfeeding she went to the Myer parenting room because it was the cleanest. However if she was not near Myer she would take a bottle of expressed breast milk for the baby rather than breastfeed in public or use one of the other parenting rooms.

Pam discussed how she didn't like breastfeeding at all and would certainly not have breastfed in public expressing the following negative feelings:

*.../When I fed him I felt like a cow, I felt like a milking cow basically, and just felt ashamed that I had to sit there and be milked...*

Kylie said she would be uncomfortable with people looking at her if she breastfed in public as is shown by the following description,
...I wouldn't have done it [breastfed in public]...I wasn't all that confident with my body that I could just sit there and do something like that in front of people and I know that people look...I used to sort of have a bit of a look at other people doing it and that sort of thing...no it's not really me...

Becky described similar beliefs as follows,

...I'd never go out and breastfeed in public, never...because too many people'd stare...I don't know why people stare at women breastfeeding but I know they do it...you've got teenagers and idiots and whatever having a gawk...

Carol talked of the following incident which she found uncomfortable when feeding at a friend's house:

...I was at a friend's a few weeks ago on their teenage son. I s'pose he'd be about eighteen, come home and I was in the lounge room and he was about to walk in an' Marilyn said oh just stay out there Brent and I, and I felt awkward 'cos I thought 'well I hope she doesn't feel bad and don't', an', you know...then I didn't know whether Marilyn felt uncomfortable with me there breastfeeding in front of her son...

Carol also felt that she could not breastfeed in public in front of strangers saying

...I don't think I could ever do it down the street or in...with a group of people I didn't know that well, didn't feel comfortable with...

Deidre talked about discomfort with breastfeeding in public although this was lessening now that her baby was attaching more readily and she was therefore 'not too exposed.' Deidre went on to say it was her nipples that she would be most concerned about showing if she breastfed in public.

But Janet said she was comfortable about breastfeeding in public and had, in fact, done so on a bench outside a large store in the Market Place. But she emphasized that she was discreet about it 'more for other people than for myself.'

Jenny did not approve of women breastfeeding in public saying,
...I mean when I didn't have kids and whatever and I'd see someone breastfeeding [in public] I'd think oh there's better places than that...

But one day she had felt forced to do so in a café when she found a parenting room unacceptable. She described the incident as follows:

...I walked in and took one smell of it and I thought I am not going to feed him here...all it smells of is urine, it was just filthy, so I just went into one of the cafes and ordered a coffee and I asked the girl if it was alright if I breastfed the baby down the back of the room...I felt a bit funny doing it...

Leonie also did not approve of breastfeeding in public and said she wouldn’t go anywhere if she had to do so and said, in words usually associated with pornography,

...I don't like flashing [my nipples] for the world...

Wendy, on the other hand, who said she was comfortable with breastfeeding in public and had done so soon after leaving the hospital, also said that she had felt the need to do so discreetly because of the way other people might feel saying,

...[I]t was a matter of trying to do it without your breasts being completely out in the open, just, you know, hiding under tops and things like that a bit...a lot of people feel funny about...I still think that it's out there in the public that are embarrassed when someone feeds...

She went on to say that some of her friends had been asked not to breastfeed in cafes, but this had not, as yet, happened to her.

Tanya also fed in restaurants and, feeling the need to be discreet sought a table where she could have her back to most people, but maintained that this was for her comfort saying,

...[W]e just sort of plan it that way...find a seat in a room away from the eyes...I prefer not to be in full view just sort of a preference...I
don’t mind feeding in public but I prefer to be discreet...more comfortable for me then anything...I’m not worried about what other people think...

This problem of breastfeeding in public was therefore of great concern to the mothers in this study and, as such, the findings have been set out in some detail. There can be little doubt that the difficulties experienced by the mothers in breastfeeding in public interfere with the recommended feeding on demand (WHO, 1998) and may therefore have an inhibiting effect on the physiology of lactation.

In regard to the parenting rooms, while in Bendigo the interviewer looked at the parenting rooms in the Market Place and agreed with the mothers that they were not suitable places to feed a baby. Because the mothers did not feel comfortable with breastfeeding in the general shopping area or the food court located in the centre of the complex they required an hygienic, accessible, comfortable and private place to attend to their babies. There were problems with regard to hygiene because the area for breastfeeding was only separated from the toilets by incomplete partitions. The chairs were made of moulded plastic and described as uncomfortable by the mothers. Privacy was also a problem, because the entrance from the outside corridor opened directly on to the area where the mothers fed and was visible to anyone who might be outside the door. Another difficulty was that the parenting rooms were open to both men and women caring for their children. Therefore, even in the parenting rooms it was not possible for the mothers to breastfeed with the degree of privacy that they believed they needed. And even if there are parenting rooms available in this shopping centre, this is not the case in all shopping centres In an Adelaide survey of 27 shopping centres, only 37% provided parenting rooms (McIntyre et al., 1999).
So far as cafes and restaurants are concerned, whilst patrons are legally entitled to breastfeed, it may be asking too much of the cafe owners to provide de facto feeding rooms in the absence of other suitable facilities. As well, even a cup of coffee might be too expensive for a mother on a low income. A further problem is that until a mother enters a cafe she does not know if the owner or manager is supportive of breastfeeding. This reticence is justified by the findings of the study by McIntyre et al. (1999), that only one third out of 66 restaurants surveyed in Adelaide were supportive of breastfeeding.

Photo 1:

Advertisement overlooking food atrium in the Market Place shopping complex.
Photo 2:

Entrance to the parenting room at the complex.
Photo 3:

View inside the door
Photo 4:

Toilet next to the feeding area.
3.4.3 The Effects of a 'Bottle Feeding Culture'

In the literature review it was stated that we live in a bottle feeding culture where fifty percent of mothers bottle feed. In this study this is supported by the fact that nine of the mothers bottle fed by the end of two months. It has also been shown that only two of the mothers had seen their own mothers breastfeeding, and that all their mothers had their babies at the time when breastfeeding rates were at their lowest. In this study further evidence that we live in a bottle feeding culture was present in Bendigo where the chemist shops openly displayed cans of formula, as well as bottles and teats, in their windows. In the literature review the advertizing of such items has been discussed as well as the efforts of Government to restrict such advertizing; but the open display of such items supports the statements of Minchin (1998) that these measures are not sufficient to curtail formula sales. Nor did they do anything to prevent the mothers in this study from buying and using formula without apparently acquiring any special skills. The ease and the naturalness of the process of bottle feeding is supported by the following statements of some of the mothers who changed to formula feeding.

Jessica, who continued to breastfeed for two months gave up breastfeeding when the baby had been awake from eight in the morning to ten at night, said

*I went to the supermarket and got some formula. I gave him a little bit of that and he went straight off to sleep and he was so happy...*

Pam, who breastfed for two weeks and who said that she felt coerced into breastfeeding by the midwives, said she became stressed because the baby became 'difficult' and said,

...[S]o I just put him on the bottle myself and I basically in the end just made the decision and did it.
And last and perhaps more explicitly Bella, who said she hated breastfeeding, said,

...[S]o as soon as I got home I tried one more night to breastfeed and that didn't work so I thought 'oh stuff it' and just put him on the bottle.

In conclusion the ease with which these mothers described the change to bottle feeding is in marked contrast with the difficulties they said they encountered when breastfeeding.

Socio-cultural factors that were considered by the mothers to be of lesser significance in this study are now examined. Of these, as has been stated, education and smoking have been treated in the socio-demographic section leaving the media, maternal employment and dummies to be considered.

3.4.4 The Media

In the publication Evidence for the Ten Steps to Successful Breastfeeding (WHO 1998) commitment to breastfeeding by the media was considered amongst the elements necessary for the implementation of breastfeeding policy. The literature in this study shows, however, that the media proprietors may limit what they disseminate in order to make a profit which, in turn, necessitates attracting readers and advertisers.

As shown in the literature breastfeeding is seldom mentioned in the popular media because, it is suggested, it neither attracts readers nor advertising. A positive commitment therefore appears to be absent. Even the case of Ms. Gatley published in The Age 9/1/1998 and outlined in the literature, may indicate an issue of gender equality rather than one of breastfeeding.
The review of popular magazines in this study supports the absence of promotion of breastfeeding by the media. The mothers, for example, mentioned that they had learnt about the advantages of breastfeeding from reading books borrowed from libraries, from antenatal classes and from their family and friends but not from the popular media. In the FGD the midwives said if they themselves were not positive about breastfeeding 'where else are they [the mothers] going to get the information?'

In this study the only mention of the influence of the popular media made by the mothers was in relation to breastfeeding in public. The understanding of what was presented to them was in the negative as well as being, in some cases, incorrect. Jessica, for example, said,

> What I've heard on the telly and on the radio about people and their opinions I thought if I did breastfeed down there [the shopping centre] I was certain to have some old people, someone come up and say you shouldn't be doing that in public.

Anne, when asked how she felt about breastfeeding in public said,

> ...[Y]ou see on the news how people don't...they get offended by it...

Other mothers' perceptions about breastfeeding in public were inaccurate to varying degrees and these ideas had not been rectified by exposure to the popular media. Carol said,

> My understanding is that you are allowed to do it wherever and whenever. I know you are allowed to breastfeed wherever you choose and in restaurants and things like that they certainly can't ask you to leave but I know there was a lot of kerfuffle about twelve months ago when one on a tram and one in a restaurant were asked to leave or something happened.
Deidre, however, was not sure if breastfeeding in public was legal and asked rhetorically, '...it's OK to do it in public, isn't it?' And Nellie said,

_The Government I think tried to ban it...the breastfeeding in public, it embarrassed a lot of people..._

Therefore there was no evidence that the mothers had obtained any accurate information about breastfeeding from the popular media and this would appear to confirm the view that the media's role is to support the conservative status quo, as discussed in the literature. Some of the mothers appeared to have absorbed incorrect information about breastfeeding without realizing they were doing so. Like the fish swimming in water, portrayed by Williams et al. (1994), who could not see that it was possible to live outside of water, the popular media did not help the mothers to see alternative viewpoints about breastfeeding.

3.4.5 Maternal Employment

As far as maternal employment is concerned, Tan and Jeffrey (1995) and Minchin (1998) consider that work is a crucial factor in the choice and duration of breastfeeding. However this was not borne out by the majority of the mothers in this study. The only mother who expressed any concern about returning to work and continuing to breastfeed was Leonie, who was aged thirty, tertiary educated and on maternity leave, and who said, when asked how long would she breastfeed the baby,

_I think it depends on what it's like for me when I go back to work. If I can arrange it or work it out that I just have to feed her at lunch time, then I'll keep feeding her probably until she's about twelve months old. If she needs more frequent feeding and that I'll sort of stop before that and maybe just feed in the night time and in the morning, I don't want her to be crying because she's hungry and I can't get there. I'll have to leave a bottle for her._
The efforts of international, governmental and other bodies to further the Mother-Friendly Workplace Initiative are therefore not at issue in this study, because only Leonie was planning to return to work and she said she did not expect her employers to give her any consideration for her breastfeeding needs.

3.4.6 Dummies

Whilst the use of dummies is a cultural factor it did not seem to be an issue in this study in relation to breastfeeding. The mothers did not discuss the use of dummies although several babies, both breast and bottle fed, were given dummies during the interviews. One of the recommendations in the WHO’s Ten Steps to Successful Breastfeeding is that dummies should not be used in the hospital by breastfeeding mothers. However, there was no evidence that the use of dummies had an effect on breastfeeding outcomes in this study.

3.5 The Mothers’ Thoughts and Feelings About Breastfeeding

The thoughts and feelings described by the mothers have appeared in several places in this study. They are summarized here because of their potential importance to breastfeeding outcomes. It is difficult to see how the negative thoughts and feelings can improve breastfeeding outcomes, and there is some evidence in the literature to suggest that they may inhibit breastfeeding, a matter to be discussed in the conclusion.

From what has already been described it can be seen that the mothers in this research project had many problems. As well as these problems they often discussed their associated thoughts and feelings. These thoughts and feelings, which included feelings of uncertainty, stress and guilt relating to breastfeeding
as well as motherhood in general, will be considered under three headings: those
experienced before the birth; those experienced in hospital and shortly after the
birth; and those experienced after returning home from the hospital.

1. Mothers’ Thoughts and Feelings Experienced Before the Birth

Most of the mothers interviewed spoke of their intentions to ‘try’ and breastfeed
because of the benefits of breastmilk to the baby. However, they did not appear
confident that they would be able to do so. For example Anne said,

_I read that some people can’t do it and have heaps of trouble... but I_
_thought I might as well give it a go..._

Liz too thought that breastfeeding could be something that she might not be able
to continue when she said,

_...I wanted to give it a try, I always said during the pregnancy, if I_
_can’t do it, I can’t do it..._

The theme of trying to breastfeed was continued by Helen who, when she first
became pregnant, decided to ‘try and see if it worked’ and Jenny who said ‘you
breastfeed if you can.’

Lesley said that she just assumed that she would breastfeed but had difficulties
from the first time she fed her baby until she ‘gave up’ and weaned two weeks
later. Pam and Becky said that they felt that they had no choice but to breastfeed.

Janet and Tanya were the only two mothers who said that they assumed they
would breastfeed and were still doing so at the time of the interview. Janet also
‘just knew’ that she would breastfeed in spite of being told ‘horror stories’ by her
friends. She said that she believed her nursing training helped her to continue
breastfeeding.
2. Mothers' Thoughts and Feelings About Their Time in Hospital

Overall the mothers demonstrated a lack of confidence in their ability to breastfeed after the birth and this can be seen in their use of the words when describing their first days of breastfeeding. For example Lesley said that she kept on 'trying' to breastfeeding even though she was not enjoying doing so, and Liz said she believed that the staff would be annoyed if she hadn't 'tried to breastfeed.'

Leonie described breastfeeding as being 'fairly difficult' and Marie described the feeding as a 'problem' when she was in the hospital.

On the positive side Jenny said that she appreciated the help she was given with breastfeeding in the hospital and felt that the problems she had in the first days were more because of her awkwardness with the baby.

The mothers also described their feelings of stress and a sense of helplessness when they were in the hospital. Deidre described how just waiting for the call bell to be answered when she called for help was 'stressful.' This, she said, was because the midwives seemed to be a long time in coming and the baby was becoming increasingly distressed and then had to be calmed down before he would begin to feed.

But Becky said it was she who needed to be calmed down, rather than the baby, when she became very distressed about not wanting to continue breastfeeding. It was after this experience that Becky said,

*I hated it [breastfeeding]...I would never do it again.*
Liz who said that she was confident that she would breastfeed before the birth said of the first days of breastfeeding her baby,

...I didn’t think I was ever going to cope. I was totally stressed out...

Similarly Lesley talked about feeling so stressed that she would ‘never breastfeed again.’

3. Mothers’ Thoughts and Feelings After Returning Home

The feelings of the mothers regarding their experiences of breastfeeding in their first weeks at home were mainly more negative than positive with only one mother, Wendy, speaking of pleasure when she said,

I get nice and close to baby, she looks at me with those blue eyes and smiles...I’ve done well with it...

Of the remaining mothers who continued to breastfeed their statements were less positive. Although Carol said she was more relaxed at home, she nonetheless said that she struggled and found it difficult to cope; while Anne, whose baby was said to sleep well, felt that she was ‘lucky’ to be able to continue breastfeeding.

Jenny, who was anaemic, maintained she had very little sleep because her baby suffered from colic, said,

...‘If there’s numerous times I could have thrown it in, but I’m glad I persevered’...

Leonie’s baby also suffered from colic and she said that she felt ‘tired from getting up all night.’ She also mentioned that she was surprised when she attended her antenatal class reunion and found that most of the mothers had weaned their babies.
Tanya, who described how she had sleepless nights because her baby suffered from reflux, said that she felt ‘exhausted.’ And Marie, also describing exhaustion, said that she was so tired that she ‘could hardly get out of bed in the mornings.’

Added to tiredness Sue, who had been in refuge accommodation, also said that she felt ‘lonely.’

Helen, who breastfed for a few weeks during which she was treated for a wound infection, said that she felt ‘frustrated, isolated [and] lonely.’ Although she described herself as being ‘disappointed’ when she changed to formula feeding, she was also ‘happy’ because she found bottle feeding easier.

Like Helen, Jessica also breastfed for a few weeks and she said that she felt she was discriminated against when she believed that her milk supply was dwindling. She felt that she had done something wrong and said,

...I shouldn’t have felt as though I was going to be alienated...

Nellie said that she was ‘disappointed’ when a paediatrician advised her to wean her baby. As well she said she felt ‘lonely’ after losing contact with her peer group.

The mothers who changed to bottle feeding shortly after returning home from the hospital also described some feelings of guilt for having weaned, but also a sense of relief for having done so.

Lesley said that she felt ‘stressed’ when she first arrived home and then ‘guilty’ when she changed to formula feeding. She added that this feeling of ‘guilt’ was made worse when the M&CH nurse suggested she should ‘hang in there,’ because
this might well be the only baby she would have and she might regret not having breastfed him.

Although Bella also said she felt ‘guilty’ for a while after weaning the baby, she described herself as ‘happy’ that she was bottle feeding.

Kylie said she kept ‘trying’ to breastfeed for the first few days after she returned home and then she became ‘annoyed’ and began to think, ‘I really don’t want to do this’. And, after weaning the baby Kylie said that she was no longer a ‘nervous wreck’. Pam had similar feelings when she said,

...[A]s soon as I put him on the bottle the stress was over... once he went on to formula, no problem at all.

3.6 Conclusion

All the themes presented in this chapter may effect or have the potential to influence breastfeeding outcomes. In this study all the mothers gave birth in hospital and the midwives taught the benefits of breastfeeding in the antenatal classes as well as how to breastfeed postnatally. Also, the WHO recommendations of the Ten Steps had been implemented in the postnatal ward. After returning home from the hospital there was ongoing help with breastfeeding from the domiciliary midwives and later the M&CH nurses as well as mother-to-mother support groups. With such help available it might be expected that the mothers would have had little trouble in initiating and continuing breastfeeding.

But, to the contrary, the findings show that the mothers encountered many difficulties both in the hospital and after returning home. In the hospital, for example, there was confusion with conflicting advice exacerbated by lack of
continuity of carer and inadequate staffing numbers. There were also difficulties experienced by those mothers who were cared for in two-bed wards, there was excessive noise and the mothers had little sleep. Whether because of inappropriate advice or impaired let down reflex some mothers breastfed constantly day and night.

On returning home many of the mothers had continuing difficulties, with amongst other factors, perceived insufficient milk supply, nipple thrush, flat nipples and sore nipples. The younger mothers also tended to reject the mother-to-mother support groups that might have given help. Finally, all the mothers spoke of difficulties with the actuality of or just the idea, of breastfeeding in public and, as has been shown, they spoke at considerable length on this subject.

One finding of this study and absent from the literature was the role of the mother's own mother. 'Mum' was the main support person for the new mother dealing with the day to day adjustments associated with being a new mother. Two of the new mothers remembered their mothers breastfeeding and this, they said, helped them to 'know' that they too could breastfeed.

At variance with the literature was the role of the partners who, in this study, appeared to be neither for or against breastfeeding and did little to help with the day to day chores that are associated with there being a new baby in a household. Recommendations arising from these findings are discussed in the next and concluding chapter.
CHAPTER FOUR: CONCLUSION

The researcher, having first decided that there was a problem in Australia about breastfeeding and having read the relevant literature, designed and carried out a research project. As the study developed it became apparent to the researcher that the cultural issues were of greater significance than had been first thought. In this conclusion therefore it will be firstly considered why there has been a divorce between breastfeeding and motherhood, a cultural issue. Then the problems facing the mothers are considered and likened to an obstacle race followed by suggestions for further research and then a final summing up.

Unlike in the case of all other primates, where there is a close link between breastfeeding and motherhood, in Australia breastfeeding, according to the researcher, has been divorced from motherhood to a large extent. As already stated in the literature fifty percent of Australian mothers were bottle feeding by the time their babies were three months old (ABS 1995; Lund-Adams and Heywood 1995).

Not only is this divorce in contrast with other primates, it is also in contrast with the situation in such developing countries as Zambia and PNG, where the researcher spent five years working as a midwife between 1988 and 1995. The contrast between these countries and Australia may be demonstrated by different experiences of the researcher in these countries and in a small obstetric unit in rural Victoria. The postnatal ward at St. Francis Hospital in Zambia had 36 beds. At one time there were 57 mothers with their babies in the ward. Although extra mattresses had been put on the floor some mothers still had to lie on a cloth on the
concrete floor. All the mothers were initiating breastfeeding and two midwives were on duty. The extraordinary thing for the researcher was that, even in this situation, one rarely heard a baby cry.

Another instance that might be mentioned happened at the Wedau airstrip in PNG where the researcher was waiting for a plane to transfer a sick baby along with his mother to the provincial capital of Alotau. The baby’s mother had not yet arrived at the airstrip, the plane was late, the heat was oppressive and the baby needed to be given some fluid. The villagers solved the problem with several of the women who were waiting volunteering to express some milk which was then tube fed to the baby. Whilst these days in Western society the question of transmission of disease might be asked, this incident serves to highlight the naturalness with which lactation was viewed by these women.

On returning to Australia the researcher compared these instances to a night when she worked in a small rural hospital where there were two new mothers who were also breastfeeding their babies and, because the babies were so unsettled, needed constant assistance throughout the shift. Why, she asked herself, are there so many difficulties in Australia? This project, she hoped, would shed light on the nature of these problems, together with the existing support that is available regarding these problems. Also, the researcher has sought to investigate possible strategies that might be designed to alleviate these problems with the aim of increasing the number of mothers who continue to breastfeed after the first days and weeks of leaving the hospital.
4.1 The Divorce Between Breastfeeding and Motherhood

Has there been a divorce between breastfeeding and motherhood in women in Australia? Three reasons are given why this might be so.

Firstly, many mothers have not seen breastfeeding take place on an everyday basis. This is borne out in this study where only two of the mothers interviewed had actually seen their mothers breastfeeding and there was no evidence any of the other mothers had seen breastfeeding as a normal everyday occurrence during their formative years.

The second explanation is the normality of bottle feeding, which has been set out in the literature. In this study the mothers who discontinued breastfeeding, not only had seen other mothers bottle feeding, but also, as the findings show, they had no difficulty in changing to bottle feeding and did so without the need to acquire special skills. Not only that, but the ready availability of cans of formula and their display in chemist shop windows has been shown in the literature and also observed by the researcher. This is in spite of attempts by the Australian Government to curtail their advertising.

The divorce of breastfeeding from motherhood has also been helped, it is felt, by the existing cultural attitude to breasts, where their erotic function has overshadowed their biological function. This in turn has made the mothers reluctant to breastfeed in public thereby imposing a restriction upon the natural practice of breastfeeding. This prevailing cultural attitude to breasts has been dealt with to some extent in the literature, because it is felt that it is an important factor in the problem restricting breastfeeding today. This restriction is borne out by the many statements made by the mothers in their need to be discreet and the
necessity to find places where they felt comfortable in breastfeeding. Of the mothers who continued to breastfeed their babies, their days were arranged around minimizing or completely avoiding breastfeeding in public. If the need to breastfeed did arise the mothers went to parenting rooms that were more often than not unsuited for the purpose, or they fed in cars, fitting rooms, and in one instance in a blocked off corridor. When they did feed in public they chose to sit at the back of cafes, they chose to wear clothing that minimized the amount of breast that showed and covered themselves with rugs while they fed. They worried that they might be asked to leave cafes or be abused by café proprietors or passersby.

Maybe these problems involved in breastfeeding being divorced from motherhood may be linked with the two aspects of feminism mentioned in the literature review, that of equality with men propounded by de Beauvoir and the need to assert the differences as proposed by van Esterik (1989) and Greer (1999). For example, from the findings in this study, the granting of equality with men through the Victorian EOA (1995) did not give the mothers the capacity to breastfeed with freedom and ease in public. The amendment to this Act that is expected to pass through Parliament at the time of writing does not actually improve a mother’s legal right to breastfeed in public, something that is covered in the existing Act. However it is hoped that the educative function of the associated publicity will help clarify the position for mothers. Perhaps it is women who must take the lead in demanding equality which is inclusive of women’s reproductive role and such a concept was summed up by Mary Robinson, the United Nations Human Rights Commissioner who was quoted in The Weekend Australian (November 13-14, 1999) as saying,
Feminism is about women getting power over themselves — not over men — and society benefiting from that and becoming more human as a result.

4.2 The Problems Encountered by the Mothers

Turning from the cultural issues which can divorce breastfeeding from motherhood, the actual problems facing the mothers in the first days and weeks after giving birth will be summarized in order to illustrate the challenge the mothers faced.

In the hospital the mothers said they encountered many difficulties. Mothers who had instrumental deliveries, Caesarian Sections or complications associated with the birth had little time to recuperate before assuming full responsibility for caring for their new babies. Some of the mothers said that they felt strange being in the hospital environment and most expressed difficulties in dealing with what they regarded as conflicting advice when learning the new skill of breastfeeding. There were also problems because of the layout of the two-bed wards, and the mothers in these rooms said they had little or no sleep for the time that they were in the hospital. Problems such as sore nipples, cracked nipples and flat nipples were spoken of.

After discharge from the hospital some of the younger mothers coped almost entirely without any support from a partner and on the basic social security income. Those mothers who were living with partners seemed to have received little help with the day to day domestic chores. There appeared to be no subsidized home help for the mothers to access regardless of how difficult a birth they might have had or what complications arose during their postnatal stay in the hospital.
Many of the mothers said that their sleep was disrupted, not only by the need to feed their babies, but also because some babies were said to have suffered from colic and two from oesophageal reflux. Mothers continued to have similar nipple problems as they did in the hospital.

The mothers also described a lack of confidence in their ability to breastfeed. This underlying lack of confidence added to the numerous problems that the mothers faced. It can be argued, that this also led to the largely negative thoughts and feelings that the mothers described. Suggestions that stress and anxiety can be linked directly to the physiology of lactation, in particular with the let down reflex, was discussed in Chapter One.

With so many difficulties confronting the mothers, perhaps breastfeeding might be likened to an obstacle race, where some mothers are able to surmount the obstacles and others are unable to do so. As might be predicted by the matters raised in the literature, it was largely the older and better educated mothers who overcame the problems and were continuing to breastfeed at the time of the interview. Many of the younger mothers were either unaware of some of the supports available or reluctant to make use of them. However the question needs to asked, if the number of obstacles was reduced, would more mothers continue to breastfeed for a longer period of time? As well, the adjustments that could be made to the supports available, so that they better meet the needs of all the mothers, need to be investigated. It is to be remembered that all of the mothers in this study said they chose to initiate breastfeeding so that they could do the best they could for their babies, but almost fifty percent had discontinued doing so at the time they were interviewed.
4.3 Suggestions for Change and Further Research

To overcome some of the problems that many of the postnatal mothers experienced in the hospital some changes need to be made. The problem of the mothers being disturbed by noise other than that of their own babies crying needs to be considered. The problems created by being in a shared ward would also need to be addressed. More thought needs to be given when designing postnatal wards to incorporate the particular needs of a mother with her baby rooming in. Whilst single rooms would probably be the ideal, the design of the shared ward should take into account the space and privacy that the mothers require. The suggestion made by one of the mothers, Lesley, discussed in Chapter Three, that there could be a room set aside for the mothers to go when they are breastfeeding might be taken into consideration. It would appear that staffing levels in the hospital would need to be increased and continuity of care needs to be a priority. Increased staffing levels would allow more time to be spent helping each mother overcome the initial problems of breastfeeding and also provide increased assistance for the mothers who have had a particularly difficult labour and birth. Appropriate policies for further training of the midwives could minimize the problems arising from mothers receiving differing advice from a succession of midwives. Whilst there might be other reasons for a mother to stay in hospital for a few days postnatally, unless changes are made, it is difficult to justify the hospitalization of mothers in order to initiate breastfeeding.

Although at home the mothers felt more relaxed and could sleep better in a familiar environment, they continued to need help with breastfeeding and possibly other mothercraft skills as well as home help. Also, given the mothers’ greater
sense of empowerment in their own homes regarding the interaction between themselves and the domiciliary midwives, there might be better breastfeeding outcomes if this service was expanded to a 24-hour on-call service to meet the needs of the new mothers in the days immediately following earlier discharge from the hospital. If mothers are to be discharged from hospital even earlier than at present affordable home help should be readily available. These views were mentioned in the Final Report of the Ministerial Review on Birthing in Victoria (1990) and it is of concern that the situation appears to be largely unchanged.

In this study the most significant support person at least outside the health services was the maternal grandmother. As has been stated in Chapter Three these grandmothers were having their children at a time when breastfeeding rates were near their lowest and they may therefore have little knowledge of the benefits of breastfeeding and breastfeeding practices that are recommended today. While much has been made in the literature of including partners in the preparation for the arrival of the baby, this study would indicate that there could be benefits if the maternal grandmothers could be included in some formal way in the preparation classes to assist them to be better able to support their daughters’ endeavours to breastfeed. At such classes care would be needed not to undermine the methods that the grandmothers practiced bearing in mind that they too did so in the belief that they were doing their best for their children.

Finally, there are areas of research that might be undertaken in order to explore issues raised in this research. Some suggested areas of such research are the fathers’ attitudes to breastfeeding from their own viewpoint, the role of the mother’s mother as a support person, the possible effect of stress and anxiety,
however they may be defined, on the breastfeeding outcomes, the possible reasons for some mothers’ overall revision to breastfeeding and the reasons for the younger mothers’ antipathy to organized support groups.

The measures described above might help the new mother to overcome the obstacles she may encounter in the immediate post partum period, but they do not address the underlying cultural problems. The findings in this study appear to confirm the statement made by Van Esterik (1989) who said of such changes that this is just ‘tinkering’ at the edges. It is suggested therefore that the broader cultural issues will also need to be addressed if breastfeeding is to become the norm. Breastfeeding in public is, for example, tainted by the pornographic connotations of the breast and is therefore something to be done in private and when the mothers interviewed in this study needed privacy the rooms provided in public places were largely unsatisfactory. A solution to this problem would be to improve these facilities and to also to provide more parenting rooms. However the researcher would see that only as a stop-gap measure, because such improvements would continue to lend support to the belief that babies should be breastfed in private. This would, therefore, continue the existing problem that young girls do not learn about breastfeeding in their formative years, because they have not seen women publicly and openly breastfeeding.

To make breastfeeding a normal part of life more intervention by government will be needed. Smith (1999) says that such a campaign would be unlikely to be supported by the commercial interests who would see no profit opportunities in such a promotion.
There are a number of actions that could be taken by government to achieve this aim. As is shown in the literature more needs to be done in providing environments in the workplace that are suitable for breastfeeding. The implementation of the MAIF needs to be strengthened as suggested by Minchin (1998). But over and above these actions by government it is suggested that an extensive government media campaign is needed, perhaps of a similar magnitude of the Quit antismoking campaign.

In conclusion, whilst this study was designed to examine the experiences of breastfeeding mothers, it was found that cultural issues emerged to be of great significance. Whilst therefore the actions suggested for change in the health care system are considered necessary to improve breastfeeding outcomes the researcher feels that unless there is also a cultural change the objectives to improve breastfeeding rates will continue to be only partly achieved.

With a fundamental shift in cultural attitudes the mothers may come to know how to breastfeed and be confident that they can do so like the mothers of PNG and Zambia. Mothers who breastfeed in a society that welcomed breastfeeding whenever and wherever it was necessary to do so, would, in turn, marginalize the need for health professionals to be at the vanguard of promoting and teaching mothers how to breastfeed.
Appendix 1

Information Sheet

To first time mothers at Bendigo Hospital,

My name is Patricia Hannigan and I would be most grateful if you could help me in a research project in which I am participating for a Master of Women’s Health at the University of Melbourne in The Key Centre for Women’s Health.

What I would like to do is to interview you approximately 12 weeks after your discharge from hospital to ask about your experience of breastfeeding and how you believed the health care system, including the hospital, met your needs. In the longer term it is hoped that this research will help to improve the support for breastfeeding mothers.

The interview would be taped and, preferably, take place in your home. It would take approximately one to one and a half hours. Your name would not appear in the subsequent transcripts of the tapes or in any report or publication based on the findings of the research. The tapes, which would be held in safe keeping by me would be destroyed after analysis of the information. Therefore your anonymity would be assured.

If you agree to help in this research would you please sign the attached consent form and hand it back to me. Please include your address and telephone number so I can contact you to arrange a meeting. If you have any questions please do not hesitate to ring me on (03) 3962 3749 and reverse the charges.

Yours sincerely

Patricia Hannigan.

Principal researchers: Martha Morrow Ph.D.
Susan Donath MA. (Economics)

Other researcher: Patricia Hannigan RM, Grad. Dip. Women’s Health (Melb).
Information Sheet

To midwives at the Bendigo Health services

My name is Patricia Hannigan and I would be most grateful if you could help me in a research project in which I am participating for a Master of Women’s Health at the University of Melbourne in The Key Centre for Women’s Health in Society.

What I would like to do would be to conduct a focus group discussion with regard to your perspectives of
- the support offered to primiparous mothers by the hospital
- what further support you believe might be helpful
- any difficulties in offering existing/further support in regard to breastfeeding.

In the longer term it is hoped that this research will help to improve the support for breastfeeding mothers.

The focus group discussion would be taped and take place at a venue in the hospital. It would take approximately half to three quarters of an hour. Your name would not appear in the subsequent transcripts of the tapes or in any report or publication based on the findings of the research. The tapes, which would be held in safe keeping by me, would be destroyed after analysis of the information. Therefore your anonymity outside the group would be assured.

If you agree to help in this research would you please sign the attached consent form. If you have any questions please do not hesitate to ring me on (03) 5962 3749 and reverse the charges.

Yours sincerely

Patricia Hannigan.

Principal researchers: Martha Morrow Ph.D.
Susan Donath MA. (Economics)

Other researcher: Patricia Hannigan RM, Grad. Dip. Women’s Health (Melb).
THE UNIVERSITY OF MELBOURNE
KEY CENTRE FOR WOMEN'S HEALTH IN SOCIETY.

Consent form for persons participating in research projects

**Name of participant:**

**Project title:** Experiences of Breastfeeding Mothers

**Name of investigators:** Martha Morrow, Susan Donath and Patricia Hannigan.

1. I consent to participate in the above project which is described on the attached page.

2. I acknowledge that
   - I have been informed that I am free to withdraw from the project at any time and to withdraw any information previously supplied
   - The project is for the purpose of research and not for treatment
   - I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements.

**Signature** _____________________________________________________________________________

**Date** ________________________________________________________________________________

(Visitor)

**Signature** _____________________________________________________________________________

**Date** ________________________________________________________________________________

(Witness)

**Participant's Address:** __________________________________________________________________

__________________________________________________________________________________________

**Telephone No.** _________________________________________________________________________
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