A prospective study exploring the early infant feeding experiences of parents and their significant others during the first 6 months of life: what would make a difference?

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The opinions expressed in this publication are those of the authors and are not necessarily those of NHS Health Scotland.

Summary

Aims

The aims of this longitudinal qualitative study conducted in 2009-2010 were:

- to explore the early infant feeding experiences of mothers, including the support offered by others along a time-line, from the antenatal period until their infant is six months old,
- to gather data to inform the development of interventions that will aim to improve the following outcomes: a) any breastfeeding b) exclusive breastfeeding c) the introduction of appropriate solids at six months d) parents' experiences of feeding their baby.

Participants and methods

Thirty six families took part, eighteen in Aberdeen and eighteen in Stirling and two hundred and twenty face-to-face or telephone interviews took place. Two researchers interviewed each woman between two and eight times in total, from the last trimester of pregnancy until six months after birth. Two families withdrew after the first postnatal interview. There were sixteen partners, eight mothers and one sister who were nominated as significant people influencing feeding decisions and who participated in interviews. Two health visitors nominated as significant influences on feeding decisions by three women were each interviewed once alone. All except one woman, when asked in pregnancy, intended to breastfeed, with the exception having breastfed a previous child. Nineteen women were primigravida and seventeen were multigravida. The Framework approach and software was used to analyse the qualitative interview data.

Findings and recommendations

Milk feeding

Antenatal

In antenatal accounts of deciding how to feed a baby, the negative emotional consequences of breastfeeding are often expected to override the longer term health benefits.

Before birth, a balanced discussion of all available feeding options and potential scenarios which realistically prepare women and which resonates with the word on the street is valued. Some couples would like the father to be involved.

The science of breastfeeding (constituents of milk, hormone pathways) is off-putting to some and should not be taught in classes. It should be available in written or web resources for the few that are interested. Teaching positioning and attachment using dolls is not popular.

Mothers who have current or recent personal breastfeeding experience (peers) are particularly valued for experiential learning and support in group settings, both antenatally and postnatally.

More woman-centred discussion and information, rather than the unpopular “don’ts” approach, about maternal diet in pregnancy, during breastfeeding and to assist weight loss after birth is requested.

“Breast is best” has multiple meanings and health benefits and/or bonding are influential in deciding to try breastfeeding, but are not always sufficient motivators for continuing. Maternal and infant wellbeing, convenience, cost, being different from or the same as social network members, maternal image, the sensory body experience and the value of being able to provide something that no-one else can, are also important.

Postnatal

The main priority for women overall with infant feeding is help in the early postnatal period to learn how to breastfeed. More health professional time should be spent with women during breastfeeds to observe and build confidence prior to hospital discharge and when at home, for as long as it takes for the woman to feel confident that she has established effective breastfeeding.

After birth, kindness, patience, reassurance and unrushed care are preferred by women and their partners, rather than a directive “fixing” approach or enthusiastic persuasion and promotion. Building a constructive relationship is important and continuity with a small number of helpers is preferred. Continuity can be problematic and where interpersonal relationships are not constructive, or where one technique or method is not effective, other helpers should be available.

On getting home community midwifery care is unpredictable and creates tensions for women who are struggling with feeding and sleep routines. Often there are missed opportunities for helping with positioning and attachment. An indication of the likely appointment time is preferred.

Twenty-four hour access to telephone help lines is welcomed. Flexible telephone use according to need is important and it should not replace face-to-face care.

As much attention should be given to the emotional feelings of the breastfeeding mother as to the technical aspects of correct positioning and attachment. Maternal anxiety, stress and panic about baby wellbeing and coping with bodily sensations when breastfeeding, particularly pain, are trigger points for stopping breastfeeding, even when women are in theory committed to continuing. Such pivotal points often occur at night and in the early days after birth. More attention should be given to anticipating pivotal points prior to feeding behaviour change, and to early problem solving to prevent the balance of motivating factors tipping against breastfeeding.

The option of involving the wider circle of family and friends in feeding discussions with a professional should be offered on the hospital ward and at home, whilst acknowledging that personal ownership, autonomy, privacy and control when breastfeeding, are very important for some women.

Couples vary in their preference for help from professionals or families and friends. Personality, communication skills and expert knowledge matter more than professional rank or qualifications. Some value the embodied knowledge of a

professional who has personal experience of breastfeeding combined with the collective experience of caring for others.

Parents who change from breastfeeding to formula feeding would like more discussion about different types of formula, making up feeds and the quantity to give.

Introduction of solids

Information for parents

An invitation to discuss the introduction of solids should be actively offered to all parents at three to four months with options for one-to-one appointments with a professional or interactive group sessions, which can be attended by the mother, father, grandparents or other family or friends involved in childcare.

Some couples request more information about the practical aspects of how to go about introducing solids, how to prepare foods and in particular what quantities of food to give and what foods to use rather than just what foods to avoid, and seek information on food allergies.

Parents would like more help interpreting information provided by baby food manufacturers on tins and packaging, particularly about the quantities and frequencies of food required at different ages and infant weights which can conflict with health professional recommendations.

Timing, influences and meanings

The introduction of solids is often an intuitive process and is triggered by the meanings attached to changes in the baby's behaviour and to parental priorities. The meaning of food is not just about or even about health and nutrient value, but includes comfort, entertainment, pleasure, a desire to demonstrate developmental progress, to be "advanced" and fit the desired social network, norm for infant growth and development.

A rigid approach to the age at which solids are introduced is unpopular with many and does not fit with the word on the street or family experiences. A secrecy culture is developing, in which families feel unable to speak openly to health professionals about their plans and behaviour in relation to solids and this may adversely affect professional - family relationships.

A medical model and rationale for the delayed introduction of solids, particularly preventing childhood obesity, is not widely accepted or influential. A more open discussion of the options for both the timing and the type of solids, with discussions about the reasons for the current guidelines is preferred, but may not change behaviour. Sedentary child lifestyles, the media and junk food diets for older children are seen as more plausible explanations for childhood obesity.

The meaning of the question "when did you start solids?" varies between parents, as does the distinction between remedies, medicines, foods and other fluids. This has implications for the validity of survey questions. The widespread use of remedies for common baby ailments such as wind, colic, reflux and teething problems can act as a trigger for early introduction of solids.

Communication about infant feeding

Communication by health service personnel should be more realistic rather than idealistic, either one-to-one or in a group setting. A realistic preparation for feeding would involve interactive discussions with recent mothers or couples who have experienced a range of feeding experiences. For milk this should include formula feeding, difficulties with breastfeeding, mixed feeding and expressing. For the introduction of solids this should include a baby who is reluctant to take solids at six months, who seems hungry at three months, a fussy or unsettled baby and practical tips on food preparation and quantities.

Communication by health service personnel should have a narrative rather than a question and answer focus. A narrative approach would ask about personal and social network experiences, hopes, fears, anticipated help after birth and lifestyle impact. This will allow professionals to assess confidence and will identify women who are likely to have increased support needs. For women it will ensure flexibility in decision making, recognise that every woman is different and put the woman at the centre of the feeding story. It will encourage a move away from a right/wrong and do/don't culture which is currently prevalent.

A more holistic and environmental approach to assessment is required including how breastfeeding and the introduction of solids fit within and outside the home and with the wider circle of family, friends and work. Particular attention should be given to women who have few family or friends who have had children recently and those who have little personal experience of seeing breastfeeding or later the introduction of solids, as they are likely to require more support.

Services and places to facilitate healthy choices in infant feeding

For women who intend to breastfeed, the main priority for resource allocation overall is the provision of skilled, women-centred help in the early postnatal period to enable them to breastfeed effectively and with confidence.

Specialist vs. generalist services

The current flat health service organisational structure, of non-specialised care in hospital and at home, provides variable infant feeding care, with pockets of excellence but also with areas where women's needs, for both breastfeeding support and help with the introduction of solids are not being met. A one-size-fits-all approach does not meet the diversity of women's needs.

How health services separate and/or focus services for specific feeding behaviours, particularly breastfeeding, should be considered. Most breastfeeding women do not wish to have separate services from their formula feeding friends and peers, although a few primiparous women with formula feeding social networks value breastfeeding only groups. Current focus is on individual behaviour change and separate discussions around antenatal education, preparation and supporting breastfeeding. Care might be more effective if it focuses less on the individual woman and more on the selection and preparation of providers of care. Separation of roles amongst health professionals paying attention to the reported ambivalence of some staff towards breastfeeding and delayed introduction of solids, together with the personal attributes that women find helpful, might be more effective.

Consideration should be given to setting up specialist feeding teams, who provide consistent, continuous, high quality feeding care. For milk feeding the team should span pregnancy until the introduction of solids. For the introduction of solids the team should start at three to four months and continue throughout the Early Years. More research is required prior to this becoming policy as there are concerns about how this would fit with existing services. Specialist teams would need to offer a range of options at different times, places and with different delivery methods which embrace up-to-date communication technology. Specialist teams would have a set of core skills, including well developed communication and group skills, with access to a hierarchy of more specialised skills and resources, which would include a dietician for specialised advice on food allergies and infants who are reluctant to take solids.

Involving family and friends

There should be the option for wider involvement of the father, family members, or significant others in the different stages of infant feeding, including preparation in pregnancy, establishing breastfeeding on the hospital ward or at home, the early weeks and around 3-4 months prior to introducing solids and continuing thereafter. Individual and/or group sessions should be offered at times suitable for working parents, be interactive to meet differing needs and be facilitated by an individual with group facilitation skills.

Partners can be a key source of help for a woman adjusting to the change that occurs in running a family home and caring for a new baby. Paternity leave is very important for many and alternative help could be considered for families where partners are absent or have to return to work early and there is no other source of help. This is particularly important for women with older children who have nursery or school schedules, which can be a barrier to breastfeeding.

Feeding-friendly places

Places, including hospital wards, health service and non health service public and commercial places could make it easier for women to breastfeed and make later healthy feeding choices. Attention should be given to respecting the desire of many for privacy when breastfeeding in public places and providing more opportunities for parents to meet in relaxed, comfortable, nurturing surroundings to exchange experiences and actively feed. Accessible, familiar well-networked, multi-purpose places with provision of crèche facilities are a valued incentive to continue breastfeeding and to make healthy infant feeding choices. They provide a respite for parents who are struggling.

Postcodes as indicators of disadvantage

The Scottish Index of Multiple Deprivation (SIMD) http://www.scotland.gov.uk/Publications/2006/10/13142739/0 is not a reliable database for identifying disadvantaged child-bearing families in Grampian and Forth Valley and we would not recommend using it for targeting resources.

1. Introduction

1.1. Aims and Objectives

The aims of this study were:

- to explore the early infant feeding experiences of mothers and their significant others, including the support offered by others along a time-line, from the antenatal period until their infant is six months old
- to gather data to inform the development of interventions that will aim to improve the following outcomes: a) any breastfeeding b) exclusive breastfeeding c) the introduction of appropriate solids at six months d) parents' experiences of feeding their baby.

The objectives stated in the NHS Health Scotland Research Brief were:

- to explore mothers' perceptions/intentions and expectations in relation to infant feeding
- to ascertain when and how mothers made their infant feeding decisions
- to explore mothers' infant feeding experiences in the immediate postnatal period, i.e. immediately after delivery when still in hospital, and shortly after going home
- to "capture" the good and/or bad times, e.g. what were the "highs" and "lows" in relation to infant feeding problems and their resolution
- to identify the people and circumstances that facilitated/enabled infant feeding
- to identify the people/circumstances that "hindered" infant feeding
- to explore what, in their current experience could be done/approached differently by themselves and "significant" others, e.g. family, friends and/or professionals in relation to infant feeding
- to fully explore the nature of the supporting role of identified "significant others" and the part played by them in response to the new mother
- to explore early experiences of weaning, as and when this takes place and the nature of the support that mothers receive from others
- to make recommendations about interventions which would warrant further development and testing.

1.2. Policy context for infant feeding

UK governments endorse the World Health Organisation (WHO) recommendation of exclusive breastfeeding, with no other fluids or solids, not even water, for six months and continued for two years and beyond (World Health Organisation, 2003). Scottish policy highlights the importance of early infant nutrition in improving health outcomes and sees it as part of a broader aim of improving dietary health and wellbeing across the whole Scottish population. A HEAT national performance framework target has been set to increase the proportion of infants exclusively breastfeeding at six to eight weeks to 33.3% in 2010-2011 (Scottish Government, 2007). To help achieve this, £19 million was made available to NHS Boards over the period 2008-2011, as detailed in Chief Executive Letter 36 (2008), to improve the nutrition of women of

childbearing age, pregnant women and children under five in disadvantaged areas (Scottish Government, 2007). Effective interventions will need to be implemented, yet as summarised below, it is not clear from the evidence which interventions work best in the UK. The tragedy is that 12% of UK women cease to breastfeed in the first four days, with 22% stopping by two weeks and 37% by six weeks, yet nine out of ten of these women would have liked to have breastfed for longer (Bolling, Grant, Hamlyn, *et al*, 2007). There are also considerable health inequalities in how mothers feed their infants, with breastfeeding rates at six to eight weeks three times lower amongst mothers living in the most deprived areas compared to those living in the least deprived areas and mothers from disadvantaged areas also being more likely to introduce solid foods earlier (Bolling, Grant, Hamlyn, *et al*, 2007). Equally Well (Scottish Government, 2008)*,* The Early Years Framework (Scottish Government, 2008)*,* Getting it right for every child (NHS Quality Improvement Scotland, 2008) and Healthy Eating, Active Living (Scottish Government, 2008*)* reports emphasise the importance of addressing health inequalities and suggest targeting support to those most in need (Hallam, 2008). Recognising that inequalities in health, education and employment opportunities are passed from one generation to another, local and national governments have committed to break this cycle through prevention and early intervention to give every child in Scotland the best start in life. The Vulnerable Families Pathway Project is a multi-agency project being led by NHS Quality Improvement Service (QIS) on behalf of the Scottish Government. This framework is underpinned by the principles and practices of the Getting it Right for Every Child (NHS Quality Improvement Scotland, 2008) model to ensure that vulnerable children (from conception to age 3) and families in all parts of Scotland receive equity of support that is proportionate, effective and timely. The finished pathway will be available in October 2010.

Providers of maternity services currently have the greatest role in facilitating and supporting women's choice in feeding their baby. There are several maternity care initiatives in Scotland which intend, in part, to integrate infant feeding policy into maternity care provision and documentation. The Scottish Woman-Held Maternity Record (SWHMR) was launched across Scotland in January 2008 (NHS Quality Improvement Scotland, 2008) with the aim of supporting a more uniform approach to maternity care, and facilitating standardised information collection and documentation. The antenatal record incorporates The UNICEF Baby Friendly Initiative (UNICEF, 2007) antenatal breastfeeding checklist, while the postnatal record has a checklist for both bottle feeding and breastfeeding. These checklists state specific aspects of infant feeding to be discussed or demonstrated prior to birth and/or during the postnatal period and also suggest that parents use them to indicate their confidence with the aspect of care or task listed. The postnatal record also signposts the Ready Steady Baby book (NHS Health Scotland, 2010).

The Framework for Maternity Services in Scotland (Scottish Executive, 2001) and The Report of the Expert Group on Maternity Services (NHS Quality Improvement Scotland, 2007) both advocate "woman-centred care, with services and care tailored to need", and suggest that women with more complex needs should be cared for by a multidisciplinary team. From this, the Keeping Childbirth Natural and Dynamic (KCND) programme (NHS Quality Improvement Scotland, 2010) was set up to ensure that the birth experience is as natural as possible. This programme also recognises the midwife as the lead professional for most low risk women. Although

the focus of KCND appears to be more on pregnancy and birth, it does promote evidence based care and information, encourage informed choice and has developed multi-professional care pathways. However, the KCND programme appears to have paid little attention to breastfeeding and has not specifically identified a pathway for caring for breastfeeding women or for other aspects of infant feeding following birth. The Antenatal (AN) pathway, which outlines a plan of antenatal visits and care needs, indicates that attention should be paid to the antenatal breastfeeding checklist in the SWHMR notes at the 2nd antenatal visit (gestational weeks 8-12) and then again at the 7th visit (gestational weeks 34-36). The Postnatal Pathway is split into three parts: the "1st hour; up to the 2nd day; and 2 days and beyond". Postnatal care emphasises continuity of care/carer, recommending documented, individualised care plans for both the mother and baby. The separation of the mother and baby within the postnatal pathways makes the appropriate management and documentation of infant feeding less clear. In the 1st hour skin to skin contact and initiation and support for "chosen method of feeding" are encouraged. On day 1, low risk mothers (green pathway) should be offered on-going feeding support and advice and one full breastfeed should be observed. Women with more complex needs are assigned to either the amber or red pathway and there is no mention of infant feeding in these. The infant is also assigned to a pathway where the "green" pathway includes advice and support on feeding and information on formula feeding as required. From day 2 onwards there is little information on breastfeeding other than ensuring documentation is complete and referring to available support "if required". Infant weight loss of >10% should trigger specialist breastfeeding advice or referral to a paediatrician. Better Health, Better Care (Scottish Government, 2007) makes specific reference to KCND objectives (NHS Quality Improvement Scotland, 2010), and highlights the potential for impacting on health inequality through early risk assessment, tailored antenatal care and maximising opportunities for building early relationships with families antenatally.

The Scottish Government also endorses the National Institute of Health and Clinical Excellence Postnatal Care Guideline (NICE, 2006) for providers and NHS premises to adopt UNICEF Baby Friendly Standards (UNICEF, 2007) thus ensuring the implementation of evidence based practice within Scotland's health boards. UNICEF Baby Friendly Standards for higher education have also been adopted by some institutions providing undergraduate midwifery education programmes. The Nursing and Midwifery Council, which regulates midwifery education, has identified a specific "essential skills cluster" which outlines the teaching and learning requirements for undergraduate education programmes for supporting the initiation and continuation of breastfeeding (Nursing and Midwifery Council, 2009).

Health professionals play an important role by supporting applications for the Healthy Start scheme which helps low income families by providing vouchers for free fresh milk, infant formula, fresh fruit and vegetables to young children and pregnant women, as well as free vitamin supplements. Eat well, be well (The Food Standards Agency, 2010), Recipe for Success: Scotland's National Food and Drink Policy (Scottish Government, 2009) and The Scientific Advisory Committee on Nutrition (2010) all recommend sustainable, affordable and accessible healthy food options with reductions in the levels of saturated fat, salt and calories in food products for infants and young children. A leaflet, Fun First Foods (NHS Health Scotland, 2010)

promoting timely introduction of healthy solid foods was launched by the Scottish Government in 2010.

1.3. Background evidence

1.3.1. Breast and formula milk feeding

There is an increasing body of evidence demonstrating the health benefits of breastfeeding including reduced risk of breast and ovarian cancers for the mother and gastrointestinal and respiratory tract infections in the baby (Horta, Bahl, Martines, *et al*, 2007; Ip, Cheung, Raman, *et al*, 2007). Several studies and policy documents highlight the link between breastfeeding and a reduced risk of childhood obesity however, recent analysis suggests that the association is unlikely to be causal (Han, Lawlor, and Kimm, 2010).

Systematic review evidence for interventions that increase the initiation of breastfeeding suggests that multi-faceted interventions are most likely to be effective (Dyson, McCormick, and Renfrew, 2008). The Baby Friendly Hospital Initiative (UNICEF, 2007) is one such example, which is being widely implemented in Scotland, and was shown to improve the duration of breastfeeding in Belarus (Kramer, Chalmers, Hodnett, *et al*, 2001), however, in the UK, only the initiation of breastfeeding appears to be increased, and possibly sustained until five days (Bartington, Griffiths, Tate, *et al*, 2006; Broadfoot, Britten, Tappin, *et al*, 2005; Hoddinott, Britten, Prescott, *et al*, 2009). Despite strong associations between attending antenatal breastfeeding education sessions or classes and initiating breastfeeding (Bolling, Grant, Hamlyn, *et al*, 2007; Growing up in Scotland Study, 2010), there is no evidence from systematic reviews of randomised controlled trials that this is a cause and effect relationship (Gagnon, 2007). Attending antenatal education sessions is associated with higher educational level, socio-economic status and maternal age, which have all been found to be independent predictors of breastfeeding (Bolling, Grant, Hamlyn, *et al*, 2007). Systematic reviews (Britton, McCormick, Renfrew, *et al*, 2007; Duijts, Ramadhani, and Moll, 2009; Palda, Guise, Wathen, *et al*, 2009; Chung, Raman, Trikalinos, *et al*, 2008; Hannula, Kaunonen, and Tarkka, 2008) have repeatedly demonstrated that additional lay or professional support in other countries can increase the exclusivity and to a lesser extent the duration of breastfeeding, particularly if interventions span pregnancy to the postnatal period. However, UK randomised controlled trials of additional peer, professional and group support, have disappointingly failed to improve breastfeeding outcomes (Graffy, Taylor, Williams, *et al*, 2004; Hoddinott, Britten, Prescott, *et al*, 2009; Lavender, Baker, Smyth, *et al*, 2005; Morrell, Spiby, Stewart, *et al*, 2000; Muirhead, Butcher, Rankin, *et al*, 2006 ; Winterburn, Jiwa, and Thompson, 2003).

Additional professional support appears to have a greater effect on the duration of breastfeeding than additional lay support (Britton, McCormick, Renfrew, *et al*, 2007), although a later systematic review in primary care questions this (Chung, Raman, Trikalinos, *et al*, 2008). A qualitative synthesis suggests that many women value social network support more than health professional support, although the need for skilled help in the early days is acknowledged (McInnes and Chambers, 2008). Continuity of care, consistent advice and women-centred communication styles

which are responsive and personalised have been highlighted as important in several UK studies (Dykes, 2005; Finlay and Sandall, 2009; Hoddinott and Pill, 2000).

"Breast is best" remains the dominant discourse in the UK and this influences how women defend the decisions they make, and can lead to feelings of guilt or a sense of failure (Lee, 2008; Murphy, 1999; Shaw, Wallace, and Bansal, 2003). For some the embodied experience of breastfeeding is connected, harmonious and pleasurable; for others, it is disruptive, unpleasant and violent (Schmied and Barclay, 1999). "Not enough milk" is one of the commonest reasons given for stopping breastfeeding (Bolling, Grant, Hamlyn, *et al,* 2007) and this may be a metaphor for low maternal confidence (Dykes and Williams, 1999; Hoddinott and Pill, 1999a; Hoddinott and Pill, 2000). Decisions made by relatively disadvantaged women are more likely to be based on embodied knowledge gained from seeing breastfeeding and personal or vicarious experience than rationally weighing up the advantages and disadvantages (Hoddinott and Pill, 1999b). UK studies have revealed a dissonance between the roles of breasts for feeding and as sexual objects (Bailey and Pain, 2001) and portray breastfeeding as a marginal activity (Mahon-Daly and Andrews, 2002). Spaces and places that are conducive to breastfeeding are often hard to find and can undermine breastfeeding initiatives and health promotion messages (Dykes, 2006; Hoddinott, Britten, and Pill, 2010; Mahon-Daly and Andrews, 2002). The Breastfeeding (Scotland) Act introduced in 2005 makes it an offence to prevent or stop a person in charge of a child under the age of two years, who is otherwise permitted to be in a public place, from feeding milk to that child. In the same year a UK survey of 7186 mothers found that Scottish residents had the most positive experiences of breastfeeding in public (Bolling, Grant, Hamlyn, *et al*, 2007). However, many women still find it embarrassing to breastfeed outside the home or even within the home in the presence of others (Mahon-Daly and Andrews, 2002). Expressing breast milk is common. It is a way of managing pain, enhancing the bonding process, while for others it provides freedom for the mother managing breastfeeding in public (Johnson, Williamson, Lyttle, *et al*, 2009; Morse and Harrison, 1988). However, for some mothers it is perceived with disgust as a mechanical and messy process and associated with embarrassment (Morse, 1992).

Women's experiences of formula feeding have received less research attention than breastfeeding. One systematic review highlights the guilt, uncertainty and sense of failure that women who bottle feed can experience (Lakshman, Ogilvie, and Ong, 2009). It also reports inadequate information about formula milk and a lack of evidence about how women decide quantities and frequencies of formula milk, confirming findings from an earlier Scottish survey (Cairney and Alder, 2001). It is argued that in the current "breast is best" culture, women who formula feed often have to struggle to maintain a positive sense of themselves as good mothers (Lee, 2008; Murphy, 1999). Defiance and defensiveness are described, with information overload about breastfeeding. Mixed feeding with flexible, partial and minimal breastfeeding, to allow the mother to separate from the baby (Morse and Harrison, 1988) has increased over recent years (Bolling, Grant, Hamlyn, *et al*, 2007; Information and Statistics Division, National Health Service Scotland, 2010).

The National Institute for Health and Clinical excellence guidance for postnatal care (NICE, 2006) recommends providing mothers and their partners or companions with information. The knowledge and attitudes of fathers can influence the breastfeeding

decisions that women make (Rempel and Rempel, 2004; Scott, Binns and Aroni, 1997), however, research in Scotland suggests that paternal attitudes are not an independent predictor of breastfeeding and that maternal attitudes are key (Scott, Shaker and Reid, 2004). Randomised controlled trials of including fathers in pre-natal education are inconclusive, with one trial of separate classes for men effective (Wolfberg, Michels, Shields, *et al*, 2004) whereas combined classes have mixed results and no trials have been conducted in the UK (Hoddinott, 2008). Involving the partner and family members when learning how to breastfeed can be valuable (Ingram, Johnson and Greenwood, 2002), however, integrating this into UK maternity services, was found not to be feasible in a Bristol study (Ingram and Johnson, 2004). In Sweden, infants of fathers with lower socio-economic status and who did not take paternity leave had significantly shorter duration of breastfeeding (Flacking, Dykes and Ewald, 2010), which confirms global research suggesting that parental leave can impact on breastfeeding duration (Tanaka, 2005). In an Australian survey, satisfaction with support provided by partners and others declined over the first six months after birth; with women experiencing difficulties integrating motherhood with other roles, like household chores, social activities, self care and work (McVeigh, 2000).

Australian research highlights challenges and dilemmas for grandmothers supporting daughters and negotiating interactions with the new family, trying not to jeopardise relationships and access to grandchildren (Reid, Schmied and Beale, 2010). Only offering advice if asked, just being there, helping new mothers to learn to do it for themselves and filling the void of health professional support were identified themes. UK research of teenage mothers suggests that grandparents can undermine their breastfeeding experiences overtly or covertly through non-verbal cues (Lavender, Thompson and Wood 2005) and conflicting advice is common (Hall Moran, Edwards, Dykes, *et al*, 2007). Particularly, new urban mothers may be more independent of their own mothers than previous generations and depend more on horizontal networks with peers, professionals and the media (Lamm, Keller, Yovsi, *et al*, 2008; Reid, Schmied and Beale, *et al*, 2010). The Growing Up in Scotland Survey (2010) suggests that an increasing number of grandparents may be involved in childcare in Scotland, and a multi-layered approach to learning and support for breastfeeding including grandmothers, significant others and personal midwives has been recommended (Lavender, Thompson, *et al,* 2005; Reid, Schmied and Beale, *et al,* 2010). However, UK antenatal education trials including grandmothers (Winterburn, Jiwa, and Thompson, 2003) and women with their personal midwife (Lavender, Thompson and Wood, 2005; Reid, Schmied and Beale, *et al*, 2010) were ineffective. Peer support is important and can be categorised into informational, emotional, appraisal and instrumental support (Dennis, 2003). However, less is known about how mothers needs for these different types of support change during the infant feeding journey from pregnancy through to introduction of solids and we know even less about the needs of fathers and significant others.

1.3.2. Introducing solids and other liquids

There have been no Cochrane systematic reviews of the evidence on how the timing of the introduction of solid foods or other non-milk fluids influences health outcomes in developed countries and there have been few interventions studies in this area. Most of the research into introduction of solids focuses on the continuation of

exclusive breastfeeding until six months, then introduction of solids with continued breastfeeding until 2 years in accordance with the WHO Guidelines (2008). Findings from the Millennium Cohort Study suggest that breastfeeding reduces hospital admissions in the first eight months, but that early introduction of solids has no effect (Quigley, Kelly, and Sacker, 2008). Evidence from a recent systematic review suggests that high energy intake in early infancy and high consumption of sweetened drinks in childhood are prospectively associated with raised childhood obesity risk (Osei-Assibey, Dick, Macdiarmid, *et al*, 2010). There is evidence that more rapid increases in weight for length in the first six months of life are associated with an increased risk of obesity at three years of age (Taveras, Rifas-Shiman, Belfort, *et al*, 2009). Feeding frequency and maternal sensitivity to feeding cues of hunger and satiety have been implicated in rapid weight gain (Worobey, Islas Lopez, and Hoffman, 2009). A UK study, analysing the content of internet posts on introducing solids in an educated sample of women, found poor adherence to guidelines, with inconsistent advice from health visitors and poor support (Arden, 2010). Women are more likely to be influenced by their social network than health professionals, with a minority conforming to recommendations and wishing "not to do the wrong thing" (McLorg and Bryant, 1989). In a survey conducted in Forth Valley, the early introduction of solids was found to be associated with: the opinions of the infant's maternal grandmother; living in a deprived area; personal disagreement with the advice to wait until the baby was four months old; lack of encouragement from friends to wait until the baby was four months old; being in receipt of free samples of manufactured food (Alder, Williams, Anderson, *et al*, 2004). Early introduction of solids is commonly linked to signs of hunger from the baby, including going less time between feeds, drinking more milk, increased waking at night, low weight or a reduced rate of weight gain, agitation, and an increased interest in food (Anderson, Guthrie, Alder, *et al*, 2001; Arden, 2010; Synnott, Bogue, Edwards, *et al*, 2007; Wright, Parkinson, and Drewett, 2004).

1.4. Research stages and methods

The following definitions were used in the study. Breastfeeding initiation refers to the baby receiving any breast milk, even if only once. Exclusive breastfeeding is measured for the preceding 24 hours and is where the infant has received only breast milk and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines (World Health Organisation, 2008). We have not used the term "weaning" as it can have different meanings. Instead, we refer to the introduction of solids and stopping breastfeeding. Introduction of solids was defined as the first ever solid food offered to and taken by the baby, even if it was only a small amount.

Prior to birth, participants are referred to as women and their partners. All references to relationships are in relation to the baby. "Father" refers to the father of the baby; "mother" refers to the mother of the baby; "grandmother" refers to the grandmother of the baby. References to the "in-laws" include the partner's parents when the couple is not married.

Approval was obtained from the North of Scotland Research Ethics Committee and from NHS Grampian and NHS Forth Valley for Research and Development (R+D) (see Appendix 1). In August 2009, we identified women due to give birth between 1st

September and 31st October 2009 in Site 2 and between 11th September and 31st October 2009 in Site 1 from maternity unit databases. We identified a cohort of 459 women booked for birth at Site 1 Maternity Unit and a cohort of 533 booked for delivery at Site 2 Maternity Unit. Our aim was to recruit 75% of our interview sample from women living in more disadvantaged postcodes, as these women are the least likely to initiate and sustain breastfeeding. We used the 2006 Scottish Index of Multiple Deprivation (SIMD) to identify women living in disadvantaged postcode areas (Office of the Chief Statistician, 2006). On the SIMD website SIMD 1 is the most disadvantaged quintile, SIMD 5 is the most advantaged quintile.

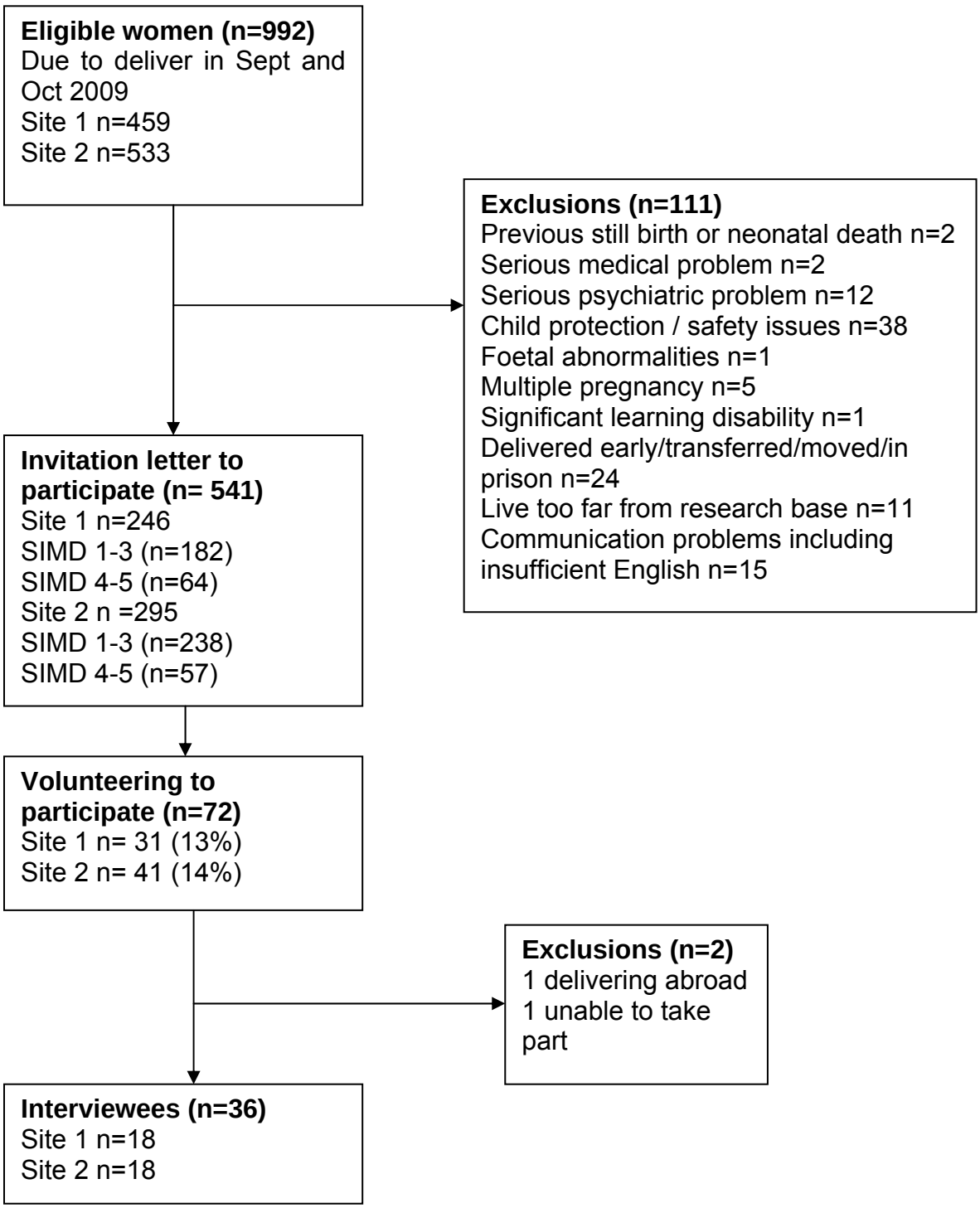
We purposively selected all women from the birth cohorts living in SIMD 1-3 postcode areas (Office of the Chief Statistician, 2006) and a smaller convenience sample, (to minimise research team travel) of women living in SIMD 4-5 postcode areas. These women were sent an invitation letter to participate in the study with an information leaflet, a short opt-in questionnaire and free post return envelope. Invitation letters were sent out on maternity unit headed paper and signed according to local protocols by a consultant obstetrician and the head of midwifery services. Invitation letters were sent in three stages at Site 2 and two stages at Site 1 as described below. Analysis of the responses from this first stage revealed fewer responses from women living in SIMD 1 and 2 postcode areas and younger mothers, so subsequent stages purposively targeted these groups. The researchers met with midwives and health visitors to inform them about the study, so that they could discuss participation with women, particularly those living in more disadvantaged areas who are acknowledged to be more challenging to recruit to research projects.

Figure 1.1 summarises recruitment to the study. At Site 2, of the 263 women due to give birth in September 2009, 26 were excluded (see Figure 1.1) and of the remaining 237, two hundred were mailed. These two hundred women consisted of all women living in SIMD 1, 2 and 3 postcode areas (162:81%) and a sample of 38 (19%) living in SIMD 4 and 5 postcode areas. In stage 2, of the 270 women due to give birth in October 2009, 63 women were purposively selected who lived in SIMD 1 and 2 postcode areas and who were aged twenty-nine years or under. In stage 3, 45 women were selected living in SIMD 1 – 5 postcode areas, aged <35 years and due to give birth between 21st and 31st October 2009. Of the 108 women due to give birth in October, 13 were excluded and 95 were invited, giving a total Site 2 mailing of 295 with 238 (81%) of invitations sent to women living in SIMD 1-3 postcode areas.

At Site 1, initially, 348 women due to give birth between 11/09/09 and 31/10/09 were identified and 63 were excluded (see Figure 1.1). Of the remaining 285, 233 were mailed. These 233 women consisted of all 169 (73%) women living in SIMD 1, 2 and 3 postcode areas, and a sample of 64 (27%) living in SIMD 4 and 5 postcode areas. In stage 2, an additional 111 women due to give birth by 31st October were identified. Nine of these women were excluded (see Figure 1.1) and in an attempt to recruit more disadvantaged women all women living in SIMD 1 – 3 postcode areas were mailed (n=13), giving a total Site 1 mailing of 246 with 182 (74%) sent to women living in SIMD 1 - 3 postcode areas.

We received 72 (13%) responses; with 41 completed opt-in forms from Site 2 and 31 from Site 1 (see Appendix 2). The majority of women volunteering intended to breastfeed and were more educated and less disadvantaged than we had hoped.

Figure 1.1 Recruitment flow chart



Women living in more disadvantaged postcode areas (SIMD 1-3) who volunteered to participate in this study had often left school aged nineteen or over or had managerial, professionals or technical occupations and therefore it was difficult to ascertain their level of disadvantage (see Appendix 2).

From the seventy-two respondents, two withdrew (see Figure 1.1) and thirty-six women were purposively sampled using a sampling frame: twenty-six (72%) from disadvantaged postcode areas (SIMD quintiles 1 – 3), and ten (28%) from SIMD quintiles 4 and 5. We purposively selected participants who intended to breastfeed (35/36); with one woman who had previously breastfed, but intended to formula feed this baby. We purposively sampled a range of maternal ages and parity: primiparous (n=19) and multiparous women (n=17). For respondents living in the more advantaged postcode areas (SIMD 4 and 5), we sampled those where either the woman or her partner had a lower age of leaving full time education or a non professional occupation. We also purposively selected immigrants, as it can be argued that their immigrant status contributes to disadvantage. Table 1.1 shows the sampling frame and the characteristics of women selected for interview.

The research team has considerable experience of qualitative research and consists of a public health nutritionist and a former breastfeeding voluntary sector worker who recruited and interviewed families, and a general practitioner and a midwife who were involved in all other aspects of the study apart from interviewing. Interviews commenced in mid August 2009 and were semi-structured, using topic guides that were modified over the course of the study to probe in more depth emerging themes and to search for disconfirming data. At the end of each interview, researchers completed a significant other form with each woman (see Appendix 3). The purpose of this form was a) to capture the characteristics (age, relationship, distance from the family and feeding experience) of the significant others mentioned in the preceding interview; b) to triangulate the interview data for significant other influences on feeding decisions (see Chapter 3). Similarly researchers completed a feeding behaviour form with each woman based on the Office for National Statistics five yearly UK surveys (Bolling, Grant, Hamlyn, *et al*, 2007), to ensure accurate data was collected about breastfeeding duration, exclusivity, introduction of non-milk liquids and solids.

Interview timings were negotiated between the mother, her significant other (if they were being interviewed) and the researcher. Data collection and analysis progressed iteratively, with all members of the research team involved in listening to interview recordings, reading transcripts, identifying research themes and modifying topic guides according to the emerging analysis. All interviews were transcribed and were entered as data units onto Framework software (National Centre for Social Research, 2010). The four members of the research team independently constructed a thematic index based on reading a sample of six information rich antenatal and first postnatal interviews, modifying it when analysing later postnatal interviews covering introduction of solids. The research team met and through discussion reached a consensus on the final thematic framework (see Appendix 4) to be used to organise, index, label and summarise data using Framework software. Analysis proceeded to identify interpretive themes through creating Framework charts and through research team discussion. Framework is a rigorous, systematic data management tool, which

allows original data and researcher interpretations to be transparently documented (Ritchie and Lewis, 2003).

Table 1.1 Recruitment sampling frame and characteristics of participants selected for interview (n=36)

Site 1																
Scottish Index of Multiple Deprivation (SIMD)	Feeding intention in pregnancy		Maternal age				Maternal age at leaving full time education				Maternal occupational classification [$]				Parity	
	Breast feed	Formula feed – but previously breastfed	≤20	21-30	31-40	41≥	≤16	17	18	19≥	1-3	4-6	7-9	Not employed	Para 0	Para 1≥
SIMD 1-3	13	0	0	3	8	2	1	1	3	8	6	4	2	1	6	7
SIMD 4-5	5	0	0	1	3	1	0	0	0	5	4	1	0	0	3	2
Site 2																
Scottish Index of Multiple Deprivation (SIMD)	Feeding intention in pregnancy		Maternal age				Maternal age at leaving full time education				Maternal occupational classification [$]				Parity	
	Breast feed	Formula feed – but previously breastfed	≤20	21-30	31-40	41≥	≤16	17	18	19≥	1-3	4-6	7-9	Not employed	Para 0	Para 1≥
SIMD 1-3	12	1	2	3	8	0	0	4	1	8	4	6	3	0	8	5
SIMD 4-5	5	0	1	1	3	0	3	1	0	1	2	2	0	1	2	3

* Scottish Index of Multiple Deprivation 2009. Available at: www.scotland.gov.uk/Topics/Statistics/SIMD/
SIMD 1 is the most deprived quintile. SIMD 5 is the least deprived quintile
[$]Standard Occupational Classification (SOC 2000) taken from the 2000 Census. Available at: www.ons.gov.uk/about-statistics/classifications/current/SOC2000/about-soc2000/index.html

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

Box 1.1 Intervention vignettes used in the final interview

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

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

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

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

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

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

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

We compared couples with differing attributes, e.g. primiparous compared with multiparous; early cessation of breastfeeding compared with late cessation; early introduction of solids compared to late introduction; differences in the level of father or significant other involvement with infant feeding. At the end of the final interview, vignettes of different infant feeding care scenarios were given to participants to read and comment on (see Box 1.1). These vignettes were designed as research tools to further the development of interventions for future research. They were not intended to be actual stand alone interventions. They emerged from a combination of systematic review evidence and the emerging data analysis. Concepts taken from existing systematic review evidence included: interventions spanning before and after birth (Chung, Raman, Trikalinos, *et al*, 2008), proactive rather than reactive care (Dennis and Kingston, 2008), additional peer or professional support and interactive

experiential learning from peers (Britton, McCormick, Renfrew, *et al*, 2007). Given that multi-faceted interventions seem more promising than isolated components, several of the vignettes were multi-faceted. The vignettes were explained as scenarios put together by the research team about help which might be offered with baby feeding, based on what we have heard from women and their families. Participants were asked to read and comment on each in turn, although not all vignettes were given to each participant due mainly to time constraints and on a few occasions due to known sensitivity to a specific topic which might potentially upset the participant. Initial spontaneous responses or hesitations and non-verbal communication were noted and probed in a reflective cognitive interviewing style for example "you seemed to hesitate there…" They produced rich data, including retrospective reflections on earlier accounts which sometimes differed from accounts at the time, had been rationalised, normalised or explained over the course of this longitudinal interview study. Differences and changes in accounts were explored by the interviewers. The vignettes can be viewed as a reflective and summative perspective on the whole feeding journey. A few had experienced vignettes A, D and T and conceptually these were less challenging for participants to identify with and tended to provoke instantaneous responses. Vignette C was more conceptually difficult to grasp for some as it entailed health service re-organisation rather than an add-on component of care. Some expanded early vignettes to include aspects of later vignettes, thus generating additional facets to the intervention. For others, there was an iterative discussion, with modification of view points as pros and cons were discussed between participants, with interviewer prompts, with some moving back and forth between different vignettes, highlighting the complexity of finding a single intervention which suits.

The study website http://babyfeedingtalk.com was set up prior to recruiting to the study and was intended as an alternative for both study participants, their significant others and invitees who chose not to participate, to contribute their views through a discussion forum. Table 1.2 shows the topics to which those accessing the website were invited to contribute. However, only twenty-five people registered with the website and seven more created an account, but did not complete the online questionnaire. Researchers reminded participants about the website at interviews. Some reported that they had not found time, others that the low number of posts was off-putting, participants preferred face-to-face or telephone interviews with the researcher and some commented that it might have been more popular if it was part of a larger more active website like Scotmums or Netmums. In view of the low website activity, we concentrated researcher time on collecting qualitative interview data from participants.

Table 1.2 Researcher posted topics on the website

Topic	Number of responses
Getting started with feeding the baby	4
Help, or hindrance, with baby feeding	1
Information about baby feeding	5
Information about what to eat during pregnancy	5
Starting your baby on solids	1

In this report, part A (see Chapters 2 and 3) presents the study sample characteristics. Part B (see Chapters 4-7) covers milk feeding, from antenatal

intentions and expectations (see Chapter 4) to actual experiences of care from the health service, and from family, friends and the voluntary sector (see Chapters 5 and 6). Chapter 7 summarises adaptations and strategies used to maximise maternal, baby and family wellbeing during the milk feeding stage. Part C (see Chapters 8-10) covers solids and non-milk fluids. Chapter 8 reports family decision making and strategies for introducing solids and Chapter 9 considers expectations and reality in relation to health service care at this stage. Chapter 10 considers maternal and family diet and attitudes to childhood weight gain and obesity. Part D (see Chapters 11-12) summarises the infant feeding journey as a whole from pregnancy until 6 months after birth. Chapter 11 looks at what would make a difference to families' infant feeding experiences, summarising findings and drawing on additional data from the analysis of vignettes used at final interviews. Chapter 12 discusses some of the strengths and limitations of this study.

Quotations from interviewees to support our findings are followed by a reference, for example (2789; PN1; mother; baby two weeks old). The 4 digit number is the mother's study number which can be cross referenced to her feeding characteristics (see Table 2.2) and to the significant others who influence her infant feeding decision making (see Appendix 5). The next abbreviation gives the time of the interview, with AN for the antenatal interview, PN for postnatal interviews. Postnatal interviews are numbered chronologically starting with PN1, and ending with PNF, referring to the final interview which took place from 24 weeks onwards, and with PNV referring to the vignettes which were introduced at the end of the final interview. The interviewee is listed third, and finally the baby's age at the time of the interview. To protect confidentiality study sites and all quotations have been anonymised

Part A: Sample Characteristics

2. Socio-demographic and feeding characteristics

In this chapter we describe the characteristics of our sample of thirty-six families who were recruited to the study. The central focus and first point of contact in this study was always the woman, who we refer to as the index case. Table 2.1 provides a summary of the 220 interviews that took place, with each woman interviewed between two and eight times in total. Two families withdrew from the study after the first postnatal interview; both mothers had stopped breastfeeding in the first week. The remaining thirty-four families were each interviewed over a seven to eight month period. There were sixteen partners, eight mothers and one sister who were nominated as significant people influencing feeding decisions and who participated in interviews. Two health visitors were nominated as significant influences on feeding decisions by three women were each interviewed once alone.

Table 2.1 Interview summary

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

34/35 antenatal, 34/36 first postnatal interviews in weeks one to four and the 34 final six month interviews were face-to-face, usually at the woman's home. In negotiation with families, we aimed to interview at four weekly intervals following the initial postnatal interview and most of these interviews were conducted by telephone. A few (n=11) were face-to-face if English was a second language; by participant choice or where interviewers felt that it would be difficult to conduct a telephone interview.

The socio-demographic characteristics and feeding outcomes of the study women are detailed in Table 2.2.

Table 2.2 Summary of interviews and feeding outcomes

Study no.	Maternal age	Age at leaving education	SIMD	Parity	Type of delivery	Formula introduced	Non-milk fluids introduced	Solids introduced	Breastfeeding stopped	No. of interviews
1010	21-30	19 or over	3	Multip	Elective C/S	Weeks 5-6		17-20 weeks	Weeks 21-24	6
1033	21-30	19 or over	5	Primip	SVD	Weeks 13-16		17-20 weeks		6
1040	31-40	19 or over	5	Multip	SVD	Weeks 3-4	Weeks 21-24	21-24 weeks	Weeks 21-24	6
1044	31-40	19 or over	4	Primip	Emergency C/S	Week 1	Week 2	>24 weeks	Week 1	6
1054	31-40	19 or over	3	Multip	SVD	Week 1	Weeks 3-4	21-24 weeks		5
1056	41 or over	19 or over	5	Multip	SVD	Weeks 21-24	Weeks 21-24	>24 weeks		6
1057	31-40	18	2	Primip	SVD	Week 1	Weeks 17-20	17-20 weeks	Weeks 9-12	6
1075	31-40	19 or over	1	Multip	SVD	Week 2		21-24 weeks		6
1094	31-40	19 or over	5	Primip	SVD	Weeks 7-8		17-20 weeks		6
1108	31-40	19 or over	3	Primip	Forceps or ventouse		>24 weeks	>24 weeks		6
1148	31-40	19 or over	2	Multip	Elective C/S	Weeks 17-20	>24 weeks	17-20 weeks		6
1167	21-30	19 or over	1	Primip	Emergency C/S	Week 1	Weeks 3-4	>24 weeks	Weeks 3-4	4
1173	41 or over	19 or over	2	Primip	Emergency C/S	Week 1	Weeks 3-4	>24 weeks	Weeks 3-4	6
1176	21-30	19 or over	3	Primip	SVD		Weeks 21-24	21-24 weeks		6
1188	31-40	18	3	Multip	Emergency C/S	Weeks 9-12				5
1208	31-40	16 or under	3	Multip	SVD	Week 1	Week 2	17-20 weeks	Weeks 9-12	5
1210	41 or over	18	2	Multip	Emergency C/S	Week 1	Weeks 21-24	21-24 weeks		5
1226	31-40	17	1	Primip	Emergency C/S	Week 2	Weeks 9-12	17-20 weeks	Weeks 17-20	5
2003	31-40	16 or under	5	Primip	SVD	Week 1			Weeks 3-4	8
2020	31-40	19 or over	2	Multip	SVD	Weeks 13-16	Weeks 17-20	17-20 weeks		8
2037	21-30	17	4	Multip	SVD	Weeks 9-12	Weeks 17-20	21-24 weeks	Weeks 21-24	6
2039	31-40	19 or over	3	Primip	SVD	Week 1	Weeks 9-12	>24 weeks	Weeks 3-4	7
2047	31-40	19 or over	2	Multip	SVD	Week 1			Did not start	7
2056	31-40	18	2	Multip	SVD		Weeks 17-20	17-20 weeks		8
2057	31-40	19 or over	1	Primip	SVD			16 weeks or less		7
2061	31-40	17	3	Primip	Elective C/S	Week 1	Weeks 5-6		Weeks 5-6	8
2103	21-30	19 or over	3	Primip	SVD		Weeks 13-16			8
2128	20 or under	17	1	Primip	Forceps or ventouse	Week 1	Weeks 21-24	17-20 weeks		6
2169	31-40	19 or over	3	Multip	SVD	Weeks 13-16		16 weeks or less		7
2181	21-30	17	2	Primip	Emergency C/S	Week 1	Weeks 5-6	17-20 weeks	Week 1	8
2192	31-40	17	1	Multip	SVD	Weeks 5-6	Weeks 21-24	21-24 weeks	Weeks 21-24	7
2203	20 or under	19 or over	2	Primip	SVD	Week 1			Week 1	2
2255	21-30	19 or over	1	Primip	Emergency C/S	Week 1	Week 2		Week 1	2
2287	20 or under	16 or under	4	Multip	SVD	Weeks 3-4	Week 1	16 weeks or less	Weeks 7-8	5
2294	31-40	16 or under	5	Primip	SVD	Week 1	Weeks 7-8	16 weeks or less	Weeks 21-24	7
2295	21-30	19 or over	4	Multip	SVD	Weeks 5-6	Weeks 13-16	16 weeks or less		6
HV1										1
HV2										1
										220

3. Significant others involved in the infant feeding journey

In chapter 3, we consider the significant others who influence women's feeding decisions. To triangulate and add rigour to our qualitative interview data, we systematically collected information about the characteristics of these significant others (see Appendix 3). The data (see Appendix 5) show a complex pattern of changing influences through the course of the infant feeding journey. Some women found the question about significant others difficult to answer. Some describe themselves and the baby as the main or only influence on decisions, and where this is the case we have noted it in the tables. At one extreme, some women describe very small social networks. At the other extreme, some describe a much larger social network influencing infant feeding decisions. There are differences in the stability of social networks, with some changing considerably during the journey from pregnancy to six months and others remaining relatively stable throughout. Distance from significant others also varies, with more geographically mobile families having more dispersed networks. There are marked differences in the number of significant others between the two research sites, with women at Site 1 reporting far more than Site 2 throughout the study. This could be explained by differing interview styles. However, our qualitative data collection protocol standardised the wording used by interviewers when introducing the significant other form to minimise this. It may also reflect a wider network of family and friends with breastfeeding experience available as influences at Site 1 or other cultural differences. Overall, having researchers from different backgrounds collecting data in two very different areas in Scotland adds rigour to our study and assisted with our search for disconfirming data in accordance with a grounded theory approach to qualitative research. Health professionals were spontaneously raised by some as significant and not by others, although all participants discussed their relationships with health professionals in the interviews. The child bearing and feeding history of health professionals was often unknown. Health professionals were noticeably less influential at Site 2 than at Site 1 at the six month stage, possibly reflecting the fact that solids had already been introduced by almost all families at Site 2 by this time, so the time for influence had passed.

There were some inconsistencies between accounts in the interviews and how women responded when the interviewer completed the significant other form. One striking example is when interviewing a couple, the father was not mentioned by the woman as a significant influence until after 2 friends, then she apologised and mentioned him. There are other examples, where accounts were given of conversations with friends, relatives or health professionals in the interview, which our interpretation of the transcript might consider a significant influence, yet they might not be named as significant at the end. For example, one mother reported discussing introducing solids with her health visitor and being told it was too early to start. She took this advice but did not record the health visitor as significant on the form at the end of the interview. This reveals the differing perspectives and triangulation that semi-structured qualitative interviewing and more closed questions can provide on data interpretation, and it can be argued that this is strength of a mixed method approach.

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Part B: Breast and formula milk

4. Intentions and expectations in pregnancy

In this chapter we consider the decision about whether to breast or formula feed. We look at when and how the decision is made, the intended duration and exclusivity of breastfeeding and the people and factors which influence the decision, including health service personnel and information.

4.1. Initiating breastfeeding

Many women cannot precisely time when they decide to breastfeed and some refer to “always”, implying a deeply rooted cultural instinct. Some recount childhood stories or work experiences of seeing breastfeeding as influential, confirming previous research (Hoddinott and Pill, 1999b). For many, feeding decisions are complex and although parents often cite “breast is best” as their reason for choosing to breastfeed, health or bonding are not always the meaning attributed to “best”. The mother‘s image; “having bigger breasts for a while”, losing weight, cost, convenience and the value of being the only person who can give breast milk: “it’s just me and the baby” are also cited, agreeing with an earlier longitudinal study of infant feeding (Murphy, 1999).

Many women state that it is their own decision to breastfeed, “an individual thing” and relate it to mother and baby emotional wellbeing, rather than the health benefits (Hoddinott and Pill, 2000):

> “you just have to do whatever makes you happy and makes your baby happy, which is completely different for everybody” (1040; AN; woman).

Some women are sceptical and distance themselves from the health benefits by relating them in the third person:

> “they do say it's more nutrients or it's more healthy balance; but when you actually look at the back of the tin to what they say is actually in your breast milk, I think it pretty much evens out. And it also depends on your diet doesn't it?” (1010; AN; woman).

Some are cynical about the benefits, as they link the quality of breast milk to their own health or unhealthy lifestyles, particularly diet. Some express feeling a moral pressure to breastfeed (Lee, 2008; Ryan, Bissell, and Alexander, 2010), being “looked down on” if you don’t try. “I will see how it goes” or ”hoping not to give up quickly” and being “open minded” illustrate that many anticipate the possibility that breastfeeding might not suit them. This can be interpreted as a lower commitment to breastfeeding, however in our analysis, women’s theoretical commitment seems strong, but they want to be realistic about the emotional challenges and prepare for disappointment, rather than set goals too high and then feel a sense of failure. The “give it a go” breastfeeding culture that appears to expect difficulty and failure has been noted in other samples of low income women (Bailey, Pain, and Aarvold, 2004).

A few women express strong self confidence and unquestioning commitment to breastfeeding, almost denying the possibility of failing and "feeling gutted" if they can't. Barriers linked to the decision to breastfeed in pregnancy centre around the embarrassment of breastfeeding in public, the personal time commitment of demand feeding, a desire for routines, sleep, and for multiparous women anxieties about how breastfeeding will fit in with other children. Overall emotional wellbeing factors are often anticipated to override the longer term health benefits in feeding decisions after birth.

4.2. Duration and exclusivity of breastfeeding

Primiparous women often aim to "go with the flow" and although many are aware of the recommendation to breastfeed exclusively for 6 months, they are reluctant to specify an intended duration. Multiparous women who have previously breastfed are influenced by past experience either positively or negatively and appear more pragmatic and/or relaxed about their plans to breastfeed. Some with difficult first experiences, particularly pain or unsettled babies are "not looking forward to breastfeeding", others express determination "to conquer it". Some anticipate a shorter duration of breastfeeding, or going "longer between feeds" than with previous children as it was "too demanding" and some acknowledge that they would be putting themselves first this time "to get a bit of your life back". Some report planning in advance to introduce formula "top ups" in preference to expressing milk. Reasons include: "to get a better sleep"; to allow the father or an older child to feed; to help if the baby does not gain weight; and for nights out or time with other children. Paid maternity leave is given by some as a reason for planning to breastfeed exclusively for longer than previously, fitting with existing studies (Tanaka, 2005) whereas others describe the importance of introducing bottles early in readiness for a smooth return to work.

4.3. The father of the baby

In general fathers support the woman's decisions about feeding, breast or formula and often appear neutral, "not really bothered" or distance themselves from the decision. Fathers describe a variety of different people as influential in forming their views about breastfeeding, including their own mothers, sisters/sisters-in-law and friends. They often cite the health benefits as the reason for supporting breastfeeding, and childhood obesity seems to be a theme which some men in this study feel strongly about. However, doubts are sometimes expressed about the importance of breastfeeding in contributing to obesity and they are more convinced by "sitting in front of the TV" and "junk food" as the causal pathway. Men who are keener on breastfeeding than their female partner were in a minority. Views differ about the importance of the father actively feeding the baby and there is sometimes disagreement within couples, with the mother viewing it as more important than the father. Some women, but few fathers seem concerned that fathers may "miss out" if women breastfeed.

4.4. Family and friends

A few women, particularly if multiparous, are self-contained in their decision to breastfeed, citing "me" as the only significant influence on their decision making. For

others, several family and friends are cited as significant influences when pregnant and some are keen not to feel “alone” and want family and friends to provide “non-judgemental” support for their decision. However, as with other studies (Lee, 2008), “rights and wrongs”, “us and them” discourses are evident. Negative breastfeeding stories are seen by some as “excuses” and some very pro-breastfeeding women describe avoiding speaking to women intending to formula feed in case they make them feel uncomfortable. Family culture is sometimes an unspoken influence: “we don’t talk about it much”, “just do it” and where “just knowing that we were breastfed ourselves as babies is enough”. Primiparous women’s feeding decisions are often covert and closely inter-woven with the positive and negative stories of family and friends and seeing other women breastfeed. Women surrounded by positive observations and stories express a stronger self confidence and commitment to breastfeed (Hoddinott and Pill, 1999b). Other mothers who breastfeed effortlessly are considered “unhelpful” or “scary” and are less likely to be role models than those whose stories are realistic accounts of the difficulties. This seems to be a pattern and fits with social comparison theory (Festinger, 1954), where with infant feeding, many women tend to compare themselves downwards with worst case scenarios rather than upwards with best case scenarios (Hoddinott, Chalmers, and Pill, 2006). For multiparous women, decisions are most strongly influenced by their own previous experiences. In pregnancy many women anticipate how they might fit or not fit with their social network of friends or relatives. Several intend to behave differently to friends and relatives, particularly in the context of whether the baby will fit into the couple’s life or whether life will revolve around the baby. Behaving contrary to expectations for example, being the only breast feeder in a social network fits with the notion of deviancy amongst more disadvantaged women (Murphy, 1999).

Generational differences are particularly apparent with some grandmothers described as having “rose tinted spectacles” or “not remembering the tricks” (Reid, Schmied, and Beale, 2010). Establishing routines is a strong theme for grandmothers and conflicts with current advice to feed on demand. Couples perceive recent breastfeeding experience amongst both relatives and health professionals as “better”. A breastfeeding culture is recounted more often on the maternal side of the couple and the influence of the mother’s mother appears stronger than that of her mother-in-law. Although many grandmothers and grandmothers-in-law didn’t breastfeed themselves, they acknowledge the health benefits and are usually “supportive”, with a minority saying “don’t bother”. For some women, family experiences and stories are as valid as or more valid than professional advice and research evidence.

4.5. Health professionals

Antenatal discussions about infant feeding vary and seldom seem to impact on women’s decision making. Some feel breastfeeding is “built up to be a big thing when it doesn’t need to be” and a more relaxed approach would be beneficial. Some midwives are encouraging, sensitive to previous experience and offer support options for example, a peer buddy system. For some a breastfeeding-centred, “rules” or “tick box” approach by health professionals was off-putting:

> “you know that it’s on demand and you can’t use bottles and you can’t do this and you can’t do that, and it’s for six months and you have to like,

> basically you are attached to this baby for six months, and she (midwife) made it seem quite negative" (2003; AN; woman).

Infant feeding checklists are a feature of the Scottish Woman Held Maternity Record (NHS Quality Improvement Scotland, 2008), as discussed in Chapter 1.2, and may be contributing to this perceived "tick box" communication style. Professional mixed messages and ambivalence towards breastfeeding were sometimes detected but where open discussions took place with an encouraging health professional, women were more confident that they would receive good postnatal support for anticipated difficulties, particularly pain.

Some primiparous women are sceptical in pregnancy about postnatal breastfeeding support and feel that it is "implied that you will get a lot of help but in practice you don't". Sharing experiences with other mothers often reinforces an expectation to be disappointed with care. For some multiparous women, particularly those with a longer gap between births, expectations are inconsistent with current health service policy, for example previously, "the midwife came to the house every day for 10 days". Lack of support in hospital is a strong concern and several mothers intend to stay in hospital until they "get breastfeeding right", with some health professionals re-enforcing this individually and in antenatal classes with advice to "just keep buzzing" until you get the help you need. The messages are that ward staff are the most likely people to help get breastfeeding established, and once home you have to "get on with it" and it is more difficult to get breastfeeding "right".

4.6. Preparing for breast and formula milk feeding

The "breast is best" message from the NHS and media is universally known, but message fatigue is evident and many women prefer more realistic information about the difficulties they may experience and the practicalities of how to succeed and this is reportedly harder to find. Even those who plan to breastfeed often appreciate a discussion of "all the pros and cons" of breastfeeding and formula feeding. Using multiple sources of information is seen as a preparatory strategy that in theory can help women maintain some control over their experiences and feeding decisions after birth, but "until the baby's actually here, you can't do anything practical, hands-on" and you "have to play it by ear":

> Woman: "Yeah, you arm yourself with information..."
> Partner: "Information, so that you can make the best choices at the time. So you're not going into it blind, but at the same time you're not trying to stick to some rigid plan that someone else has created" (1033; AN; couple).

However, too much information is seen by some as "a bad thing" which raises anxiety and "panic" and fits with other recent UK reports of information overload (Lee, 2008).

4.6.1. Health service written and audio-visual information

Most receive NHS leaflets and audiovisual (DVD) information, but it appears to have little impact on infant feeding decisions. At one extreme, "being bombarded" with

leaflets is perceived as replacing valued face-to-face discussion. Several comment about the poor quality of resources, offering conflicting information, seeming out of date and failing to address the practicalities and the difficulties experienced when breastfeeding:

> "you get a booklet which I suppose is quite detailed, but when it actually comes to breastfeeding, it's absolutely useless" (1010; AN; woman).

However, written information is useful for some women whose social networks never speak about breastfeeding and those often more educated women who are interested in knowing the theory of how it works. DVDs are seen as either making it "look really simple" and unrealistic or "making it seem very complicated", with several couples put off watching it, because of stories they had heard from others. Visual imagery is crucial and can be off-putting with a video shown in a breastfeeding workshop described as "like a 1970's Scandinavian porn movie". Rather than seem dismissive and in a spirit of altruism, some acknowledge that in theory DVDs may be "useful" for men who can't attend classes and workshops, however, for many couples it remains in the box unwatched. Our interpretation is that the commonest reason given – "lack of time" - is seen as an acceptable excuse but in reality many anticipate idealistic pro-breastfeeding health service messages on the DVD. Some feel that too much information might raise anxiety levels and prefer on-the-job learning with a skilled helper after birth. Imagery on posters in hospitals is seen as important in raising awareness for families and posters can be a source of information for partners who may be less likely to do additional reading. Although "posters everywhere" are generally seen positively as "encouraging" breastfeeding, they can be seen more negatively as presenting an unbalanced "one-sided" view with more factual posters being preferred to those with more "emotive" messages which may be seen as "propaganda". Past posters with memorable culturally appropriate slogans seen in childhood can have a lasting impact:

> "you can't get fitter than a breastfed nipper' and do you know what, I don't know why, it's just totally stuck in my head" (2181; AN; woman).

4.6.2. Other sources of written and audio-visual information

The internet is viewed as a rich source of contemporary more realistic information with chat rooms and forums popular, as they provide opportunities to ask questions, especially embarrassing ones or those perceived as "too trivial to bother health professionals with". Unreliability is a concern, with mothers using their own judgement to "weed out what's good and what's not". Some find internet information "scary", "confusing" or only describing "worst case scenarios". The internet is seen as a flexible resource that can respond to the individual values and needs of each couple, in contrast to "one size fits all" health service information resources. There were a few examples of celebrities as role models. Some acted as negative comparisons: "I don't want to be like Britney Spears" and some were conditionally positive, acknowledging their privileged position: "Jordan copes well with three kids but she probably gets a lot of help". Books are valued by a few.

4.6.3. Classes and groups

Experiences and availability of appropriately timed pregnancy classes vary. A focus "on the practicalities" and hearing "real experiences" with mothers is most highly valued, especially when a woman's social network has no experience of breastfeeding. Having a chance to chat with other mothers about potential problems like sore nipples and hear their "tips" can be beneficial. A relaxed interactive atmosphere is important as couples feel "awkward", "anxious" and "embarrassed". Some want "more balance" and "less pressure to breastfeed" with formula feeding covered as well. Realistic stories including the experiences of women who have failed to breastfeed are requested. Large NHS classes with 30 couples are a barrier to asking questions, with "too many different types of people coming from different starting points". For some, more "like-minded" smaller interactive classes provided by the voluntary sector are preferred. Some prefer more in depth couple discussion with an individual health professional rather than a group and multiparous women tend not to go to classes, as few perceive any benefit.

NHS breastfeeding classes or workshops are generally not available for partners, which "seems a bit stupid, because dad needs to know what's going on as well". Most women but not all partners agree classes should be open to partners and some partners are "dragged along" feel "nervous" or "did not want to look stupid". Several women want breastfeeding to be a "joint effort" with a desire to move away from intensive mothering (Lee, 2008) and express frustration when classes are only available in the daytime. However, women and men are both unsure about how they might cope with the emotional discomfort of seeing an unknown woman breastfeed in a class, and some group leaders inform men that they might have to leave if a baby needs breastfeeding. A few men attending breastfeeding classes found them "really useful", "interactive", with "lots of visual cues". Others describe more negative experiences, particularly with more factual didactic classes which "dragged" and "could have been done in ten minutes". Some feel classes for men are unnecessary, as their role is emotional rather than technical support:

> "I don't think it's really sort of necessary for the partner to be there as well, on the basis that if they see the mother doing it wrong, they'd say "oh you're doing it wrong", you start being critical and it can stress out the mother" (2061; AN; partner).

Some women describe NHS classes involving dolls and knitted breasts as unrealistic, inadequate and immature "like something you would've done at playschool". Women felt "daft", "awkward" and particularly embarrassed holding dolls if men were present. Dolls were felt to be a poor substitute for early help with positioning and attaching the baby after birth. For some, factual information about antibodies and the constituents of breast milk is "too technical" "like standard grade biology" and superfluous. Some classes leave women with unanswered concerns about practicalities, like expressing and what to wear when breastfeeding in public. Some identify mixed messages between what breastfeeding workshops say and reality or the "word on the street".

4.7. Equipment and the consumer society

A few buy breast pumps for expressing in pregnancy but most adopt a wait and see approach. Many buy equipment for bottle feeding in pregnancy or inherit it from family and friends, "just in case" breastfeeding does not work out. This can be interpreted as a lack of commitment and confidence or as a desire to be realistic and prepared rather than idealistic about the likelihood of succeeding. Shopping and consumerism when preparing for a new baby is evident, however, women have many anxieties about clothes that will facilitate breastfeeding and concerns about their image and appearance. Tips about nipple creams, nipple shields, dummies and nursing bras are often gained from peers rather than professionals.

4.8. Lifestyle after birth

Many primiparous couples have discussed and planned in theory how their lifestyle will be changed by both the presence of a baby and breastfeeding. Several have made plans for relatives to stay or help out. Some make preparations for the new baby, for example by filling the freezer and practical recommendations like this are welcomed by parents. As already discussed, several had plans to either introduce formula or express milk to free up time for other priorities, whereas others, particularly couples with children were prepared to put "life on hold" again for a while and prioritise breastfeeding. With regard to housework and baby care, for some couples "it's a team effort", "it's not just me that's having a baby", and they anticipate that this will include all aspects of parenting and household chores. Negative stories of the lives of friends and relatives being dominated by the needs of a baby were sometimes discounted, and many expressed a desire for the baby to "fit" within their lives and to be different from their peers. Primiparous women anticipate time for themselves will be "quite tricky" once the baby is born and multiparous women worry about how they will juggle the needs of a new baby with other children and still find time to "get my hair done".

5. Expectations versus reality about health service care

Chapter 5 describes parents' early and continuing experiences of baby feeding, and the care offered by health service staff, in hospital and at home. It considers the mismatch between expectations about what will happen and the reality of what does happen when feeding a baby.

5.1. On the hospital ward

Some mothers are happy with the breastfeeding help they receive, with staff "bending over backwards to help", "lovely people", but many women identify shortfalls in care, related to how busy staff are, their expertise, interpersonal skills, the breastfeeding rules in operation and the lack of continuity of care, confirming the findings in reviews of qualitative research (McInnes and Chambers, 2008). There is often a large gap between antenatal expectations (see Chapter 4) of what breastfeeding will be like and the help that will be received and what actually happens, as documented in other studies (Bailey and Pain, 2001; Hoddinott and Pill, 1999a; Sheehan, Schmied, and Barclay, 2009).

Staff workloads are central to the accounts of hospital postnatal stays, with frequent references to midwives having to "dash off", "running in and out", saying "we'll get to you" and participants "feeling really guilty" for saying "can you give me a hand"? Proactive offers of help were expected and preferred:

> Mother: "I asked each time I went to feed her, I buzzed the buzzer to get help. Like they didn't come and offer help, I had to ask for it. So that would be..."
> Father: "Yeah someone a bit more timid or shy..."
> Mother: "Might not..."
> Father: "I don't want to bother them, I'll just persevere. Or I don't want to bother them, I'll just give up" (1033; PNV; couple; baby six months old).

Night time when the ward is quieter can provide an opportunity for staff to sit "unrushed" with breastfeeding mothers. "They were able to dedicate somebody to sit with me all the time". However, some mothers report feeling "left to it" with night staff "less approachable" or "unavailable because of the drug round" and our interpretation is that staff do not always see breastfeeding support as a priority. Night time may also be the time when formula feeds are introduced to quieten a screaming baby or allow a mother to sleep.

Shared wards are seen to have pros and cons compared to individual rooms. There is company, but also noise, and a lack of privacy, with women feeling uncomfortable just "having a curtain between me and somebody else when I'm getting checked". Handling of breasts occurs despite the known unacceptability of this practice to women (McInnes and Chambers, 2008) and negotiation between staff and women about the public / private aspects of providing breastfeeding help on the ward are sometimes neglected:

> "I was sitting there with this woman moving my breasts around and the person in the bed opposite was just kind of watching. It was like, 'Let's just sell tickets for this shall we?" (2061; PNV; mother; baby five months old).

Fathers who are very closely involved in the pregnancy and birth are unhappy at the lack of welcome on the postnatal ward. They are "packed off", not able to be involved, yet some would like to be present to learn about positioning and attachment, as they feel they will then be able to assist more at home. Some women wish partners could stay overnight for support and comparisons were made with personal or social network experiences of other countries where this is possible.

5.2. Going home

The decision when to go home reveals conflicts of values for many and can be the tipping point for feeding decisions in either direction. Parents need to balance the conflict between being encouraged by both professionals and family or friends to "stay as long as it takes" to get breastfeeding established, with the health service pressure to leave to create empty beds and the undesirable aspects of hospital rules, noise and lack of privacy:

> "they kept asking 'have you had any thoughts about going home soon?' within the six hours, but I'd already said 'no' I'd really like to stay in a night and make sure the feeding was established" (2192; PN1; mother; baby three weeks old).

But pressure to stay to establish breastfeeding can tip the balance towards formula feeding:

> "I could feel myself welling up because I had my heart set on getting out that day …that's why I said we'd go on to the formula" (2255; PN1; mother; baby three weeks old).

Some first time mothers go home early as they feel "scared" or "totally by myself" and are not getting help. Some "couldn't wait" to get back to the comfort, quiet and privacy of their own home and have the support of their partner. Some mothers with other children prefer to stay longer, to "have a rest", "bond with the baby" and "get a bit of toast in peace", although others are keen to get back to their children or to avoid a repeat of a previous unpleasant hospital stay. Going home may be a "relief", or it may add to feelings of apprehension. The buzzer is no longer at hand, and when they walk out the door "oh God, I can't do it now".

5.3. Midwives and health visitors being present at breastfeeds

In agreement with other studies, midwives "being there", listening and normalising women's experiences are important (Bailey, Pain, and Aarvold, 2004; Schmied, Cooke, Gutwein, *et al*, 2008). For some, postnatal help meets their needs, either in hospital, or at home:

> "I rang the health visitor the next day and said she's not feeding and she came straight up … showed us how to latch on….and she came back and

did it two or three times…. she sat with us for a whole feed" (2294; PNV; mother; baby six months old).

Others have dissatisfying experiences, with staff "too busy to help", "having a quick glance and saying "yep, OK". Women appreciate staff who "sit with them", rather than "standing just a couple of seconds" to make sure the baby gets on, and then "running away again" as others have reported (Dykes, 2005):

> "the midwife would be here and she would sit and just go "oh like that" and you'd be fine for then and then later on when you tried to do it yourself it's like, 'where?', 'what did she do?'" (1167; PNV; mother; baby six months old).

A trusted skilled professional being present for a whole feed is very important for many. In contrast some, particularly younger, more disadvantaged women, prefer not to receive intensive professional help to learn how to breastfeed and would rather make their own mistakes and learn for themselves. For them having a health professional sitting with them may seem "pressurising" or "intrusive":

> Mother: "if the wean [baby] wasn't latching on, and then the woman kept coming back, and coming back, and telling you what to do ….."
> Father: "that would even annoy me, as being the father, I'd be saying – 'Listen, the wean's just not wanting it..."
> Mother: "I would say that that would be better for older women. With me being younger, it would intimidate me" (2287; PNV; baby five months old).

Reassurance and confidence building, and the ability to teach mothers to latch their baby on themselves are valued more highly than a technical "everyone tries to fix it" approach. Help is also needed "when the milk comes in", because "you think you've got it, but it completely changes". Once home, an important barrier to effective help is the need for the helper to be present when the baby is awake and wanting to feed. Our interpretation is that some health professionals may be reluctant to offer help with a breastfeed because of time constraints, staff shortages and a lack of confidence in their skills to provide effective help:

> "I've offered to wake her up and they say, no, just let her sleep … I'm wanting to make sure I'm doing it right" (2103; PN1; mother; baby three weeks old).

5.4. Consistency and continuity of health service information and care

The issue of conflicting advice has been widely reported (McInnes and Chambers, 2008) and participants in our study similarly describe "staff who had different opinions of how to do things", or use different "techniques and approaches":

> "one of the midwives suggested that we give her a bottle and then I could go back to breastfeeding, once I'd had a rest … which was my intention until another midwife told me that I couldn't do that … once she'd been on the bottle then it was best to keep her on the bottle. And she was quite

> firm to the extent that it was quite unpleasant". (2181; PN1; mother; baby two weeks old).

An alternative viewpoint voiced by a few more confident women is that it is useful to hear different "tips and suggestions" and then make your own decisions, confirming earlier findings that conflicting views are not always problematic (Hoddinott, Chalmers, and Pill, 2006). Continuity of care, with "the same faces at every stage" is considered important, "to build up a rapport" and develop trust, and as breastfeeding is "quite an intimate thing", to minimise the number of different people "looking at and touching your breasts". Continuity of care for a problem avoids having to "go over old ground and try things which haven't worked". Again there is recognition of stretched health professional resources making such continuity "unfeasible": two consistent carers are seen as a compromise. Women with few problems, who are less dependent on professional help, are less concerned with how many people they see, "as long as they all say the same". Some women will forgo continuity if it means that they have to wait longer to see specific people. Meeting a heath professional in a context outside of healthcare can cause embarrassment and discomfort and there is a wish by many to retain as much privacy as possible and a small number of helpers.

5.5. Medicalisation, rules and "the right way to feed"

Medicalisation of communication about breastfeeding, with a focus on input, output, hind milk and foremilk has been described (Mahon-Daly and Andrews, 2002; McInnes and Chambers, 2008). In our study, medical terms were particularly common in relation to frequent feeding; including "growth spurts", "cluster feeding" and "scatter feeding" and these jarred with participants who suggested a need for health professional "jargon busting". Interviewees feel breastfeeding is surrounded by rules whose rationale is often unclear. Expressing must not begin before 8 or 12 weeks, there should be no creams, nipple shields or formula feeds, bottles and teats confuse the baby, babies must feed within a certain time after birth. Even when babies are not feeding well, the perception is that staff cannot say "give her formula" and the onus is on the mother to decide. There seems to be a "code of conduct now that they can't mention the 'F' [formula] word". Participants appreciate the health visitor who when they give a bottle of formula, says, "Fine, we call it a crisis bottle, nothing wrong with that":

> "it all seems to be, 'don't ever do anything that would interfere with breastfeeding', it's all got to be very purist which is fine, but it just doesn't fit in with the rest of your life and I think in a way people just give up because it's too difficult" (1075; PNV; mother; baby six months old).

There is confusion in women's accounts about whether there is a "right way to breastfeed" or whether each mother and baby are different and should be helped to find a way that suits them. Having a "right way" increases the likelihood of conflicting advice, anxiety and feelings of failure or anger when a recommended method or technique does not work out. Going it alone and finding your own way to breastfeed can be empowering for some but can leave others floundering and changing to formula milk, often with disappointment:

> "this woman said "if you had a proper latch you wouldn't get sore nipples, and if you were feeding properly you wouldn't have got mastitis". I was angry and shocked, it was horrible" (2294; PNV; mother; baby six months old).

Our interpretation is that breastfeeding-centred rules, intended to promote a consistent approach and exclusive breastfeeding, conflict with the desire of most women for flexibility and to fit breastfeeding into their lives. In an ideal environment where skilled help is widely available, a "right way" may be achievable, but in the current context women feel they are being set up to fail.

5.6. How health services meet women's needs

Antenatal preparation may be useful, but you need help "when you're actually doing it". Beforehand, you "can't see any further than the birth" and "only remember 50%". Participants are in agreement that priority should be given to providing skilled help with breastfeeding in the early postnatal period, when latching on is "critical", and "you're tired and panicking". "If we don't get help at the start, that's when we all quit".

Problems with "latching on" are a key reason for stopping breastfeeding (Bolling, Grant, Hamlyn, *et al*, 2007). Our study supports this and reinforces research showing that breastfeeding women value positive support which builds confidence, with health professionals staying with you and providing practical help (Sheehan, Schmied, and Barclay, 2009). "Reassurance" is the word most frequently used by participants to describe the help they need. Getting "a good feed" boosts confidence: "brilliant", "we're on the right track here"! Although new mothers anticipate that they will be "shown" or "taught" the technicalities of what to do, so that "the baby is properly fed", and they "really know how to do it right", the reality is often different, and mothers may leave hospital feeling that "this isn't going to work". However, the largest gap is in emotional support as women expect to "pop the baby on and be fine", but "it's not like that", and it's "more difficult" than anticipated. Support needs change with time as some babies latch "like a natural" initially, but it is a "false start", and feeding then deteriorates. The assumptions that multiparous women will need less help, and will "just get on with it", are not invariably the case. Some appreciate reminders about later pitfalls, such as frequent feeding:

> "they've already told me because it's my third I'll probably get quite ignored because they're too busy" (2295; AN; woman).

As already described, pressure on health professional time in hospital and at home is seen by women as a key barrier to gaining the help that will enable them to breastfeed successfully. The frequency of midwife postnatal visits varies from daily to every 2 to 3 days, with some so short that "they can't help much, can they?" Some find it difficult to ask for more frequent visits, whereas a previous complaint about care after birth resulted in more visits than needed. The number of visits is not always related to breastfeeding difficulties or need:

> "they were 'oh we'll come round every second day if you're happy with that'. It was quite quickly they changed to that. And I said I was and, again, looking back I think why didn't I say 'no', I want someone here every

> day till I suss out this feeding thing?" (2061; PNV; mother; baby five months old).

Families find it difficult not knowing when the midwife will visit, "even knowing just morning or afternoon", comparing this unfavourably with the health visitor, who "makes an appointment". The frequency of health visitor visits varies too, a minority visit often in the early days if breastfeeding is problematic, sometimes before the midwife visits finish; others visit weekly from two until six to eight weeks; some visit at two weeks then meet mothers at the clinic. Access to telephone numbers and sources of 24/7 advice are valued.

For some "the best help" is provided by a specialist led breastfeeding problem clinic; for others, it is a breastfeeding group run by a health visitor or a lay worker. Groups are particularly valuable for first time mothers or newcomers to an area, as "you know you're not alone", you can practice feeding in public and "make friends", although it may be difficult to take older children (Hoddinott, Chalmers, and Pill, 2006), and breastfeeding groups tend to attract older and more advantaged women (Hoddinott, Britten, Prescott, *et al*, 2009).

6. Expectations versus reality outwith health service care

In this chapter we look at help offered by fathers, family and friends, and the voluntary sector. We examine different perspectives on the involvement of fathers in feeding and on the help preferred with feeding, household chores and caring for other children.

6.1. The father

Some first time mothers and some fathers are concerned that fathers will be "left out" because of breastfeeding and will "lack confidence" and have less opportunity to bond with the baby. Without feeding, fathers can feel "less viable"; feeding is "special" with life giving qualities and "not just a mum thing, a dad thing as well". It brings relaxation, eye contact and a real bond. If fathers are not involved in feeding in the early days, when "it's mainly feeding and changing" they can think, "who's getting the better deal here?" and feel that they are doing the majority of the "nasty bit". This can pose problems for mothers who do not want to share feeding. Our interpretation is that because bonding is widely publicised as a benefit of breastfeeding, new parents may be anxious that non-breastfeeders - fathers, grannies, older children - won't bond with the baby unless they are actively involved in giving feeds. Giving expressed breast milk or formula is seen as the principal way in which fathers can be involved and help:

> "one of the positives about the bottle feeding is (father) gets to play more of an active part, so when I was breastfeeding he was very much sort of surplus, just sort of hanging about, not quite sure what to do… but now that we're bottle feeding he's more involved and he's much more confident" (2181; PN1; mother; baby two weeks old).

In contrast, other fathers feel that although it's "really nice to feed him and have him look adoringly up at you", breastfeeding is the woman's role. They believe that bonding with the baby, and support for their partner can be achieved through playing, changing, cuddling and bathing.

There are differing opinions about whether fathers should be involved when women are being shown how to breastfeed. Some couples think it is important; he will be "the primary support person at home", and two people listening to the often large amount of information provided will maximise the chance of remembering important points. He can also help when "you can't see" how the baby is feeding at the breast. Other women see it as "me time, for bonding", or may feel "self conscious", or think their partner might be critical:

> "you've got to do it yourself and I understand some partners would think that was being helpful… I'm not convinced" (1094; PNV; mother; baby six months old).

Fathers who are committed to breastfeeding may be a key source of emotional support for breastfeeding women, both primiparous and multiparous, "constantly there", helping them to "keep calm", providing encouragement and reassurance, and "feeling for me". Women report that without this backing they would "give in", or say

"enough's enough", and if he wasn't "behind you, it could swing you or make you feel like piggy in the middle". Other fathers may support breastfeeding, but have little awareness of the importance of "what you say and how you say it" in the postnatal period. Fathers who are less committed to breastfeeding may still be "a rock", but find it difficult to encourage their partners to continue breastfeeding when they are "toe curlingly sore", and "the baby's screaming", and they may give "permission to stop". Our interpretation is that primiparous women who do not report the father as a significant positive influence on feeding are likely to feed for a shorter time, agreeing with other studies (Rempel and Rempel, 2004). Women's traditional role as providers of emotional nurture continues to be evident, with some describing fathers "feeling put on the back shelf", or "needing their confidence built in handling the baby". Traditional cultural roles, with the man working outside the home and the woman at home prioritising child care contrast with couples where roles merge, for example, flexible working, working from home and the "share everything including feeding" couples. The latter were more likely to express milk or give formula milk to fulfil this role, however, clear patterns between gender roles and breastfeeding duration were not evident in our data.

6.2. Family and friends

Support from family and friends vary depending on circumstances, including geographical distance, the quality of relationships, health and age. Some women are "a one man band" and don't look for help from friends and family, others value company and help in the house which lasts "after the first few weeks". New parents may find they are "bombarded" with visitors in the early days, "a nightmare", people "wanting a happy experience but none of the hard work". Visitors may be particularly difficult for women who feel uncomfortable feeding in front of others. Some women stay longer in hospital to get feeding established before everybody wants to visit, and suggest visiting hours at home would be a good idea, to avoid visitors who "put their bum on the couch and stay there". Women who have had a caesarean section need extra help, when "even things like putting a wash on is suddenly a big deal". Some couples particularly appreciate help with meals*: "*She filled the freezer… that was ace*",* which may reflect a food value bias in the families volunteering to participate in this study. The nutritional quality of the maternal diet for breastfeeding and maternal wellbeing is important for some:

> "grannies and grandpas are very close and they know I need iron in my diet, so I have not made dinner for ten days. They've been making steak pie, lots of red meat, mince and tatties, lasagne, everything, it's great" (2128; PN1; mother; baby two weeks old).

Grandmothers who have had a positive breastfeeding experience themselves are an important source of emotional support for breastfeeding mothers, especially when they are "non-judgmental" and "don't impose", but "listen and allay fears", or say "try this". Our data fits with research describing the sensitive and complex negotiations that occur around infant feeding between generations (Reid, Schmied, and Beale, 2010). Grandparents in general also offer practical help in the house, often coming to stay if not local, or "taking over" the household duties when fathers return to work. This may be a mixed blessing if they have "weird attitudes to breastfeeding" or "perch themselves in the living room" when the midwife comes, when it should have been

the father present. Sometimes help which women anticipate, or would like from their own mother does not materialise, or "dies off" after the first few weeks, leaving them feeling let down. Grandmothers may focus on the baby rather than giving "tips and reassurance" or practical help:

> "I kind of was hoping maybe that my [laugh] mum might do the dishes and things when she came round, but she's just been having cups of tea and playing with the baby" (1108; PN3; mother; baby two months old).

Multiparous mothers identify a need for help with caring for other children. They worry before the birth that the children "have lots of energy" and may be "jealous", "interrupt feeding", or "need attention", and appreciate visitors who play with the children or take them out "to give me a break" or drop them off at nursery. Time deadlines for getting children to school or nursery can be a barrier to breastfeeding if reliable help is not available. Women appreciate baby/children's groups which take children of mixed ages.

For primiparous women in particular, female friends or relatives may provide valued reassurance and help. They may offer confidence boosting compliments about how well the mother is doing, phone regularly to see how things are going or give suggestions and practical help with feeding, shopping and caring for the baby:

> "my friend definitely helped, and having her in the house and she was getting her to latch on and having her experience as well" (2103; PN1; mother; baby three weeks old).

Many mothers are keen to "get out" and meet other women "going through similar experiences" via a range of groups – buggy walking, breastfeeding, parent and baby. These provide new friends and "a bit of womany talk and me time". Breastfeeding groups may provide "easily the biggest encouragement and source of information" for some women and become "a haven" even for young women who feel they "won't fit in", being "the only person under 30 by a long way". A few fathers may be aware that they lack this source of peer support from other fathers, looking to colleagues, who may understand "it's really tough in the first few weeks", or may have forgotten what it is like. There was little spontaneously raised data on peer support needs for fathers, which could suggest that this is not seen as a priority.

6.3. The voluntary sector

There was very little mention of the voluntary sector providing help or support after birth. What little there was referred to the value of a National Childbirth Trust group as a place to share experiences with like minded mothers and a church providing home delivered meals for the first two weeks after birth to all new mother members. Both examples were in Site 1. This is likely to reflect the recruitment of our sample from more disadvantaged areas and may confirm the widely held belief that voluntary sector services attract more educated, professional mothers.

7. Adaptation and strategies to improve maternal, baby and family wellbeing

Chapter 7 looks at adaptations and strategies used to deal with the emotional and physical demands of baby feeding. Introducing formula, stopping breastfeeding and expressing milk may help parents to feel in control, get enough sleep and return to some sort of normality.

7.1. Maternal, baby and family wellbeing

Parents struggle to maximise the overall wellbeing of the family, and to balance the baby's breastfeeding with the needs of other family members. They are aware that:

> "for the wean's sake, breastfeeding's best, but for the woman and wean's sake, or the family and the wean's sake, breastfeeding might not be best" (2287; PNF; father; baby five months old).

It is not the only thing going on and it "can't take over or you start to get negative, lose pleasure in it and it gets too much".

Once home, the issue of who wants to be and who is in control of baby feeding behaviours comes to the fore. A dominant theme is "getting into a routine", with "regular times for feeding and sleeping", allowing other activities and "me time". This is a priority for many, particularly first time mothers. Some are guided by the positive and negative stories of family and friends, others by expert sources or parenting manuals:

> "I'm using The Contented Little Baby book, trying to follow her recommendations... Some of it's a bit too strict for me, but I want her to get used to self-settling" (2039; PN2; mother; baby seven weeks old).

Couples may have differing priorities for the use of time. For some, it is sleep, others want to "go to town, do the housework", or go to the gym. In practice, breastfeeding dominates, "has no pattern" and may feel "out of my control":

> "I sort of anticipated that she would feed every sort of four hours then sleep, and then I'd plug her in again, and then another four hours. And really the anticipation of that and the actual reality were totally different ... it's just so random … I think that was the biggest shock for me, that her demand couldn't be regularised, they [feeds] had to be as and when she felt like it" (2294; PN2; mother; baby five weeks old).

Even those who appreciate being able to "sit and put your feet up", and "try not to predict how it will work", "happy to feed whenever she wants", mention the lack of consistency and the time taken to breastfeed. Some find they have more time later when "there is a bit of routine" and the baby's "on, feed, off, no messing about". Multiparous women compare the present experience with previous ones and may breastfeed for longer– or for less time – depending on whether the baby "is not such a hungry baby" or is "feeding more than the others", or sleeps more or is more colicky. Mothers who fit the "intense mothering" model (Lee, 2008) "go with it until

they settle down and sort of give up yourself for that". These women describe feeling like "I've lost my right arm" when apart from the baby and seem more likely to breastfeed exclusively for longer.

Sleep is a crucial factor in family wellbeing: "sleep deprivation is a form of torture", and "the baby sleeping longer means the world of difference":

> "most of the problems aren't that bad really until you try and deal with them when you're utterly shattered" (1108; PN1; father; baby two weeks old).

Various strategies are used to cope with lack of sleep. Partners of multiparous women get up to see to other children in the morning; first time fathers look after the baby and may give a bottle when the mother goes to bed early; women may "nap when the baby does", or get family to "walk the baby so they can sleep". Some couples try "controlled crying" to get the baby down in the evening. Some mothers get reassurance at the breastfeeding group where other mothers are "the same", in contrast with "formula feeding friends whose babies sleep six hours". A minority of mothers cope well, are "used to waking, don't find it a hassle", and "get through it somehow".

7.2. Introducing formula milk

In the early days, introducing formula feeds is a means of dealing with anxieties about whether the baby is "getting enough" breast milk, particularly at night when "she's screaming" or "won't latch" or the mother is "panicking thinking that she's going to get dehydrated". If formula is given, and the baby "sucks away on the bottle like it was going out of fashion", "gulps it down" and "must have been starving", this further undermines confidence in breastfeeding and breast milk. Formula feeds may also "give a break" for sore nipples. Often parents try formula milk to "fill her up", so she "goes down for longer", although this does not always work:

> "he's up every two hours … I tried two bottles, the two last meals before bed and it made no difference, it was exactly the same. So I was just giving myself more work by sterilising and things, so I decided just to go back to my breast" (2295; PN3; mother; baby three months old).

Other mothers whose babies wake frequently at night prefer to start solids earlier (see Chapter 8), instead of giving formula, because their babies are happy and thriving on breast milk.

Women who continue to breastfeed beyond the early weeks may introduce formula to allow them to go out without the baby. Some prefer this to expressing breast milk (see Chapter 7.4), which may be difficult, disliked or time consuming which outweighs the benefits of having time out. This is particularly the case when breastfeeding does not fit with a social network:

> "I've got younger family who were having 21st birthday parties … and I couldn't go... with my age, it's (breastfeeding's) not a big thing that people do, people don't understand breastfeeding, so they don't understand that you can't go" (2128; PNF; mother; baby five months old).

Formula may also be introduced to help women manage other family commitments:

> "sometimes it's at six o'clock … he has the bottle then and, it sounds terrible, but I'm just so busy trying to feed the rest of the family and cook …, and I did feel that my milk supply was not great then either, probably just running about like crazy" (2192; PN5; mother; baby four months old).

The father plays an important role in the decision to introduce formula milk as this can allow him active involvement in feeding (see Chapters 4.3 and 6.1).

7.3. Stopping breastfeeding

Sometimes, the introduction of formula feeding can mark the end of breastfeeding and again fathers play an important role in the decision. Women who do not have a positive family experience of breastfeeding, and who are concerned about breastfeeding in public, are most likely to stop in the early days. Such women are particularly vulnerable to perceived criticisms, "they said that she never had enough of the breast milk", and health professional rules that it's "either breast or bottle" with mixed feeding frowned upon are unhelpful (see Chapter 5.5). Concerns about the future health advantages of breastfeeding give way to the immediate relief of feeling in control of a baby who is "happier and more content" and whom other people can help to feed:

> "now that he's bottle fed he's totally settled down and he seems to be getting into a wee bit of a routine, so we're much better" (2003; PN2; mother; baby six weeks old).

Whenever they stop, women may feel "very guilty and quite emotional", and value positive support from health professionals, friends and family, reassurance that "I shouldn't beat myself up about it".

Formula feeding is not always straightforward. The baby may not sleep for longer, he may be a "picky eater" who "once he's decided he's has enough, that's it, you can't entice him to take any more". She may be "sicky", have wind, colic, reflux, eczema or constipation. Changing the type of milk from breast to formula or different types of formula, the frequency of feeds and quantities are common strategies to control the baby behaviour. Interviewees complain of receiving less information about formula feeding than breastfeeding, relying on "what it says on the tin", rather than being told about different types of formula, making up feeds and the quantity to give. Our impression is that whereas demand feeding and responding to feeding cues are central to the health professional discourse on breastfeeding, they are infrequently mentioned in relation to formula feeding.

7.4. Expressing

Expressing breast milk is another strategy women use to aid their wellbeing, helping them to manage pain, avoid feeding in front of others, and to obtain independence from the baby, perhaps paving the way for later bottle feeding. It is also a way to "share the feeding with other members of the family" and allow fathers (see Chapters

4.3 and 6.1) and family members to bond with the baby, and couples to gain confidence and control of breastfeeding through the measurement of breast milk output (Johnson, Williamson, Lyttle, *et al*, 2009). "I prefer that (expressing) … because I can see it; I'm in control of it". Expressing is often a strategy recommended by health professionals when dealing with latching on problems or mastitis, in spite of the fact that antenatally women are warned not to express "until breastfeeding is established":

> "she had said to me if I don't express it I could get really not well with it, so I expressed a bottle straight away to try and get rid of the lumps" (2037; PN1; mother; baby two weeks old).

Sometimes women prefer not to express, allowing them to maintain control over the baby:

> "his mother has asked me twice when I'm going to start expressing. Her sister has asked me and her sister's daughter... I know why they're asking me because they want to take him overnight, which I'm not happy with" (2128; PN2; mother; baby five weeks old).

Expressing is often problematic, limiting women's opportunities to leave the baby. You could be "sitting there hours", what you get is like "gold dust", and "it was very easy initially until I got cracks". Some health professionals provide "really good" information; others "looked at the pump as though it was a bit of an alien", or encouraged hand expressing, "which is great if you can do it", but "certainly the first six weeks I couldn't get any milk out hand expressing".

7.5. Lifestyle choices

7.5.1. Household chores

Many women have a high level of satisfaction with the practical help which partners provide, both in the early postnatal period when most are on paternity leave, and later on, unlike an Australian study where help declined over the first 6 months (McVeigh, 2000):

> "we're sharing absolutely everything, we take turns with the bottles, we take turns with the nappies, we take turns with the sleep" (2181; PN1; mother; baby two weeks old).

In the early days, first time fathers in particular may do "pretty much all of the housework", or "change all the nappies". "He's turned into a domestic goddess! I just sit and feed". There is a different approach in other families, where women describe "having to point him in the right direction, or hint heavily", and he "seems to think I'm superhuman". Other women expect to "do most of the housework because you're not working". Once back at work, first time fathers often "take over" with the baby when they come home from work, giving mothers a break to "have a sleep" or get time to themselves. Fathers of older children may focus on their care, making

meals, taking them to nursery and school, and ”helping with baths and bed”, leaving mothers to concentrate on the baby.

Some women are “quite independent”, and are reluctant to ask for help or to accept help when it is offered. They “want to see if they can do it on their own”, “get a routine”, because the help “won’t be there long, and then you just have to get on with it”, and there’s no-one to see the mess. Others anticipate telling visitors that “no-one can hold the baby until they hoover”, or say:

> “see while I'm in the shower, somebody want to brush the floors? I wasn't backwards in coming forwards” (2039; PN2; mother; baby seven weeks old).

7.5.2. Returning to work

Most, but not all working fathers took at least one week and up to 4 weeks leave at the time of the birth. A few, with their own business were too busy to take leave. A minority manage to work flexibly in the early weeks, allowing them to be “more involved”, and at home to get older children up and dressed, or take them to nursery/school. Couples may “dread” the father’s return to work, because he has “done all the housework, changing nappies and burping”, and she will “go crazy with no-one to talk to” and no “steadying hand”. Multiparous mothers can find having the father at home disrupts routines with older children and are relieved to re-establish them. Most women report that contrary to expectation, they cope quite well, that it “encourages them to get out, make friends”, or to “get into a routine and organise myself”. Parents also worry that fathers will “miss out”, particularly those working long hours with few days off, only seeing the baby when she’s “grizzly and sleepy”, and will be too tired to help much. Men find it “quite tricky to go back to normal”, lacking sleep and “missing the baby”, and worry that the competing priorities of work and home will impact on their relationship.

Mothers who return to work during the baby’s first six months report varying impacts on feeding, depending on the hours and place of work. Some already work part time from home, or are able to negotiate this, allowing them to “carry on breastfeeding as long as possible”. Those returning full time describe “pulling the baby into a routine, not so much feeding on demand”, and stopping breastfeeding entirely or introducing formula in the day, because expressing would be too difficult in their workplace, or in a new job “on 3 months probation, you’re not going to go in and request a fridge”. By contrast, taking the baby to a child minder is “really easy” with formula feeding.

7.5.3. Time priorities

Time priorities for mothers and fathers vary and are a key determinant of feeding decisions and also parental wellbeing. Parents may look for time alone with or without the baby; with or without older children; as a couple with or without the new baby; with grandparents, relatives, or friends, both inside or outside the home. Primiparous women anticipate time for themselves will be “quite tricky” once the baby is born, but in spite of this, the reality of lacking “me time” with others, or “alone time with nobody” can be “a real struggle”. For some, whose babies “go a bit longer between feeds” as they get older, and sleep during the day, there may be some

opportunity to “keep up with the e mails” or “do the housework”, or to read or “watch TV when he feeds”. Activities which can be done with the baby, “stop you sitting in the house all day”, and provide “company” are important, such as “getting fresh air and going for walks”, attending groups, and “socialising” with family and friends. In the early days, friends who are formula feeding may be “out and about, visiting friends”, whereas women who are fighting to establish breastfeeding “feel miserable” and “can’t even go over the doorstep”. Some turn to new friends, who are “going through the same and you can talk a bit more to”. Most women rely on partners for “a bit of space”, to “have a bath, read a magazine”, or as the baby gets older, “go to aerobics” or out with friends. Getting “out of the baby bubble” and “back to normal”, out of the liminal, or in-between stage of breastfeeding is important, usually requiring the help of formula milk (Mahon-Daly and Andrews, 2002):

> “(husband) encouraged me to go to see my sister ….I can’t wait … just to be able to sit and be me and not be (the baby’s) mum or (husband’s) wife or anything like that” (2294; PN5; mother; baby four months old).

Mulitparous women often “never had time” for themselves before the new baby, “it’s all gone previously”, and appreciate the opportunity “to have a bath” or “get my hair cut”. Time to themselves may mean time with the baby, when older children are at nursery or school. Time for couples without the baby is also in short supply, with most “not even bothering about going out any more, just for now”, and parents of older children having already “put things on hold”. Couples may have “settled down”, even if still young, and “don’t go out as much”, feeling that “the child comes first”. However, there is awareness that the couple relationship needs to be sustained, with the chance to “chat without whispering in bed”:

> “it’s simple things like holding his hand and going for a walk because …, it sounds so silly, but even though you're living together, sometimes you don’t actually see each other. It’s kind of you're passing in the corridor” (2128; PN3; mother; baby two months old).

At minimum, it may be “watching the TV together” after the children are asleep, or “a DVD and a bag of popcorn”. Going out requires babysitters, usually grandparents, and means expressing milk, or giving formula, which some are happy to do whilst others avoid. This may become a bone of contention between the couple, with mothers who are unable to express and unwilling to give formula saying “I’m feeding the baby and that’s it”, or partners reluctant to give formula milk, when the mother is keen.

7.5.4. Breastfeeding in public

Women who spontaneously mention concerns about breastfeeding in public antenatally appear more likely to have stopped breastfeeding at the end of the first month:

> “I was a bit kind of... not anxious, but a bit sort of thinking about if I was breastfeeding if I was going out somewhere because thinking where do you do it? You don't want to go and shut yourself away in a room … and I probably wouldn't be that comfortable feeding in public to be honest. …It

> wasn't an influence for me to stop because … I'm sure I would've got used to it" (2255; PN1; mother; baby three weeks old).

Feeding in front of male relatives or visitors may be avoided, or the father's family who "never breastfed" and are "quite shocked", so "I'll always ask if I can go upstairs". Feeding in public feels like "stripping", although feeding rooms may provide sufficient privacy and there "should be more". The breastfeeding group provides a place to practice feeding in public (Hoddinott, Chalmers, and Pill, 2006). In contrast, others "don't care about feeding in public", or lead home based lives so it is not an issue and find "it gets easier the more children you have", although they appreciate how the legal protection for breastfeeding in Scotland has raised awareness of the issue.

Part C: Solids and non-milk fluids

8. Introducing solids: decisions and strategies

In chapter 8 we look at the timing of the introduction of solids, and at how fathers, family, friends and other sources of information can influence decisions. We consider cues from babies and strategies used by parents, which influence what foods, milk and non-milk drinks are given, in what quantity and how frequently.

8.1. The timing of introducing solids

All parents were aware of the recommendation not to introduce solids until 6 months, however, few families in our sample waited this long. In this chapter we explore the complex decisions and strategies around the timing of this decision and build on earlier work around the symbolic and practical meanings of infant feeding (Murphy, Parker, and Phipps, 1998). There was little discussion antenatally of families' intentions regarding starting their infant on solids: the topic wasn't raised spontaneously by interviewees as their focus is on the early stages. It is an important developmental stage for parents, and there is some confusion about how the time of introduction is defined. Introducing a bit of baby rice or fruit puree or giving a little taste or "the odd little morsel of banana" is not considered to be "properly" introducing solids by some parents and health professionals:

> "I would still like to hold off for as long as possible before we tried weaning her properly. The baby rice she's getting is just like thicker milk" (2181; PN6; mother; baby five months old).

In our study there were some contradictions between interview data and the answers to structured questions on feeding asked at the end for the purpose of collecting sample characteristics data, indicating that the way questions are worded is important. This has important implications for how parents interpret survey questions about the timing of introducing solids or exclusivity of breastfeeding and therefore the quality of the data collected.

8.2. Who influences decisions

As with the milk feeding stage there is variable involvement of the father in decision making. Some primiparous, but particularly multiparous women tend to make the decision entirely by themselves, reflecting their ownership and control over infant feeding. For many there is growing confidence over time, getting to "know" the baby, and "it's more my decision now". Some refer to a "mothering thing", "I can't really explain it" and a deep intuitive sense of maternal knowing:

> "I thought well, if I lived in the jungle I would just give him a wee bit on my pinkie and I know it was probably a bit early, but he's just a big sort of solid baby, and I thought I'll just go by my instincts" (2169; PN4; mother; baby three months old).

Some consult widely with friends, family, health professionals and use leaflets, the internet and books, to “feel more informed” and to be “happy to make decisions for myself”.

8.2.1. Fathers

Moving on “to the next stage” of introducing solids has different symbolic meanings for couples (Murphy, Parker, and Phipps, 1998). For some it is an opportunity for fathers of breastfed babies in particular to become more involved in feeding. For the mother this removes the onus as “solely my responsibility for food”, and frees her “to go out for a day and not have to think about the food”. Fathers can be completely involved with some wanting to witness the next stage asking mothers to wait until he is home from work or passive, even indifferent about infant feeding “he just does as he’s told”:

> “It's really up to me. He doesnae … - in fact I think if I hadn't of said to him, he would have just thought that the baby would be on bottles until she was one (laughs). That's a man thing! (laughter)” (2047; PN4; mother; baby three months old).

Work restrains the involvement of some fathers, which couples describe as “hard” but “just one of these things, you just have to do”. Other fathers take over as carers when mothers return to work: “he knows the drill as well as if not better than I do”. There was a sense of less support for fathers: “it’s not like I can really have guy sort of talk about babies”. To cope with their responsibilities some men look it up in books and are “quite envious” of internet chat rooms like Mumsnet because there’s not a dad’s one: “it’s nice to moan and have other people who are in the same position moan as well!” Some first time fathers expect the introduction of solids to be harder than it is. In a minority of cases the father is the main driver for introducing solids, particularly when he sees the mother struggling with the “tiring” and “hard work” of breastfeeding.

8.2.2. Family and friends

Experiences of introducing solids are shared widely with family, friends, acquaintances at groups, child-minders, and nursery staff: “I think I've spoke to everybody I know about it”. The generality of experience means that unlike breastfeeding “everyone's an expert” with some finding this “the least helpful thing” and choosing to ignore it or “just pick the one I like” and others trying “any advice we’ve been given” and feeling “any advice is good advice”. Often the most influential are those who support or validate the woman or couples own views and are of “similar mind and outlook” with those who have behaved differently felt to be of no help:

> “my friends say “oh how are you getting on?” and you say “oh I'm not getting much sleep” and they're like “oh that's dreadful, just give her a Farley Rusk” and I think ‘oh no!” (2103; PN5; mother; baby four months old).

Most have a “first line of call” if anything is worrying and this is often the mother’s mother or a close relative, but sometimes other sources. Speaking with other mothers “at the same stage” at groups (see Chapter 9.3) is particularly helpful, providing social comparisons (Festinger, 1954) and normalising experiences. Downward social comparisons are particularly evident and hearing about the “struggles” of others can be “reassuring” and “make you feel better” in terms of your child being “quite normal”. Upward comparisons are more evident in the types of food being given (see Chapter 8.4). As with earlier stages, family and friends who give you tips: “this is what we’ve tried and it worked for us, see how you go” but “step back and let you get on with it”, “don't interfere too much” and “are not pushy” are ideal. However, for some who are struggling to get their babies to take solids, the special qualities of some grandmothers or others who take over feeding are particularly appreciated: “she sat and ate the lot and I was like “how do you do that?” (laugh)”.

The older generation, especially grandmothers use their experience to comment “I think she’s hungry” and encourage the early introduction of solids, which is supported by previous research (Alder, Williams, Anderson, *et al*, 2004). Many acknowledge that advice has changed since they had children and those with recent experience are seen as more knowledgeable about current guidelines. Constantly changing guidelines are to some extent undermining the experience of older generations, even those who fed children relatively recently. Couples reflect that some “couch things very carefully because she knows things have changed” and our study confirms the complex negotiations between generations reported in other research (Reid, Schmied, and Beale, 2010). Grandparents sometimes undermine breastfeeding when advising to introduce solids: “he's getting very big; you'll not be able to keep up with him for long”. Some relatives are “desperate” to look after and feed the baby, particularly when mothers return to work and some mothers acknowledge difficulties when they “don’t have much control” and leave meals for the baby to ensure that they decide what their baby eats.

8.2.3. Written and audio-visual information

Commercial books and the internet are referred to more often than NHS information (see Chapter 9.2), but more so in Site 1 than in Site 2 of our study. Peer recommendation is influential, and in particular “everyone raves about” Annabel Karmel books as “one of the best things I’ve got”. “Practical recipes”, tips on “types of food” and offering “all-in-one information which I keep in the kitchen” are the helpful qualities. Older books which “do not focus on baby-led weaning” are also used but felt to be not as good, indicating the importance of contemporary fashions. Online resources are used frequently: “I Google search for whatever I need”, particularly in terms of seeking experiences of other women about questions which you “don’t want to be daft and ask the health visitor about”. Parents are aware that the information online can be “a bit hit and miss” and NHS resources are considered more trustworthy and “unbiased” but seem not to meet their emotional and social requirements. Emotional attachment and the feel-good atmosphere of websites are evident with some “loving Mumsnet” and describing the ideal website as “practical, factual, expert advice with a sense of happy community”. Websites provide “lots of helpful top tips”: “this is what we’ve tried and it worked for us, see how you go” and fits with research about the importance of facilitating women’s own decision making

rather than advising or telling them what to do (Hoddinott, Chalmers, and Pill, 2006). The connectivity of discussion forums and chat rooms to a wider network of mothers provides the valued opportunity of finding someone with the same experience, and not being alone. The flexibility of proactive or more passive engagement is also valued. Some, particularly those who are less confident about proactively seeking advice, don't post their own questions, preferring to "look at people's questions to save me asking". Others are more proactively engaged and ask questions to get reassurance: "don't worry about that, that's particularly normal" and often place "more value in other mothers' points of view, as opposed to kind of so called experts". Netmums; Mumsnet; Facebook (Emma's Diary); Ask A Mum; Maternity Action; the NCT Yahoo group; e mails from Bounty and commercial baby clubs sending "a list of signs your baby is ready for solids" were mentioned. Free samples, Bounty packs and adverts in mother and baby magazines were also links to online information. Variety is evident with something to suit all individual preferences and values and "after delivery you get quite a lot of things that introduce you to baby websites". Mothers are influenced to purchase particular products by vouchers received and some have a feeling of being "inundated with freebies, vouchers and booklets".

8.3. Rationale for when solids are introduced

8.3.1. Baby cues

All mothers are "aware of the signs" that a baby might be ready for solids however; the interpretation varies according to the priorities, values and meanings attributed to this stage (Arden, 2010). As has been found previously (Anderson, Guthrie, Alder, *et al*, 2001; Bolling, Grant, Hamlyn, *et al*, 2007; Synnott, Bogue, Edwards, *et al*, 2007; Wright, Parkinson, and Drewett, 2004), mothers who choose to introduce solids earlier tend to be particularly influenced by signs suggesting the inadequacy of milk such as the baby waking up frequently or waking earlier, feeding more frequently, "taking every bottle and sucking it dry" and appearing to be "not satisfied after feeds" – "looking for more". Other signs are interpreted as indicating a need to progress to more advanced foods, such as watching others eating and drinking, reaching out for food, "everything goes in her mouth" and "trying to steal our food". Mothers who are keen to follow the guidelines and wait until 6 months interpret baby behaviours or comments from others that "she must be hungry" differently. They see the baby behaviours as part of developing awareness and interest in other things and show patience: "I don't feel like she's desperate for food" or "not absolutely demanding it yet":

> "he was interested in watching us eat from a bit earlier which I think some people take as a sign, but he watched us do everything as well, so I kind of thought well he's not ready to eat just because he's interested in food" (1108; PNF; mother; baby six months old).

Some want to let babies actively "lead", "set the tempo" and not "force it", allowing them to be "in control" and "dictate how things go". Some mention "baby-led weaning" which they research themselves as health visitors "don't really explain a lot about it" and wait until the baby picks things up and put them in the mouth. Those who introduce solids prior to 6 months feel their decision is vindicated and to "have paid off" if the baby is content, happier and more settled, "obviously ready" or has

“gone on leaps and bounds”. There is a desire for the baby to progress to “real food”, and “he’s more or less sitting up by himself, so we have him in a high chair”, “quite exciting the next stage”. This supports the symbolic meaning of the introduction of solids as a sign of progress through the developmental stages, with advanced and rapid progress desired as a sign of infant wellbeing (Murphy, Parker, and Phipps, 1998). A visibly content, thriving baby is the desired goal, rather than short or long term intangible health benefits and changing feeding behaviour is a developmental milestone which parents can have some control over. Solid food as a reward and pleasurable in comparison to milk is also evident: “she was really excited” and “he just loves food”:

> “I think if we’d started him on solids at day one I think that would've been the answer to be quite honest (laugh) but not very practical! [to baby: yeah you would've liked that wouldn’t you? milk was no good for you was it, no]” (1010; PNF; mother; baby six months old).

Babies as communicative beings permeates parents descriptions, with suggestion that parents own priorities and doubts are reflected in their interpretation of non-verbal communication: “Why did it take you so long?”, “Well why am I not getting any of that?”. There is a tendency to introduce solids earlier if you have a “bigger baby” or if baby behaviours are interpreted as “hungry” compared to “less hungry babies”.

8.3.2. Parental cues

As with milk feeding, the aim of introducing solids is to balance the often conflicting desires for a contented baby, sleep for the baby and the family, and time for other things, rather than intangible short and long term health benefits. Our study builds on findings that the introduction of solids and other drinks is influenced by the symbolic meanings which food fulfils for parental goals as well as the baby’s need for food or nutrition (Murphy, Parker, and Phipps, 1998). Symbolic and practical meanings for parents include the incorporation into the family and existing feeding routines; more involvement of the father; freedom and time to go out with others taking over the feeding; more sleep; improved parental wellbeing; returning to work and holidays and who is in control.

Giving solids can incorporate the baby into the family with other children “excited that she was eating”, and with fathers more involved (see Chapter 8.2.1). Fathers who are keen cooks look forward to making family meals and “pureeing a bit for the baby” and solids take less time than milk: “I can get more done during the day”. For some multiparous women, previous experience and routines of introducing solids dominate, rather than responding to baby cues and they expect all their children to behave similarly: “It's just easier to keep to the same way that I did it with him” and “I feel more comfortable kenning what I'm doing”. There can be concern over babies who differ from previous experience. Domestic arrangements can determine when solids are introduced; if fathers are away for a few weeks or for the more advantaged with holidays as, “it is easier if the baby is still just on milk” with worry about the risks of pureeing vegetables in foreign water. As with introducing formula and expressing milk, solids allow women time away from the baby and self care can resume with activities like getting “hair done” making “a big difference” to wellbeing. Solids are often introduced to improve highly valued sleep or prevent a baby waking at night

and disturbing other children. Wellbeing is often of paramount importance, particularly for those breastfeeding, who are “getting a bit drained” or “couldn’t physically carry on” and “beginning to look a bit shattered”.

The pleasure and excitement of the baby taking solids for the family is evident together with a desire for entertainment (Murphy, Parker, and Phipps, 1998) and experimentation to see what happens. Some experiment with the timing and type solids as early as three months to “give it a try” and “just a taste to see if she liked it”. Sometimes parents start solids then stop, for example if the baby is “not fussed about it”, when breastfeeding is “going brilliant” or if the baby becomes constipated, is unwell and goes on fluids only, forcing parents to start again.

Work is a strong theme determining decisions around the introduction of solids, with a few feeling that it has not made a difference to their decisions. Particularly those who continue breastfeeding find it difficult to even contemplate going back to work at 6 months. Some who return to work late or decide not to return have the “privilege” or “luxury” of delaying the introduction of solids and “having trials to make sure that he's comfortable with other people feeding him” – a priority for many. Some are reluctant to put their own needs first:

> “I'm still off work, so I feel it's kind of selfish to put him on to food quite early just so I can get a night's sleep” (2003; PN5; mother; baby three months old).

Mothers who delay their return to work feel under less pressure which makes “the transition really smooth” and for those keen on baby-led weaning it doesn’t “interrupt her development”. In contrast, mothers returning to work earlier become “a bit more apprehensive”, “a bit stressy". Returning to work can “spur” parents on to introduce and increase solids faster; cut back on “the dream feed at midnight”; get into “a more decent routine” and get solids “properly established” before someone else has to take over. The importance of relatives, friends or childminders “fitting in to what I wanted” is important to reduce worry at work and some parents feel less “in control” of the child’s feeding if they attend a nursery or childminder, relying on “hope and trust”.

8.4. Type, quantity, frequency delivery of solids

The type of food first introduced usually follows recommendations of baby rice then followed by or along with fruit and/or vegetables and baby porridge. Subsequent food order, the pace and amount of change and the quantities for first babies vary. They depend on parental values and preferences; variation in the interpretations of baby behaviours; the meanings given to food and strategies to reach desired goals. Some start with baby rice but it “made him retch”, “got spat everywhere”, the baby “didn’t like it” or it was thought to cause medical symptoms “problems with her stomach” or “bunged him up”. Parental negative views about baby rice are common with previous children not liking it, “it’s too bland” or “really disgusting”. The desire by some to give pleasurable foods is apparent. A baby crying can be associated with unsatisfying bland baby foods and the symbolic meaning of food as pleasure, comfort and wellbeing is implied sometimes light heartedly: “Oh, give him a Mars Bar and that’ll keep him quiet” (Murphy, Parker, and Phipps, *et al,* 1998). The goal of a

contented thriving baby is paramount and if “baby rice isn’t cutting it” and they’re still waking during the night, introducing “something a bit stodgier to fill them up” is a common strategy. Instructions to mix baby rice with the “baby’s usual milk” is impossible for breastfeeding mothers who don’t express milk and can lead to the introduction of formula. Food choices are sometimes based on perceived baby taste preferences, which may reflect parental preferences or values: “he prefers fruit” or “he prefers savoury than sweet” or “harder foods rather than soft ones”. A minority start with “what we’re eating”, liquidised beans and sausage with tatties, liver and onions, with some adding salt to homemade food for “a tiny bit of flavour”. Others stick more to recommendations, trying to give them “as healthy food as possible”; no “junk food”; avoiding anything “too sweet” with added sugar or using virtually no salt or low salt stock cubes. Those adhering to recommendations remember “that her food’s got to be relatively bland or just taste of what it tastes”.

Purées, smooth or runnier foods are often given first particularly by those who introduce solids earlier, for example, fromage frais mixed with pureed fruit or vegetables. This is slowly followed by lumpier, “more textured” foods. Some feel they can “go for broke” introducing fish, meat, wheat and eggs quickly and “all the stuff that couldn’t be allowed till 28 weeks” and are keen for development to progress rapidly: “he flew through the first stages” and is now on “just mushed up real food rather than puree”. Some resist recommendations: “there’s no right and there’s no wrong”. Those following “baby-led weaning” think “there’s no point starting with purees”, or use them alongside finger foods. They put things in front of him “see what he does with them” and he may “suck on it, chew it or play with it”. When solids are introduced later, progress to lumpy foods can occur in “hardly any time at all” or even from the start. Some fathers encourage mothers to introduce lumpier foods and finger foods, to try new things and be less restrictive in order to prevent habits and provide pleasure:

> Father: “If you leave it, he’ll just get used to smooth foods… I’m talking about stuff he’s entitled to, not a sandwich. I put a little bit of ice cream on his tongue and he was loving it”
> Mother: “You see I wouldn’t have done that” (2056; PNF; couple; baby six months old).

Some couples have difficulty getting their child to take solids: “she gags quite a lot”; “spits it straight out”; “resists”; “wouldn't open his mouth”. Some try different foods and techniques to get the child to eat, with some failing. Others accept that the baby is not interested or acknowledge that this aspect of development is slower for some: with babies described as “not that great at it yet” or needing to get “the hang of” swallowing. Some parents are “nervous” or “apprehensive” about starting solids, “more so than anything else I’ve had to do” and this is related to anxiety about potential harm to the baby, particularly choking: “you’re feart to shove the spoon in too far, or they’ll choke” and some empathise with how it feels for the baby to have thicker foods in their throat and learning how to swallow by trial and error.

Homemade food is seen by many as the ideal, cheaper, better for them, avoids constipation, “smelly poo” and “all the chemicals in jars”. Brands of readymade foods are frequently quoted, particularly organic ones which are considered “natural” and “they don't have anything else in them” and “as close as you can get to homemade”.

Readymade foods may be used initially for convenience, are seen as less wasteful rather “than making a huge batch of something, only to find he doesn't like it”. Some mothers may feel “a bit guilty” about using them but their decision is then vindicated by the baby’s preference:

> “I used to lovingly spend every weekend in the kitchen cooking stuff for her that she would never eat, and we’d give her a jar and she would devour it, so (laugh) I think it’s probably from that as well, it’s quite heartbreaking when you spend all this time cooking and they don’t want your food!” (1010; PNF; mother; baby six months old).

Readymade foods are used to provide variety, to find out “what he likes and what he doesn't like” and they are perceived as advantageous “to stop them getting fussy” or “causing problems if they won’t take it when you're away from home” or “in an emergency”. There is a suggestion that upward food comparisons are being made with foods eaten by other babies via social networks, the internet and books, with some introducing foods not eaten by the rest of the family:

> Mother: “Pumpkin, that’s another one I bought because we wouldn’t normally have that”
> Father: “I've never tried pumpkin!” (1167; PNF; couple; baby six months old).

The assumption is that early introduction to a wide variety of foods is beneficial and many comment on the “big choice nowadays” with some influenced by products on supermarket shelves, free samples and consumer marketing through the media:

> “I got that from HiPP Organic, they just said it’s a modern baby tea, they sent me one teabag as a sample, you're supposed to infuse it in hot water, let it stand and cool down and then the baby can drink it and I can drink it. It comes in a teabag, yeah, she didn’t like it… I don’t much like tea without sugar and milk anyway” (1148; PNF; mother; baby six months old).

This example of a tea to be shared by the mother and baby is further evidence that parental food preferences may be determining the types of foods commercially available for babies. Further examples of supermarkets offering what might be considered adult foods like spaghetti bolognese and banoffee pie for babies are given and this can be interpreted as reducing the dietary gap between adults and babies and a contemporary trend.

There was some uncertainty about quantities of solids to give and parents would like more health service guidance. Particularly those making homemade food express concerns that some babies do not self-regulate the amount of food they eat: “he'd never stop if we didn't stop”, and “she’s a wee gannet, she’ll keep going”. Backs of the packet are often referred to for guidance but this can be vague or misleading: “it just tells you to increase it as required”. Others want to maintain a balance between milk and solids, by not giving too much solid food.

Mothers buy or are given special equipment for introducing solids such as blenders, spoons, bowls and cups for the introduction of other liquids to avoid introducing bottles. Equipment and how food is delivered is important. Particularly mothers who value breastfeeding use cups, which are often given out by the health visitor in weaning packs or at a six month check in order to get babies used to them ”learn the technique” and “experiment” to avoid ever needing to use a bottle:

> “so really I just wanted to get (baby) used to drinking water quite quickly – just get her to associate a cup of water with her meal, so that she learns to drink (laugh)!” (1040; PNF; mother; baby six months old).

Some mothers are wary of introducing cups “it would choke her” and prefer bottles or plastic spoons which the baby “thinks it’s… I don’t know, novel, it’s quite funny”. This again illustrates the symbolic meaning of food as entertainment (Murphy, Parker, and Phipps, 1998) with some babies given the cup “to play with” at the same time as they are eating solids. Peer recommendations about which bibs to use and which implements to use, particularly when directly observing other mothers and babies in groups provides valued object and social comparisons. Blenders are seen as pureeing food “properly” and some without one tried “to mash it with a potato masher and a fork and things, and it was too lumpy”. Blenders are purchased particularly by those introducing solids early, who are often the more disadvantaged (Bolling, Grant, Hamlyn, *et al*, 2007) as parents “don’t want her to try swallowing something and I don’t want to be in a panic”. Several describe public eating places as “more accommodating now with children” with access to bottle warming equipment, high chairs, appropriate spoons and bowls. The importance of food delivery objects as well as the variety of adult style meal choices in ready meals suggests that fashion and possessions are symbolic meanings for some parents when introducing solids.

8.5. Continuing milk – breast or formula

As described in Chapter 7.2 and 7.3 the reasons for introducing formula or stopping breastfeeding are complex, often unrelated to health goals and are only partly to do with solids. Most mothers who are still breastfeeding at the time of introducing solids plan to continue for more than 6 months, some for at least a year and a few for as long as two years even if it’s only just once or twice a day. Some are keen for the baby to make the decision to stop. Some prefer to introduce solids: “it is a shame to introduce formula” when “we’d got that far” and believe solids are healthier:

> “it’s great to know exactly what he’s getting, because with formula, it’s all these bits and pieces and chemicals in it” (2061; PNF; mother; baby five months old).

Some choose to introduce formula before or after introducing solids rather than expressing breast milk to mix it with solids: describing: “kind of beating myself up to start with, thinking it has to be breast milk”. Other mothers stop breastfeeding after introducing solids as they link this to developmental progress and it feels like “a natural step”, “she’s getting our little girl now” and moving out of the baby stage. Others describe decisions to stop in the context of breastfeeding outside the home describing the baby as “getting really, really distracted” and “far too interested in like other babies”. Although increasing demand for milk feeds is cited as a reason for

introducing solids, many parents say that initially there isn't much change in the quantity or frequency of milk feeds with introducing solids. Later less milk is given particularly at night, with some receiving advice to reduce breast milk to help if the baby is not taking solids readily or to offer solids first and then milk. Although parents may introduce "hungry baby milk" prior to introducing solids, once solids have been introduced there is often little change in the type of formula given. The preference is to remain with the milk "that she's happy with" and likes with reluctance "to change in case it causes him an upset". A minority of mothers introduce different milks at this stage such as "follow on" or "Good Night" milk, perhaps for health or nutrient reasons, for example concerns about the baby receiving less calcium as breast milk feeds reduce.

As highlighted in Chapter 8.3.2, those who have been able to take longer maternity leave feel under less pressure to introduce solids earlier and more able to continue breastfeeding. Returning to work has many practical implications and meanings for the introduction of solids and mothers who wish to continue breastfeeding value continuity of the emotional bond. Some felt that their planned return to work had not impacted on their plans for feeding, unlike others. Work places vary from being responsive to parents' breastfeeding, helpfully allowing flexible working hours, the ability to "work from home" or onsite nurseries where you can "easily just go". Others described stressful work situations which impacted on their feeding milk and solid feeding decisions.

8.6. Other fluids

Some parents, particularly those breastfeeding had not introduced any other drinks at the time of the final interview at 6 months because they don't perceive a need. Liquids other than milk are more likely to be introduced earlier for those giving formula milk (see Table 2.2), often on recommendation by the health visitor:

> "formula doesn't count as a re-hydrating drink like breast milk does, so she'll need water along with it" (1167; PNF; mother; baby six months old).

The reasons given by parents for introducing water include colic, hiccups, colds, to try and help loosen mucus, to keep fluids up in an ill baby, when teething, if bit girney or fractious, to cool her down or for constipation. For some believing in baby-led weaning, "drinking a lot of the bath water" is perceived as a reason for starting water. Our interpretation is that water is perceived as a cure all remedy by parents, health professionals and families. Other remedies include herbal teas as a cold remedy and sugar water for hiccups and juice for constipation. As with introducing formula and solids introducing water may "free you up a little" and provides some flexibility as it can be given by somebody else. Other liquids particularly water are introduced alongside solids, because "they might be thirsty" and reflecting maternal preferences: "if I was eating that I'd quite like a drink to go with it" or "something to wash it down with", again possibly reflecting fears of choking. For others, drinks are given between meals or after meals or to sip throughout the day. Cooled boiled water is the drink most commonly given with mixed success. Some are perceived to enjoy it, others to hate it or are not interested: "what is this, it's not milk". Mothers try wide ranging strategies including warming and cooling, those "you're not supposed to" like adding no added sugar cordial, other juices starting with the less sweet and moving onto

sweeter ones at different dilutions, using different delivery methods – spoons, cups, bottles, over “like weeks of trying, not like a day” in an attempt to achieve their goal of getting babies to drink fluids other than milk. This parental desire to control fluid intake is in contrast to a widespread acceptance of babies choosing which solids they like. Once successful they “stick with it” and parents express incredibility: “I do not know why she won't drink water, she just won't”. There is an assumption that fluids other than milk are necessary and important, with milk being associated with the baby stage. Not all mothers prioritise non milk fluids, with some “a bit hesitant to give him the baby juice” or “trying to keep off the juice as long as possible” because of concerns about an “awful lot of sugar and stuff” in juice and being “afraid of her developing a sweet tooth because I've got a horrible sweet tooth”. As with solids there is a sense of experimentation, trying things out of “curiosity”, “just for different flavours” and to “try something else exciting to play with”.

9. Expectations and reality about health service care

Chapter 9 covers the input and influence of health professionals and health service information on the introduction of solids. It draws on interviewees' reflections on preferred type, timing and style of information on solids in response to a vignette (Box 1.1, vignette T). The use of medicines and other remedies for babies and how this can interact with feeding is covered.

9.1. Health professionals

The NHS and health professionals who "consider a lot of factors and give a more professional view" may be a more trusted source of advice about the introduction of solids than the experiences of family, friends and commercial internet sites. However, parents see themselves and the baby as being the key decision makers about solids, with health professionals playing a smaller role than in the early stages after birth (see Chapter 3). Women feel that compared with milk feeding, the introduction of solids is less well covered by health professionals: "I don't see why putting your kids on solids isn't as important as birth or feeding". Discussions with health professionals about introducing solids vary from well co-ordinated multi-disciplinary care to none at all to:

> "it's all sort of snuck up on you, sort of like 'hang on, how much should he be getting? when do you introduce drinks?" (2057; PNV; mother; baby six months old).

For example, a health visitor assistant may visit at home, provide a starter pack with information and go through how to introduce solids, providing follow up at the baby clinic or by 'phone. Some have access to specialised "weaning" groups run by health professionals. However, in general, parents felt "there's not the same kind of structured support in place for weaning" in the health service and sometimes information is given at the baby clinic and is "quite a rushed thing".

An issue for some women is the timing of information received on when to introduce solids. There is less frequent contact with health visitors now since implementation of Health for all Children 4 (Scottish Executive, 2005) so women may choose to start introducing solids themselves prior to having the chance to discuss this with the health visitor. This is particularly the case in Site 2 where participants tend to introduce solids slightly earlier than in Site 1. There is evidence of quite fixed health professional routines: "They'll not tell you about them (solids) until six months" and time schedules which seem inflexible and not centred on the needs of families:

> "she (health visitor) said she wasn't planning to do that (discuss solids) for probably another four weeks, so obviously it'll depend how things go over the next few weeks, whether I've started giving him food or not before then" (2003; PN5; mother; baby three months old).

Multiparous women in particular are confused by the change in advice on the timing of introduction of solids, which leads them to question the new rules, especially as these imply that they may have done something wrong with previous children:

> "having an age-gap of 15 years …that it's gone from three months to four months to six months …, and you're getting all this conflicting information about weaning. …when (older child) was weaned, he was three months 'cos you started at three months, he's all right, so why can you not do it now?" (2056; AN; woman).

The current health status and observable wellbeing of a child discounts the possible longer term intangible health benefits of later introduction of solids. Primiparous mothers or those with much older children often wait to "find out about introducing solids first and see what health visitors suggest", which provides reassurance. They are more likely than multiparous mothers to find advice from health visitors helpful, particularly when suggestions facilitate the woman's own decision making rather than stating do's and don'ts. Many of the communication styles preferred by mothers learning to breastfeed (see Chapter 5) are the same as those preferred when introducing solids, particularly reassurance, offering choices rather than assuming that there is only one way and being non-judgemental.

Mothers whose children are not taking readily to solids may be advised by health professionals to "cut back breastfeeding and that might stimulate taking in solids more", and some mothers are given a message that "after six months there isn't any nutritional benefit" in breastfeeding, which can undermine the current recommendation to continue breastfeeding alongside solids until the age of 2 years (World Health Organisation, 2003).

9.2. Health service written and audio-visual information

Many mothers receive written materials such as leaflets on introducing solids from the health visitor, although some do not. These include the Fun First Foods leaflet (NHS Health Scotland, 2010) which has "a fair bit of information" and the Ready Steady Baby book (NHS Health Scotland, 2010). Some women use the NHS website for information, feeling that "the NHS comes from an unbiased perspective" and that they "would pretty much trust most of the NHS". However, the majority of parents are finding non-NHS information sources more useful (see Chapter 8.2.3). Primiparous women in particular find the NHS leaflets helpful with regard to "what kind of foods to give", "how much to give", how to defrost and freeze, "how much water to cook vegetables in" and "you shouldn't put salt in the water", however, there are often unresolved practical questions which are difficult to convey in writing. In particular parental anxiety about the baby choking and the potential to harm a baby though giving solids are more appropriately discussed or demonstrated:

> "they (leaflets) say "move onto lumpier foods" but it's like, how lumpy? (laugh) Because neither of us really know, and you don't want to give her something that's still too runny, but then you don't want to give her something that she's going to choke on" (1167; PNF; mother; baby six months old).

Others feel that although the information is "quite good" they would like more guidance with regard to quantities as they feel this is a bit "vague". Parents with previous children tend to pay less attention to the information provided, and "didn't bother to look at the leaflet, I'd seen it before". Previous experiences are the strongest influence on their decisions about introducing solids (see Chapter 8). As

with verbal information, the timing of written information is an issue. Some would like it earlier when they start to think about solids, others feel leaflets given earlier may be "put in the cupboard" and "you mislay it".

9.3. Classes and groups

Mothers vary in whether they prefer individual health professional discussion, groups or a mixture of both. Group sessions specifically on the introduction of solids are not always available and are mainly targeted at primiparous women. In response to the vignette on a group or individual discussion about the introduction of solids, those who have not had access to a group think in theory groups are "a great thing", a "very good service". For some, information about solids is provided at breastfeeding groups and meets women's needs. Many of the characteristics of groups that are popular are the same as those described for breastfeeding (see Chapter 5.6), with an "open discussion and chatting to each other" preferred to a didactic rules based style:

> "they tell you that there's "a way" of doing it, when in fact what you want to know is that there's loads of different ways of doing it" (1075; PNV; father; baby six months old).

In particular groups are valued for socialising and sharing experiences "not just about feeding" which fits with the pleasure and entertainment meanings attributed to introducing solids (Murphy, Parker, and Phipps, 1998):

> "it should be a group, one to one can be all serious, group is a bit more light hearted, feeding the baby should be fun, it's a great time" (1010; PNV; mother; baby six months old).

Social comparisons and normalising experiences are important, with reassurance to reduce anxiety about the immediate harms of solids to the baby: "you think you're going to kill your baby the first time you give it something solid". Couples want practical information, "how to know that they're getting hungrier for foods rather than milk", "how long do you keep with a particular taste before you move on", "how to actually go about it", "what are good foods", "how much" and advice on the best equipment to use. Benefits of groups include "other folk ask things that you hadn't thought about"; to "know you are not alone" to "see what they're doing" and "it gives you a lot of confidence": For others, groups are "not very informative" or useful. Groups require self confidence, with disadvantages centring around being shy or embarrassed about "saying what's bothering you in front of other people" and therefore a one-to-one session with a health professional may be preferred. Groups may provide more standard, "by the book advice", whereas individually "it's more tailored to you". A "choice is great", with suggestions of an individual appointment on the back of a group, or an initial individual appointment to assess "where your baby is at and what's going on" then a group session later "when you're starting to do it". Most couples think that fathers should be invited, with mothers suggesting "it's their turn now"; it "gets them involved" and they are "just as much part of it as mum". Some fathers may be keen to attend and be involved, feeling "things are getting away with me" now they are back at work. However, some women may feel "it's the mother who feeds babies anyway" and prefer a mother and baby focus.

As with written information, timing is important particularly for women returning to work and some groups “fell at the wrong time”. Those preferring family orientated sessions feel they should be at a time when working fathers or “anyone who’s going to feed the kid or be around” can attend, such as evenings or weekends. There are differing views on the age of the baby when discussions are offered. Some feel that three to four months is “perfect”, it gives enough time to “get yourself prepared for it”, and “people do it whether they’re talking about it or not”. Others feel that three to four months may be “too early” as people would assume that if they’re “prepared to discuss it with me at three months, it must be fine” or “by six months you've forgotten about it”.

9.4. Consistency and continuity of health service care

As with earlier stages, conflicting advice about the introduction of solids is an issue (see Chapter 5.4) with health professional advice to “stave them off as long as possible” hedged by compromises: “as close to six months as possible, but at the very earliest seventeen weeks”. As discussed in Chapter 8.2.2, “everyone is an expert” about introducing solids, so the conflicting opinions and experiences of family, friends, the media and the health service abound. In contrast to a study of a highly educated sample of women (Arden, 2010), some women do not see conflicting opinions or advice as problematic, as they like to listen to a wide range of views and then decide. They appreciate health professionals being flexible and discussing a range of options. The health visitors use strategies to justify why they are differing from the guidelines:

> “(the health visitor said) the paediatricians are actually quite happy for you from seventeen weeks to start giving them some baby rice if you feel that they are getting very hungry” (2056; PN5; mother; baby four months old).

Rather than being told not to give them anything at all and guidelines about the timing of introducing solids, parents would prefer to have consistent information about “what’s right to give them and what’s not”, like gluten and salt, particularly when babies seem really hungry. Jars and ready–made meals add to the confusion by saying on the label “from four months” or “from seven months” when advised that “you can use this stuff from six month, that’s okay”. Particularly primiparous women are confused about what may be introduced when:

> “there's so much conflicting information. The health visitor says the official line is six months, however, if you want to try her on a little really, really sloppy baby rice she'll be okay. GP said six months is the absolute minimum that you should be giving them any solids, but if she is a hungry baby you could try her on fruit puree, but nothing with wheat in it such as porridge” (2294; PN5; mother; baby four months old).

9.5. Medicalisation, rules and “the right way to feed”

A rationale for waiting until six months to introduce solids is only mentioned spontaneously by a few parents. Some report the health visitor, or occasionally family and friends, talking about “nutritional requirements”, or saying it was okay to start because “he holds his neck alright” or waiting for the kidneys or the stomach,

intestines and digestive system to mature. Some talk about being influenced by the rationale that the gut is more permeable before six months and waiting until then is "better in terms of not getting allergies" which is a particular concern where there is a family history of allergy. Few link the timing of introduction of solids to obesity but see more of a link with the types of foods introduced (see Chapter 10). Information about the rationale for waiting until six months to introduce solids may be considered unreliable, or as yet another rule in a no win situation for parents:

> "they say if you wean them too early it can lead to obesity in later life …, but also if you leave it too late it's no good, … there's so much kind of information out there that you just... as one of my friends says "parenthood is just one big guilt trip!" (laugh) You feel bad if you did it this way, you feel bad if you do it that way" (2039; PNF; mother; baby six months old).

Health professional advice can help some but can be perceived as failing to recognise "that every baby's different". Those who doubt or discount the medical and health related reasons for delaying the introduction of solids justify their beliefs by looking for evidence of ill effects when their baby starts solids, and assume that all is well if none are immediately observed:

> (talking about her first child) "she said 'his stomach's not ready for it'. And I was like, 'well he seems to be alright, he's not being sick, he's not had diarrhoea, he's been absolutely fine', so I didn't see the problem. He wasn't ill with it. If he'd been ill with it, I would have stopped" (2287; PN3; mother; baby three months old).

The visible evidence of the health and wellbeing of family and friends where solids have been introduced early is recounted and decisions justified in reference to experiences with older children. Delayed or theoretical health benefits are hard to grasp. The medical model of suggesting that there are right and wrong ways to introduce solids can create parental anxiety and undermine confidence, leaving others to try and undo the adverse effects:

> "my mum kept saying 'it's just trial and error, there's no right and there's no wrong....', because I'm quite bad for getting a bit... even now I'll still sometimes be 'oh it's all going wrong' and get over anxious and kind of like 'oh, not doing it right and she's not getting what she needs" (1167; PNF; mother; baby six months old).

Conflict arises with families feeling criticised for starting solids early and there is evidence that it is adversely impacting on the health visitor-mother relationship in some cases, withholding information or feeling that they have to hide it "it was like a guilty secret". This fits with other studies describing how health policy constructs mothering as either "good" or "bad" in relation to infant feeding (Lee, 2008). Women are developing strategies to increase their chances of being seen as "good mothers" in the eyes of health professionals, but are more open amongst other mothers in person or on internet discussion forums. Mothers attending groups report witnessing the secrecy and withholding the truth by others and some really struggle with deviating from health service recommendations:

> Father: “We feel that we've done the right thing, but there was not...”
> Mother: “It was a hard decision for us, wasn't it?”
> Father: “Aye, it was a hard decision because we were going against...”
> Mother: “The rules, if you like”
> Father: “The rules, we were breaking the rules” (2294; PNF; couple; baby six months old).

Some mothers may try to “ride it out” and play the numbers game to try and keep health visitors happy:

> “he was overdue by eight days, so I thought if I can get to eight days before four months, that would be fine you know, because if he was born on his due date that would be fine” (2169; PN4; mother; baby three months old).

Often, women look to health visitors for approval when they plan to break the rules, and are relieved when they are “happy that we’ve lasted twenty weeks,” or “they were fine”. Other health visitors prefer to deny reality, “don’t tell me if she starts (having solids), I’m better not knowing”.

Most of the conflict with the medical rules centres around the timing of introducing solids, however, some families mention dietary rules about types of food to give: “healthy as possible”, “persevering with savoury things”, remembering that “she doesn't get any salt or virtually no salt anyway” and avoiding “gluten and dairy”. This can sometimes be difficult to follow as gluten free rusks have got quite high sugar but the sugar free ones have gluten. There is frustration with manufacturers for not making “everything all in one” and some parents “don’t know if rice has gluten it” and would like more information about the risks of allergies linked to specific ingredients.

Water and juices can be suggested by health visitors, families and friends as remedies for a wide range of symptoms even for exclusively breastfed babies, as discussed in Chapter 8.6. In addition, parents give over the counter and prescribed medicines and remedies throughout the first six months of life, with only a minority not giving any. There is confusion by parents as to what “counts” as a medicine, “Bonjela if you count that”, “I suppose they do swallow them (teething remedies) but in tiny bits” and some thickeners like Carobel which are prescribed are foods. Medicines and remedies are most often given for colic, wind, reflux and teething. Calpol / paracetamol, is used around the time of immunisations sometimes prophalactically and for teething because you can see that “he’s in pain”, “out of sorts” or “a bit grumpy” however, some express reluctance because of its sweetness. Some try different remedies “we kind of just got everything they said and just tried it!” finding they are “a bit hit and miss” but others find they work “freakishly well!” Medicines and remedies are used to varying degrees of success and for some “nothing seemed to work”. For some a remedy is trusted and they “buy huge batches of it (Infacol) and just use it” sometimes “for ages” and are reluctant to stop in case the baby is upset again. Medicines and remedies are started on the advice of health professionals, from previous experience for multiparous women, through peer recommendation and websites or magazines provide customer reviews, which help parents choose “the best” or compare costs. Culturally appropriate remedies are sent by relatives living abroad.

Often medicines and remedies are introduced on a spoon and can trigger the decision to introduce of solids if the baby readily takes them, particularly if they seem to like the taste. Banana flavoured antibiotics can trigger the introduction of a taste of real banana to check if “she was put off” banana or associates it with “something horrid”. In this case the parents didn’t see this taste of banana as meaning the introduction of solids. Our interpretation is that the remedy culture is subtly influencing the transition from milk to other liquid and solid foods. If a rationale for late introduction of solids is gut and renal maturity, remedies with their variable salt, sugar and nutrient constituents are currently undermining this rationale.

10. Maternal and family diet and obesogenic culture

Chapter 10 covers maternal and family diet and considers attitudes to baby and childhood weight gain and obesity more generally.

Most mothers report little or no discussion or information about their own diet during pregnancy, with the Ready Steady Baby book (NHS Health Scotland, 2010) often mentioned as the main source. Those who do discuss maternal diet report that the focus is on "what to avoid" rather than which foods to eat to benefit the health of the mother and baby. Some women would like more discussion and information but others prefer not to be "told" what to eat. Similarly, few discuss or receive information on the quantity or the type of exercise suitable in pregnancy. A key theme spontaneously raised by mothers is their keenness to lose weight after birth, although this was not a focus of this study. A few prioritise exercise after birth, resuming pre-pregnancy routines and attending the gym very soon after birth, valuing their own personal wellbeing as important to integrate with infant feeding (see Chapter 7.1). Although women are aware that breastfeeding encourages weight loss, even in women who wish to lose weight this fact does not tip the balance sufficiently when faced with the practical and emotional difficulties experienced with breastfeeding after birth. Some find it "tragic" that weight loss is how the health service is choosing to encourage women to breastfeed. Some mothers would like more information and discussion about their own diet while breastfeeding, as they are concerned that their diet might be "upsetting" the baby. Colic, wind and unsettled babies are particular problems which mothers may associate with the quality and constituents of their breast milk linked to their own diet.

Throughout this study, several parents, and particularly fathers, express strong views on obesity in childhood, at one extreme likening it to "child abuse" or "neglect". There is evidence that in pregnancy some couples discuss plans and have a vision for how active their child will be and how they will avoid "junk foods" to prevent obesity. A prevalent view is that "fast food", "junk food" and the media contribute to the problem, rather than early infant feeding, supporting previous findings (Pocock, Trivedi, Wills, *et al*, 2010). A predominant view is that obesity is "in the family" or related to the family "genetics" and "your metabolism". Lack of exercise is often seen as more important than food and parents are conscious of the difference in activity from their own childhood, particularly in children playing outside and in the use of computers and they observe that there were fewer overweight children when they were young. Interestingly the behaviour of earlier generations is perceived as "better" in relation to physical activity, but not in terms of when or the type of solids introduced (see Chapters 8.1.2 and 8.4).

Prevention of obesity is one of the many benefits of breastfeeding that parents are "told about" by health professionals. Although parents recount that "all the evidence suggests" a link between milk type and later obesity, many parents express doubt or disbelieve that it is a causal link, and have been found to rarely cite it as a strategy for childhood weight control (Pocock, Trivedi, Wills, *et al*, 2010). Some parents who value a natural and unprocessed diet, who breastfeed and provide home-made food, "would like to think" breastfeeding has an effect as this supports their personal beliefs, values and decisions. For the minority of parents who do believe there is a

link between infant feeding and obesity, their line of argument is that bottle fed babies "tend to be bigger" and that this is mainly due to the fact that breastfed babies are more able to regulate their own intake. This again links to the wider belief system of "baby-led weaning" with it being important to "listen to your baby" and not "force feed them" as it "influences your eating behaviour as you're older". A minority of parents suggest that there may be a link between the type of person who chooses to breastfeed and what their diet would be like. Couples who persevere with breastfeeding are seen as likely to have "a different approach to all ways you feed your child" and put "more value in what goes in his mouth". In contrast, parents who choose packaged foods and formula milk are less likely to think "about what the child's taking in".

Many parents believe there is likely to be a stronger link between childhood obesity and the introduction of solids, particularly the type of food introduced rather than the quantity. They describe strong parental control over infant feeding reflecting their beliefs that feeding "your baby a healthy diet from the word go" and "developing tastes for healthier foods" which hopefully "carry on when they're older" will "keep them on the straight and narrow in terms of weight". However, many parents believe that later diet in childhood is likely to be more influential and see sustained healthy balanced diets as important to prevent weight becoming "an issue". Some parents suggest that the baby will encourage them to eat more healthily as a family, as they do not want children to observe them eating unhealthy foods like crisps and it has been shown that strategies to reduce childhood obesity may impact on wider family behaviours (Grimmett, Croker, Carnell, *et al*, 2008). Some mothers who have experienced weight issues themselves or who describe having a problematic "sweet tooth" feel quite strongly about types of food to avoid:

> "if you do feed them the wrong things at an early stage it's just a time bomb waiting to happen, because they'll get so used to that taste, that kind of sugary taste" (1210; PNF; mother; baby six months old).

A key theme which parents focus on is weight gain in infancy, with the main concern being poor rather than excess weight gain. For a number of parents weight gain is symbolic of good health. Health (therefore weight gain) is more important than breastfeeding to these families and faltering weight, together with the health professional advice that accompanies it, can tip the balance against breastfeeding, confirming other studies (Sachs, Dykes, and Carter, 2006). Gaining too much weight is rarely a concern and is seen quite positively, with some parents suggesting that a "wee bit of fat's nice and healthy". The importance of gaining weight well or there being a "proper" way to grow appears more prevalent among first time parents. For these parents, there may be an intention in pregnancy to supplement with infant formula if weight gain is insufficient. Several parents who already have children comment during pregnancy that they plan not to worry so much about the baby's weight gain this time and pay less attention to weight after birth, acknowledging that weight gain had become a "huge part of life" with the first baby, with some feeling that there is too much emphasis placed on this by health professionals.

Part D: The Infant Feeding Journey

11. What would make a difference?

In this chapter we pull together the findings described in the earlier chapters, drawing on our analysis of responses to the intervention vignettes, which were presented to women at the very end of the interview study.

11.1. Postnatal hospital stay and the early days

There is consensus that a skilled and trusted person watching entire feeds on the ward and in the early days at home is crucial for establishing breastfeeding particularly for first time mothers or mothers who have previously experienced difficulty breastfeeding. This is a sensitive intimate task performed at a very vulnerable time for women who have just given birth, and can often engender strong and sometimes unanticipated emotions either at the time or retrospectively. Some women in retrospect wish that they had voiced both their requirement for more help and their emotional support needs at the time. Establishing a trusting relationship with a helper and privacy are of paramount importance for many, and even a professional observing such an intimate behaviour as breastfeeding can be uncomfortable, embarrassing and feel intrusive to some women. An overly technical approach to positioning and fixing is disliked, particularly when staff, often described as an older professional, handle the woman's breast or the baby without negotiation. Asking permission and negotiating how best to help a woman breastfeed is important as some women, particularly younger ones prefer help on an equal footing woman-to-woman, so that they do not feel "supervised" "monitored" "nannied" "intimidated" or "pressurised". Some express a desire for helpers to have breastfed themselves, so that somatic and emotional experiences can be truly shared. For others, this is less important than their status as professionals with the collective experience of having helped many women learn to breastfeed. More emphasis should be given to emotional support and continuity of care to allow trust and confidence to develop. Women want to be treated individually rather than just offered a generic "oh this is how it should work". Night time can be an opportunity for the un-rushed skilled help that some women need to establish breastfeeding, if staff are available, aware of need and committed to supporting breastfeeding. However, it can be a time when staff suggest introducing formula milk.

11.2. Characteristics of the ideal people providing breastfeeding help

The ideal helper is someone who understands and cares about the situation. There are two quite different perspectives about personal qualities necessary to achieve this. Some feel that the helper should have personal experience rather than "telling you what to do from a textbook". Difficult personal experiences are particularly seen as underpinning empathy and the embodied experience of "knowing" what it feels like. For these women a professional background is less important: "experience shouldn't be out of a book, should be life experience, somebody that's been through it." This perspective appears to value feelings and sensory perceptions more highly than cognitive approaches. An alternative more cognitive perspective is that

personality, really wanting to help and interest are more important than having a child or having personally breastfed and that “people who haven't done it tend to know a bit more because they've read up on it”. For these women, there is a reluctance to rely on individual personal experience, which is seen as potentially biased. Being patient; understanding; reassuring; friendly; good at listening; having time to sit and show you or speak you through it; being unrushed; gentle; are all described as key attributes, which improve confidence and the self-efficacy so important to successful breastfeeding (Blyth, Creedy, Dennis, *et al*, 2002; Nichols, Schutte, Brown, *et al*, 2009). It is interesting to reflect that these attributes have nurturing, mothering and calming roles. There is no mention of enthusiasm, promotion or encouragement to breastfeed. Staff shortages, busy and hectic workloads are perceived as a barrier to providing the quality and continuity of care that would most help women. Knowing the history or “at least have them read your notes beforehand” is important as repeating histories “does get you down a lot.” In terms of help and advice surrounding the introduction of solids, it is important this is provided in a “non-judgemental” way. Care that “encourages parents to take the lead” and “works with you, rather than telling you how it’s done” is valued, but takes time. Women appreciate continuity of trusted helpers with these positive skills but continuity of care can be detrimental if the helper is disliked or has an unhelpful approach, and some women value hearing different views. The negative consequences to self efficacy and confidence of some communication styles are voiced: “I must be doing something wrong”, and are described by some as “intrusive” or “patronising”. Our thesis is that maternal and infant emotional wellbeing is the end-point determining most behaviour, rather than breastfeeding or the health reasons for delaying introduction of solids.

11.3. Timing of information

There is consensus in this study, where most women intended to breastfeed that care in the immediate postnatal period is a priority for resources, rather than the provision of feeding information before birth or later in infancy. Although realistic preparation and sharing of experiences with other parents is valuable in pregnancy, there is a preference for learning the detailed technicalities of positioning and attachment on the job immediately after birth. There may be pivotal time points where the negative emotional feelings of panic, anxiety, pain, tiredness and failure well up quickly in the early days after birth. Changing from breast to formula milk is the commonest strategy employed to regain control and the anticipated pleasure and joy of having a new baby. More anticipation and prevention of these pivotal time points is important if breastfeeding cessation rates in the first few weeks are to decline. Other pivotal time points can occur later, particularly at around three to four months, when babies can become unsettled and baby cues are interpreted as indicating the need to introduce solids. Providing information and opportunities for discussion of a range of options at this time, with a clear and credible rationale for the current policy is recommended. When discussing the vignette describing a specialised infant feeding team, the service is seen as most beneficial for the many unaddressed concerns about introducing solids, again in the context of “the many conflicting ideas out there”. Some describe “sallying along” with breastfeeding until they're four months and then wanting to speak to health visitors again. For many, the ideal is twenty-four hour availability of specialised feeding help in the first couple of weeks, or at least at evenings and weekends.

11.4. Face-to-face or telephone

In our intervention scenarios, we explored the option of proactive telephone calls for 14 days, which provoked mixed responses, with a strongly felt preference for face-to-face care. Current postnatal care is already meeting some women's needs, with a few receiving daily midwife visits who "thought that it (the vignette) was already happening". For some, telephone care would be "really good" and "less intrusive than home visits". Several advantages of telephone support are given by women, particularly those who value their privacy, their image and being seen as in control and coping well with motherhood: "it doesn't matter what you look like", "it's easier if you don't like to get upset in front of people". Others dislike speaking on the phone and find it difficult to be honest about their needs: "I would just be like "yeah I'm fine, having a marvellous time!" where if someone's actually in front of you and you're like "look, I need a bit of help"". Some would prefer calls less often: "I would get annoyed if somebody phoned me for 14 days unless you were having problems". The issue of limited NHS resources was raised when discussing this scenario, with several commenting they would prefer the telephone to supplement rather than replace existing care.

11.5. Proactive or reactive care

Some studies have recommended that breastfeeding support should be proactive rather than reactive (Dennis and Kingston, 2008; Graffy, Taylor, Williams, *et al*, 2004; Hong, Callister and Schwartz, 2003; Renfrew, Dyson, Wallace, *et al*, 2005). Certainly for smoking cessation in pregnancy encouraging results are reported for proactive telephone support (Solomon, Marcy, Howe, *et al*, 2005). In hospital, proactive offers of help were preferred to having to buzz busy staff and women describe the difficulty of asking for help (see Chapter 5). Proactive telephone calls are perceived as useful or "brilliant" as women are reluctant to trouble busy staff with what they perceive to be minor concerns. However, in contrast some think it would be intrusive and unnecessary "as you're so bombarded by support and people and stuff going on", and "you never know when you're going to be asleep". Reactive twenty-four hour telephone help lines are valued for the perception that "you can get in touch with somebody right away" and being able to choose how and when to receive help is the ideal. When discussing the vignette about a specialised infant feeding team, having the option to directly access the team by phone or email is attractive to some but for others, "it sounds like you have to tap into it and sometimes it's hard to go to people". Parents would like to be proactively invited to individual or group sessions to discuss the introduction of solids at around three to four months after birth.

11.6. Involving fathers and significant others

Some couples would like more shared opportunities before and after birth to learn and hear feeding experiences of other new parents, as the couple is considered more likely to be effective than if the entire onus falls on the woman to remember all the information received. In particular, women would welcome discussion of how partners may support them with breastfeeding. However, sharing feeding and the special value attributed to actively feeding a baby can be a tipping point for early

introduction of formula milk, particularly for women who find expressing milk difficult or distasteful. As in other research (Lee, 2008; Murphy, 1999), some couples value feeding as so important for bonding and infant development that it should not be left to the mother alone and prefer it to be shared. "Intensive mothering" (Lee, 2008) with breastfeeding on demand is desired and valued by some women but reluctantly embraced by others. Views that men might "interfere" were particularly expressed when the partner was not present at the interview, which in itself might reflect their ambivalence towards infant feeding in comparison to fathers who attend several face-to-face interviews. Several are against the promotion of fathers (or others) being present when women are receiving professional help with breastfeeding, with one to one relationships with trusted helpers preferred. There is a sense of some women wanting to maintain control and ownership of breastfeeding and seeing it as their unique special "me time" with a new baby, with distractions unwelcome. Men saying "it's up to you" can infer ambivalence or even dislike of breastfeeding; however, such men can provide non-pressurising emotional and practical support which increases women's confidence and helps them to master breastfeeding. Such woman-centred support contrasts with the perceived breastfeeding centred "pressure" from the health service, and attempts to include fathers into the prevailing medical model of supporting breastfeeding may be resisted. It is also important for many that partners and significant others are involved in discussions surrounding the introduction of solids as this is a time, particularly for those who have breastfed, when others can play a bigger role in feeding. It should not be assumed that involving partners and significant others in all aspects of the feeding journey will either be effective at increasing healthy infant feeding behaviours or be valued by all expectant or new parents.

11.7. Places

There are mixed feelings about hospital postnatal wards as places to learn how to breastfeed and conflicts frequently arise. Place, with the multiple meanings attributed to it and the influences that it has on both service provision and individual behaviour, has been shown to be of paramount importance for effective breastfeeding interventions (Hoddinott, Britten, and Pill, 2010). For primiparous women advice to "stay in hospital" until you are confident with breastfeeding implies that hospital staff are the most likely to successfully establish breastfeeding, as twenty-four hour skilled help is available. However, hospital wards can be noisy, uncomfortable, busy places with little privacy and staff are not always able to fulfil expectations. For women with children at home, staying on the hospital ward can provide a welcome respite from family demands and an opportunity to bond with the new baby. Current policy for early hospital discharge, combined with the closure of community maternity units has left a gap in appropriate places with twenty-four hour breastfeeding help in the early days after birth. Community health services often have insufficient resources to allow staff to sit through feeds at home and twenty-four hour help lines are seen as a poor substitute for face-to-face care. Once at home, parents can feel they are "left to get on with it" and pivotal points can lead to earlier cessation of breastfeeding than desired. Most couples prefer the convenience of home visits if there are problems with breastfeeding and describe difficulties "getting to hospital with a crying baby"; public transport as "a bit of a hassle" and driving restrictions after a caesarean section problematic. Others with access to transport and help are happy to travel to the hospital or elsewhere to receive the expert skilled

help with a breastfeeding problem that they need, and breastfeeding problem clinics or groups are highly valued by some. Privacy, comfort and feeling relaxed when learning to breastfeed are of paramount importance, but are seldom available outside the home. Medical centres are often more relaxed and personal than hospitals. Breastfeeding groups can provide a safe place to practice performing breastfeeding, prior to venturing to breastfeed in more public places (Hoddinott, Chalmers, and Pill, 2006). Parents describe a lack of appropriate places to breastfeed outside of the home, in contrast to their satisfaction with places with high chairs and facilities for re-heating solids. Groups or more informal baby and toddler friendly venues to meet other parents to share experiences are important. The baby cafe movement in England (Williams, 2003) can be seen as an initiative to address this gap and lunch clubs "where everyone can get fed" are suggested by some parents, which agrees with the reported need for more informal community learning initiatives (Abbott, Renfrew, and McFadden, 2006) to fill the gap between the health service and the home. "Dropping in" to appropriate infant feeding places is valued and is suggested as an extension to the specialised infant feeding team vignette, illustrating the importance of integrating women's needs, place and services.

11.8. Specialisation or generalism to ensure quality of service

Responses to the vignette describing a specialised infant feeding team covering pregnancy to the introduction of solids ranged from "that's like utopia" or "ideal world" and "a good idea" to there's "no need". A popular aspect is that the team would provide help on everything: breast, formula and solids. Many would like a feeding team to continue after 6 months and into childhood, for more advice on quantities, types of food and allergies. The early postnatal period for breastfeeding is also acknowledged as crucial for specialised help with breastfeeding problems and once again the need for 24/7 specialised help was raised. Negative perspectives were voiced by some couples who are satisfied with the help they received or who had few problems with infant feeding. Some reflected that it might be good for others, especially for "young lassies that's a bit naïve"; for first time parents or to concentrate efforts on the ones having difficulty and a few became more positive about specialised teams as the interview progressed and other vignettes were discussed. Resistance to the Medicalisation of infant feeding and bringing up babies is apparent: "you can get sick of people telling you [what to do]". Others feel "invaded by a plague of people" in hospital and describe good relationships and satisfaction with existing continuity of midwife or health visitor care. Continuity is again a strong theme, and many feel that the present system is not good, with too many rules and regulations, task driven and fragmented care: "they don't make you feel comfortable and supported". There is agreement that once you're past the first few weeks "feeding is probably one of the biggest worries". Health visitors are seen as "so stretched" and covering "everything and anything". A feeding team is seen to have the potential for more knowledge, to work very closely together and provide specialist services like dieticians for concerns about food allergies and eczema. There is less concern about who is in the team "as long as they knew what they were talking about" and even "other mums who had been through it all". The professional mentioned most frequently is the dietician "because that would've mopped up the confusion about when to give egg/when not to give egg, when to give meat/when not to give meat, when to give dairy/when not to give dairy". This suggests that open access to tiered teams of personnel with different professional backgrounds and personal

experiences warrants further consideration, in contrast to the current flat one-size-fits-all midwifery and health visiting service and health professional gate keeping to access dieticians. Several raise concerns about the costs of such a service in the current economic climate. Our interpretation is that further research into piloting specialised infant teams is warranted as the current health service structure of non-specialised infant feeding care varies within and between localities and Health Boards and is failing many families. Given the rapidly changing evidence base for the importance of early childhood nutrition in determining later health outcomes and the current lack of support surrounding the introduction of solids for many, new thinking is required and putting more pressure on parents to change their behaviour without providing them with the skilled support they would like, is likely to result in dissatisfaction. As we now move on to discuss, current health service provision is based on a philosophy of idealism rather than realism, and a medical rather than a holistic model of infant feeding.

11.9. Realism or idealism

Throughout this study we heard many accounts of where there is a mismatch between the idealism of the World Health Organisation (2003) guidelines endorsed by UK governments of exclusive breastfeeding until six months, with no additional fluids or solids and the real life experiences of women and families (see Figure 11.1). Similarly we heard many accounts of how current health service care for infant feeding is variable, with poor availability of the skilled help that women need and are aware that some women get. This we would argue is as a result of health service idealism in believing that all midwives, health visitors, auxiliary staff, general practitioners, paediatricians can be trained to an adequate standard and have the personal qualities that best help women to succeed in meeting the WHO guidelines. The medical model often fails to acknowledge that most infant feeding decisions are a complex balance of multiple meanings attached to feeding behaviours, with health benefits only one of many competing motivating factors. The health service's strongly conveyed and well heard messages promoting "breast is best for health" and "no solids until 6 months" ideals are therefore clashing with the experiences and values of women and their significant others. Some health professionals take a more holistic, realistic and woman-centred approach, others, including some voluntary sector representatives take a more idealistic breastfeeding-centred stand with strict adherence to the World Health Organisation (2003) and government policy. These philosophically different positions appear to be a root cause for both conflicting advice and dissatisfaction with health services. There are many stories of couples feeling pressurised to breastfeed or to not introduce formula milk, bottles or solids before 6 months, with accompanying feelings of guilt and failure. Deciding to give formula milk or introducing solids before 6 months can compromise women's identity as "good mothers" (Lee, 2008; Murphy, 1999) and portray them as "bad mothers" whose decisions are putting their child's health at risk. The increasingly dominant discourse of couples sharing infant feeding which is now being reflected in government policy and the research agenda (including this study) may be as a direct result of resistance to the current idealism, rules and right / wrong based messages. By sharing feeding, a potentially stronger bond with the father is created and can be a strategy for parents to frame themselves as "good parents" when they break the rules. Similarly the need for sleep, "me time" and helpers who nurture can be interpreted as improving the sense of wellbeing necessary to be a "good parent".

Parental wellbeing can be considered a more vital determinant of child health than breast milk or delayed introduction of solids. The medical message about the health risks of maternal smoking and a poor maternal diet can be seen as further undermining women's confidence in the quality of the milk they produce, which reinforces their desire to find other ways to be considered a "good parent". Consumerism is apparent throughout the feeding stories, from mothers wanting free time to go to the shops, the desire for the perfect bowls and spoons, advertising and marketing of baby foods, nipple creams and was not explored in depth however, it might be argued that this is linked to being "a good parent".

Throughout this study there are accounts of dyadic judgements and values: right and wrong; good and bad; do's and don'ts, breast or formula – with mixed feeding unacceptable. These are to some extent inherent in a medical model of infant feeding based on evidence based guidelines and often lead to a checklist style of clinical practice. Despite widespread health professional training through Scotland's participation in the UNICEF Baby Friendly Initiative (UNICEF, 2007), reports of conflicting advice have remained prevalent in the literature for over a decade (Hoddinott and Pill, 2000; McInnes and Chambers, 2008). We would argue that until the philosophical differences inherent in idealism and realism are more openly acknowledged, discourses of conflicting advice in infant feeding are likely to dominate rather than the rarer discourse of listening to multiple perspectives which allow women to choose for themselves. It can be argued that women's desire for realism has been reinforced by policy makers setting the bar very high, by applying the WHO global recommendations to exclusively breastfeed for 6 months. This recommendation is particularly relevant to developing countries with unsafe water supplies to protect child health and reduce mortality. However, in countries where infant mortality and morbidity are low, breastfeeding and delayed introduction of solids are not perceived to be of sufficient weight in the overall balance of motivators when compared with emotional wellbeing or other health behaviours like sedentary lifestyles and eating high fat, sugar rich processed foods. It is debateable whether setting the policy bar at the high six months level is as, or more effective than setting it at a lower more achievable level. It can be argued that the policy of delaying the introduction of solids until 6 months has resulted in fewer babies being given solids before 4 months, as they were 10 years ago (Anderson, Guthrie, Alder, *et al*, 2001). An alternative policy model is to create environments conducive to the general public changing their behavioural norms, in accordance with ecological models of behavioural change (McLeroy, Bibeau, Steckler, *et al*, 1988). Setting the bar so high, given the well documented shortage of postnatal care resources to help women, is setting new parents up to fail and this is causing dissatisfaction. Incrementally setting the bar day by day seems to be preferred by women in today's society where there are many competing demands on time and differing values and where emotional wellbeing is fragile and precious.

Figure 11.1 Idealism and realism in infant feeding

Idealism – women and partners		**Realism – women and partners**
Exclusive, prolonged breastfeeding is the ideal. The endpoint that determines feeding behaviour is maximum health gain and bonding. Breastfeeding is the focus of the first 6 months, with other activities taking second place. Intensive mothering with demand feeding. Partners supportive in all other aspects of baby care. Prepared to persevere however difficult, and put breastfeeding first. Expressing milk allows others to feed or baby free time. Baby behavioural cues before 6 months can be resolved without giving solids.	*MISMATCH and CONFLICT*	Feeding decisions determined by a complex balance of factors. The end point that determines feeding behaviour is a happy mother, baby and family. Breastfeeding is one of many competing activities, agendas and values. Sharing responsibility allows fathers, grandparents and others the unique bonding opportunity of active feeding. Immediate gains of stopping (pain, anxiety, time, sleep) outweigh the delayed rewards of breastfeeding. Expressing milk can be difficult, distasteful and as time consuming as breastfeeding. Giving solids has multiple meanings and delaying is counter-intuitive.
Idealism – health service		**Realism – health service**
All health service staff to fully support exclusive breastfeeding to 6 months to maximise health benefits, regardless of their own personal experiences as parents. All health service staff are trained in core breastfeeding education and support skills. Staff have sufficient time to sit with mothers during breastfeeds and provide the help they need until breastfeeding is established. Breastfeeding help will be of consistent high quality. The transition between hospital and home will be smooth with good communication between staff. Proactive care to prevent problems. With correct technique, breastfeeding will be painless and effortless. Rules work. Compliance.		Not all health service staff are fully supportive of breastfeeding and some formula feed their own babies or introduce solids early. Not all staff are trained or have up to date skills to support breastfeeding. Staff shortages, competing demands and rushed staff cannot offer the support that some women require to continue breastfeeding. Breastfeeding help is variable. Communication between hospital and community is often suboptimal with centralised maternity services a barrier. Reactive care when problems are established. Pain and distress are complex emotional, somatic and cultural phenomena, which are seldom resolved by a technical approach alone. Resistance to rules is common. Deviance.

Discussion: strengths and limitations

Our study is one of few longitudinal interview studies following women's infant feeding decisions from pregnancy until the introduction of solids at around six months after birth. It builds on the work of an earlier longitudinal study in England (Murphy, Parker, and Phipps, 1998; Murphy, 1999), and differs as it broadens the focus by including significant others and investigating their involvement and possible impact on the infant feeding journey. Our study is also unusual in including both primiparous and multiparous women, providing an opportunity to compare feeding behaviour in the two groups. With thirty-six families and two hundred and twenty interviews, it produced a large and information rich dataset, strengthened by purposive sampling at two sites and a multidisciplinary research team. The Framework approach is recognised as a systematic, transparent and rigorous approach to qualitative data analysis (Ritchie and Lewis, 2003). When developing our thematic analysis, we searched carefully for disconfirming data and made every attempt to reach theoretical saturation. Families in our study showed extraordinary commitment to this research project, with only two families withdrawing compared to a pre-study estimate of twelve withdrawals. This provides us with a large dataset which will generate further research questions, analysis and published papers. Families seemed to enjoy participating and consideration should be given to the extent to which sharing their experiences in a reflective way with a researcher might have modified their responses over the course of several interviews. Over a seven month period, the researchers developed trusting relationships with the families, as illustrated by their openness. However, some learned responses and rationalisations probably occurred, and we noted some inconsistencies between responses close to the time of a decision or experience and later accounts. The interviewers introduced themselves as independent researchers from a University, which can assist openness and avoid some of the pitfalls of participants saying what they think the interviewer wants to hear and certainly women in our study did not appear reluctant to openly discuss perceived short-comings in the health service. However, health service care for a few women recruited to our study may have been different, when health professionals knew that a participant was in the study, although our recruitment strategy aimed to minimise this. We believe that this occurred more often in Site 2 than in Site 1, because of our close working relationship and qualitative research within Site 2 in a recent study. There were a few examples when it was evident that health professionals had a heightened awareness of the care they were providing to study participants.

We set out to recruit women from disadvantaged areas, who are notoriously difficult to engage in research. We chose not to recruit through midwives, as there is well documented evidence that they are under work-load pressures, and that research may not be a priority in busy antenatal clinics. Our approach to send invitation letters to all eligible women living in disadvantaged areas, with a sample of women living in more advantaged areas is an equitable approach and avoids cherry picking of participants who recruiters perceive as suitable. Although our sample includes more than 70% of women living in the three more disadvantaged quintiles, the most disadvantaged quintile is under-represented as are younger mothers. It is clear that the SIMD postcode classification (Office of the Chief Statistician, 2006) is not always reliable at identifying disadvantage. It is likely that the more advantaged women

living in disadvantaged areas responded to our invitation, given their occupations. It is important to consider how volunteering women might differ from non-volunteers in other respects (Trautha, Musa, Siminof, *et al*, 2000), for example, their level of confidence engaging with an unknown researcher, their strength of opinion about aspects of infant feeding; their desire for their voice to be heard; their attitudes towards the health service and its involvement in this type of research and their altruistic values. We gained evidence of the latter when intervention vignettes were discussed with families, as a common response was to infer that aspects might be appreciated for other people in different, often less advantaged circumstances to themselves.

Using vignettes in qualitative research is a well recognised tool however, using them to develop possible interventions for further research testing is as far as we know a novel approach. It should be emphasised that the vignettes were constructed as analytical tools and not as standalone interventions for potential implementation. For this reason, we have not written them up separately, but used them to triangulate our analysis of other emergent themes from the data. Vignettes A and T are already happening in some areas and to some extent and are the most suitable to be translated into clinical practice. Indeed watching a breastfeed in hospital is a component of the Baby Friendly Hospital Initiative (UNICEF, 2007). All of the other vignettes require further research and modification prior to considering implementation.

Scotland is uniquely positioned to conduct infant feeding interventions and randomised controlled trials of infant feeding policy spanning pregnancy and the early postnatal period, as it has both Guthrie 5-7 day and Child Health Surveillance Programme, six to eight week routinely collected infant feeding data. We anticipate that this study will form a platform for further mixed method intervention studies and applied policy research, to enable changes in both policy and practice to be evidence based and cost effective.

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Appendices

Appendix 1 – Ethics and R + D process

Ethics committee and NHS Research and Development approvals

Application to the North of Scotland Research Ethics Committee and to NHS Grampian and NHS Forth Valley for Research and Development (R+D) approval was made on 21st April 2009. On 14th May 2009, the North of Scotland Research Ethics Committee provided provisional approval for the study conditional on removing any mention of the gift voucher incentive from our information leaflet and recruiting materials, even though it is recognised as a useful strategy to recruit hard to reach, more disadvantaged groups. We revised information leaflets and responded to the committee on 30th May 2009 and received final approval for the study on 11th June 2009. Our proposed timetable was to commence recruitment in June 2009. Unfortunately there were delays gaining NHS research passports at both Sites due to staff processing the passports meeting deadlines for end of year Chief Scientist Office Reports and annual leave. NHS Forth Valley granted R+D approval on 24th July 2009 and NHS Grampian granted R+D approval on 10th August 2009. Recruitment therefore began six weeks late in Stirling and eight weeks late in Aberdeen, through no fault of our own. One month of additional researcher time funding was agreed with NHS Health Scotland to enable analysis of the final six month interview data to take place. These delays and the large volume of data because of the participation of thirty-four families (proposal estimate was twenty-four) remaining in our study until the final interview at six months have curtailed the time available for analysis. We anticipate that peer reviewed publications will be based on more in depth analysis than the findings described in this report.

Appendix 2 – Recruitment charts

Site 1 Respondents to opt-in form

Mother occupation	Feeding intention	Children	Age	Education*	Nationality	Lives with	Father occupation	Father education*	SIMD quintile+
Seismologist	BF	0	32	4	Chinese	Husband	Geomechanist (Geoscientist)	4	5
Social Worker	BF	0	25	4	British	Partner	Forklift driver/warehouse	2	1
Executive Assistant	BF	0	31	1	British/Scottish	Husband	Electrician - own company	1	3
Catering Assistant	BF	2	39	1	Scottish	Husband and children	Warehouse man	4	3
E Learning Co-ordinator	BF	1	39	3	British	Husband and daughter	Hospital Doctor	4	3
Care Assistant	BF	0	29	4	Nigerian	Husband	Geologist	4	1
Welfare Rights Officer	FF	1	39	2	Scottish	Daughter	Assistant Manager	1	1
Warden	BF	0	25	4	Scottish	Partner	Offshore worker	2	3
Consulting engineer; Teacher	BF	1	35	4	British	Son	Oilfield Engineer	4	5
Teacher	BF	0	42	4	British	Husband	Taxi Dispatcher	4	2
Sales Assistant	BF	1	21	1	Scottish	Son			2
Shop Supervisor	BF	2	29	1	Scottish	Husband and children	Engineer	4	3
Sales administrator/youth worker	BF	0	33	2	Scottish	Partner and his children	Metering manager	1	1
Service desk manager	BF	0	34	4	Scottish	Partner	Network analyst	4	4
Hairdresser	BF	1	31	1	Scottish	Husband and daughter	Chartered Accountant	4	3
Photographer/Business Director	BF and FF	0	33	2	British	Husband	Photographer/Business Director	2	5
Teacher	BF	0	28	4	British	Husband	Youth Pastor	4	5
Optometrist	BF	1	34	4	British	Husband and son	Project Manager	4	1

Site 1 Respondents to opt-in form continued

Mother occupation	Feeding intention	Children	Age	Education*	Nationality	Lives with	Father occupation	Father education*	SIMD quintile+
Banking	BF	2	34	4	Nigerian	Husband and 2 children	Portering services, NHS	4	2
Maternity Leave	BF	1	28	4	Nigerian	Sister-in-law	Engineer	4	4
Sales assistant -body jewellery	BF	1	23	1	British	Partner	Sales assistant	1	1
Sustainable Development Advisor	BF	2	42	4	New Zealander	Husband	Engineer	4	5
Day Centre Officer	BF	1	45	3	Scottish	Husband and daughter	Retail Sales	2	2
Executive secretary and librarian	BF	0	33	4	British	Husband	IT Engineer	4	5
Housewife	BF	2	28	4	Scottish	Husband and 2 children	Supervisor	4	3
University Tutor	BF	0	31	4	British	Partner	Assistive technologist	4	3
Operational Manager - (NHS)	BF	0	35	3	Scottish	Partner (fiancé)	Technical Librarian	4	2
Business Development Manager	BF	1	32	4	Scottish	Husband	Operations Director	2	5
Admin Officer	BF	0	37	4	British	Partner	Banker	2	5
Teaching Assistant	BF	1	32	4	Nigerian	Husband and son	System Engineer	4	3
Industrial Chemist	BF	1	33	4	Scottish	Husband and daughter	Mechanical Engineer	3	3

* Education level 1=age 16 or under, 2=age 17, 3=age 18, 4= age 19 or over and 5=don't know
+ SIMD 1 = most deprived; SIMD 5 = least deprived (Office of the Chief Statistician 2006)
BF = Any breastfeeding
FF = Formula feeding

Site 2 Respondents to opt-in form

Mother occupation	Feeding intention	Children	Age	Education*	Nationality	Lives with	Father occupation	Father education*	SIMD quintile+
Factory worker	FF	3	36	3	Polish	Partner	Factory worker	5	1
Animal Registrar	BF	0	33	4	British	Husband	Education Manager	4	1
Admin Assistant	FF	0	21	2	Scottish	Parents	Housing Assistant	No reply	1
Corporate co-ordinator	BF	0	20	2	Scottish	Partner	Joiner	4	1
Registered childminder	BF	2	37	2	Scottish	Husband and 2 children	Funeral director	1	1
Glass fitter	FF	0	20	1	Scottish	Myself	Line painter	2	1
Warehouse	FF	0	26	1	British	Alone	Merchant Navy (African)	5	1
HR Manager	BF	0	27	4	British	Husband	Retail Manager	4	1
Admin Asst / student	BF	1	32	4	Polish	Husband/daughter	Software engineer	4	2
Self employed credit agent	FF	2	34	4	Scottish	Husband and 2 children	HGV driver	1	2
Ward administrator	BF	3	39	3	British	Husband and children	Civil service	1	2
Logistics co-ordinator	BF	1	30	1	British	Husband and son	Plumber	1	2
Accountant	BF	1	31	4	Scottish	Husband and son	Professional artist	4	2
Lawyer	BF	2	31	4	Irish/Scottish	Husband and 2 children	Police officer	4	2
Personal assistant	BF	0	26	2	British	Husband	HGV Mechanic	1	2
Health records assistant	BF	0	20	4	Scottish	Mum, Dad and 2 sisters	Insurance salesperson	2	2
Accounts assistant	BF	0	18	1	Scottish	No-one	Poultry worker	1	2
Supply lecturer	BF	2	41	1	Scottish	Husband	Optician	4	3
Customer services	BF	0	31	4	Scottish	Husband	Electrician	4	3
Staff nurse	BF	2	36	4	Scottish	Husband and 2 children	Machine operator	1	3
Chartered surveyor	BF	0	28	4	Scottish	Husband	IT infrastructure architect	3	3
Risk analyst	BF	0	39	2	British	Husband	Engineer	2	3

Site 2 Respondents to opt-in form continued

Mother occupation	Feeding intention	Children	Age	Education*	Nationality	Lives with	Father occupation	Father education*	SIMD quintile[+]
Support worker	UNDEC	0	27	1	Scottish	Partner	Joiner	1	3
Primary school teacher	BF	1	33	4	British	Husband and daughter	Assistant port manager	4	3
Early childhood educator	BF	0	29	4	British	Husband	Paediatric nurse	4	3
Packer	BF	1	31	4	Polish	Parents	Butcher	4	3
OT	BF	2	32	4	Scottish	Husband and children	Farmer	3	3
Banking advisor	BF	2	29	2	Scottish	Husband and 2 children	Electrician	1	4
Actuary	BF	0	36	4	Scottish	Husband	Delivery manager, Royal Mail	1	4
Social worker	BF	1	31	2	Scottish	Husband and daughter	Self employed	2	4
Staff nurse	BF	3	38	4	British	Husband and children	Financial Controller	4	4
Never had a job	FF	0	17	1	Scottish	Mum, Dad, Brother	Labourer	1	4
Never had job	BF	1	18	1	Scottish	Partner and child	Don't know	1	4
Childminder	BF	2	30	4	British	Husband and 2 children	Photographer	4	4
Lab technician	BF	0	32	1	British	Husband	Engineering operator	1	5
RMHN	BF	2	32	4	British	Husband and family	HGV driver	1	5
Stay at home mom	FF	2	33	3	British	Husband and children	Postal worker	3	5
Accountant	BF	0	27	3	British	Husband	Training Co-ordinator	3	5
Partner - Marketing Agency	BF	1	37	4	British	Husband, son, 2 dogs	Chartered Surveyor	4	5
Office Manager	BF	0		4	British	Husband	Senior Civil Engineer	4	5
HR Director	BF	0	39	1	British	Husband	Project Manager: civil engineering	2	5

* Education level: 1=age 16 or under, 2=age 17, 3=age 18, 4= age 19 or over and 5=don't know
[+] SIMD: 1 = most deprived; SIMD 5 = least deprived (Office of the Chief Statistician 2006)
BF = Any breastfeeding
FF = Formula feeding

Appendix 3 – Significant other form

Structured data completed at the end of every interview

Who are the significant others in relation to infant feeding?

Definition: The person or persons identified by the mother who has/have the strongest influence on the feeding decisions made by the mother of the baby, regardless of the direction of influence (e.g. pro or anti breastfeeding). The significant other can be any person (including a health professional) and the most significant other may change with time over the course of this study.

Relationship to mother of baby	Initials	Age (<20, 21-30, 31-40, 41-50, 51-60, 61-70 etc)	Distance (miles) from the mother (none, <1 mile, 1-5, 6-10, 11-49, 50-99, >100 miles)	Children of their own (no.)	Previously breastfed?	Most recent job	Comments (positive or negative influence?)	Interview date(s)

Appendix 4 – Framework index

1 - Case Summary
    1.1 - Case Summary

2 - NHS information
    2.1 - Written information
    2.2 - Posters / displays
    2.3 - DVDs / TV / radio / other audio-visual
    2.4 - Internet
    2.5 - AN: midwife verbal
    2.6 - AN: other health professional verbal
    2.7 - AN and PN classes / workshops / groups
    2.8 - Telephone help lines

3 - Non-NHS or unspecified information
    3.1 - Written information
    3.2 - Posters / displays
    3.3 - DVDs / TV / radio / other audio-visual
    3.4 - Internet
    3.5 - AN and PN classes / workshops / groups
    3.6 - Telephone help lines
    3.7 - Other voluntary organisations information / peer supporters

4 - Promotion in general
    4.1 - Promotion in general

5 - Feeding decisions and behaviour (couple) - intention to breastfeed
    5.1 - Decision to start BF
    5.2 - Timing of decision
    5.3 - Any friends / others influencing decision to start breastfeeding
    5.4 - Any family influencing decision to start breastfeeding
    5.5 - Media / other influences on decision to start breastfeeding
    5.6 - Multips only - previous feeding experience
    5.7 - Any health professionals influencing decision to start breastfeeding

6 - Feeding decisions and behaviour (couple) - initiating/establishing BF
    6.1 - Initiating/establishing BF - views/experiences/problems/perseverance
    6.2 - Initiating/establishing BF - influences of others (not father)
    6.3 - Initiating/establishing BF - influences of health professionals

7 - Feeding decisions and behaviour (couple) - introducing formula
    7.1 - Introducing formula - views/attitudes/triggers/how decision made
    7.2 - Introducing formula - influences of others (not father)
    7.3 - Introducing formula - influences of health professionals

8 - Feeding decisions and behaviour (couple) - stopping breastfeeding
    8.1 - Stopping breastfeeding - views/attitudes/triggers/how decision made
    8.2 - Stopping breastfeeding - influences of others (not father)

8.3 - Stopping breastfeeding - influences of health professionals

9 - Feeding decisions and behaviour (couple) - introducing other fluids
9.1 - Introducing other fluids - views/attitudes/triggers/how decision made
9.2 - Introducing other fluids - influences of others (not father)
9.3 - Introducing other fluids - influences of health professionals

10 - Feeding decisions and behaviour (couple) - introducing solids
10.1 - Introducing solids - views/attitudes/triggers/how decision made
10.2 - Introducing solids - influences of others (not father)
10.3 - Introducing solids - influences of health professionals

11 - Introducing non-food substances - remedies, medicines etc
11.1 - Non-food substances - views/attitudes/triggers/how decision made
11.2 - Non-food substances - influences of others (not father)
11.3 - Non-food substances - influences of health professionals

12 - Experiences of formula feeding
12.1 - Experiences of formula feeding

13 - Expressing
13.1 - Expressing-knowledge/skills/views/attitudes/triggers/how decision made
13.2 - Expressing - influences of others (not father)
13.3 - Expressing - influences of health professionals

14 - Baby-led decision making
14.1 - Baby-led decision making

15 - Equipment
15.1 - Purchase or gifts of equipment relating to breastfeeding
15.2 - Purchase or gifts of equipment relating to formula feeding

16 - Time
16.1 - Time taken to breastfeed
16.2 - Mother time alone with baby / older children
16.3 - Mother and father time together with baby
16.4 - Father time alone with baby / older children
16.5 - Mother and father time together without baby
16.6 - Mother time alone - no baby / other children
16.7 - Father time alone - no baby / other children
16.8 - Time spent with significant other friends - mother / father
16.9 - Time spent with older generation - baby's grandparents
16.10 - Routines / organisation / control

17 - Couple roles after birth (baby)
17.1 - Feeding baby
17.2 - Changing / bathing / winding / cuddling baby
17.3 - Couple - emotional support to each other
17.4 - Sleep

18 - Couple roles after birth (running the house / work / mat/pat leave)
- 18.1 - Older child care / adaptation to baby / children helping with jobs
- 18.2 - Household chores
- 18.3 - Work / maternity leave / paternity leave
- 18.4 - Having relatives / significant others staying in the house

19 - Couple roles after birth (social life)
- 19.1 - Social with friends and family at home
- 19.2 - Social with friends and family outside the home
- 19.3 - Social going out as a couple (without baby)
- 19.4 - Social going out as an individual (without baby)
- 19.5 - Social - breastfeeding, play, toddler, mother and baby groups
- 19.6 - Feeding in public

20 - Significant other and others in community - roles after birth
- 20.1 - Feeding baby
- 20.2 - Older child care
- 20.3 - Household chores within the house
- 20.4 - Changing / bathing / winding / cuddling baby
- 20.5 - Emotional support for mother / father
- 20.6 - Asking for help/help offered pro-actively -by family/friends/community

21 - What could have been done differently/ideal world - feeding and general
- 21.1 - AN information / preparation
- 21.2 - Health professional individual care after birth in hospital
- 21.3 - Structural aspects of postnatal ward
- 21.4 - Health professional individual care after birth at home
- 21.5 - Household roles / childcare / significant other roles
- 21.6 - Groups / activities for mothers / babies / older children - transport
- 21.7 - Societal policies e.g. longer paternity leave

22 - Health / wellbeing of couple and baby
- 22.1 - Couple - emotional or mental health or wellbeing / hormones
- 22.2 - Couple - physical (not emotional or mental health)
- 22.3 - Health / wellbeing of baby

23 - Hospital postnatal stay
- 23.1 - Continuity of care
- 23.2 - Conflicting advice
- 23.3 - Staff workload
- 23.4 - Health professional support received - midwives and others
- 23.5 - Visitors / partner access / privacy
- 23.6 - Length of stay
- 23.7 - Other women on the ward - experiences
- 23.8 - Readmission

24 - Care in community after hospital discharge
- 24.1 - Continuity of care
- 24.2 - Conflicting advice
- 24.3 - Staff workload

24.4 - Health professional support received - midwife and health visitor
24.5 - Health professional support received - other e.g. feeding specialist

25 - Obesity / weight / food / diets
25.1 - Baby weighing
25.2 - Childhood weight
25.3 - Childhood exercise
25.4 - Adult weight
25.5 - Adult exercise
25.6 - Diet in pregnancy

26 - Observations - couple effects within interview
26.1 - Observations - couple effects within interview

Appendix 5 - Significant others involved at different stages of the infant feeding journey

Table 1 Summary of significant other involvement in pregnancy

Pregnancy								
Study No.	**Total in network**	**age<40**	**age>41**	**<10 miles**	**11-49 mile**	**>50 miles**	**Breastfed**	**Health professionals**
1010	2 (plus self)	1	1	1		1	2	
1033	2 (plus various FR)	1	1			2	2	
1040	self							
1044	3 (plus self)	3		1	1	1	1	
1054	4 (plus self & various HP)	2	2	1		3	3	Various
1056	4	1	3	2		2	2	1
1057	5 (plus various HP & media)	3	2	3	1	1	3	2 (plus various others)
1075	3 (plus self & BF support group)	3	3				1	
1094	2 (plus various MW & society)	1	1	2				Various MW
1108	7	3	4	4	3		4	
1148	6	3	2	3		3	5	
1167	4	2	2	1	2	1	3	
1173	1 (plus self via society & Nestle)	1				1	1	
1176	1 (plus self)	1		1			1	1
1188	7 (plus self)	4	3	4		3	6	
1208	2	1	1	2				1
1210	1 (plus self)		1	1			1	
1226	1		1	1				1
2003	2	2		1	1		2	
2020	1 (plus self)		1			1	1	
2037								
2039	3 (plus self & health professionals)	2	1	2	1		3	Health professionals in general
2047	1		1	1				
2056	1 (P plus self)	1		1				
2057	1 (P plus self)	1		1				
2061	self							
2103	6	4	1	5			4	1
2128	1 (plus MW Team, magazines & chat rooms)		1	1			1	MW team
2169	self							
2181	self (plus adverts)							
2192	self							
2203	self (plus MWs)							MWs
2255	2	1	1	2			2	
2287	self							
2294	2	1	1			2	2	
2295	self							

Key
FR – Friend
HP – Health professional
HV – Health visitor
MW - Midwife
P – Partner / husband

Table 2 Summary of significant other involvement at the first postnatal visit

First postnatal interview								
Study No.	**Total in network**	**age<40**	**age>41**	**<10 miles**	**11-49 mile**	**>50 miles**	**Breastfed**	**Health professionals**
1010	3 (plus self)	2	1	2		1	1	
1033	3 (plus various FR)	2	1	1		2	2	
1040	self & baby							
1044	2	1	1	1	1			
1054	3 (plus all HP)	1	2			3	3	All
1056	4	1	3	2		2	3	2
1057	5 (plus baby)	1		1				4
1075	1 (P plus self)	1		1				
1094	4 (plus self)	2	1	3			1	1
1108	2 (plus self)	2		1		1		
1148	8	3	5	5		3	5	2
1167	4 (plus self)	1	3	3	1		1	2
1173	2 (plus baby)	1	1		1	1	2	
1176	1 (plus various hospital MW)		1	1			1	1
1188	6 (plus self)	3	3	3		3	5	
1208	1 (P)	1		1				
1210	self							
1226	1 (plus self & various hospital staff)		1	1				1
2003	2	2		1	1		2	
2020	self							
2037	2 (plus midwives)	1	1	2			1	Various MW
2039	2	1	1	2			1	1
2047	1	1		1				
2056	self							
2057	baby							
2061	1 (plus self)	1		1			1	1
2103	1	1				1	1	
2128	1 (plus MW team)		1	1			1	MW team
2169	1 (P plus self)	1		1				
2181	self (plus 2 MWs)							2 MWs
2192	self							
2203	self (plus MW)							1
2255	2 (plus various friends & relatives)	1	1				2	
2287	1 (plus self)	1		1			1	
2294	1		1	1			1	1
2295	2 (plus self and HVs)	2		2			1	HVs

Table 3 Summary of significant other involvement at 3 months after birth

3 months (week 12+)								
Study No.	**Total in network**	**age<40**	**age>41**	**<10 miles**	**11-49 miles**	**>50 miles**	**Breastfed**	**Health professionals**
1010	1 (plus baby)		1	1			1	1
1033	1 (P)	1		1				
1040	self & baby							
1044	1 (P)	1		1				
1054	3 (plus baby's weight)	1	2			3	3	
1056	3	1	2	1		2	2	1
1057	4	2		4				3
1075	2	2		2			1	
1094	2	2		2			1	
1108	1	1			1		1	
1148	3 (plus various HV)	2	1	3			2	Various HV
1167	5 (plus general other mums)	1	4	4	1		2	2
1173	self & baby							
1176	1		1	1			1	1
1188	3	2	1	2	1		2	
1208	1 (P)	1		1				
1210	2 (plus self)	2		2			1	2
1226	2 (plus self)		2	2				2
2003	self							
2020	self							
2037	1 (P)	1		1				
2039	2 (plus self & health visitors)	1	1	2				Various health visitors
2047	self							
2056	self & baby							
2057	baby & BF group members							
2061	1							1
2103	6 (plus BF group members)	4	1	3	2	1	3	1
2128	2		2	2			2	1
2169	self & baby							
2181	baby							
2192	self							
2203								
2255								
2287	1 (P)	1		1				
2294	1		1	1			1	
2295								

Table 4 Summary of significant other involvement at 6 months after birth

6 months								
Study No.	**Total in network**	**age<40**	**age>41**	**<10 miles**	**11-49 miles**	**>50 miles**	**Breastfed**	**Health professionals**
1010	baby							
1033	3	1	2	2		1	1	1
1040	self & baby							
1044	4	4		2	1	1	1	1
1054	4	1	3	1		3	4	1
1056	9	6	3	5	1	3	8	
1057	1	1		1				1
1075	2 (plus self)	1	1	2			1	1
1094	3	2	1	3			1	
1108	2	1	1	1	1			1
1148	4	2	2	3		1	3	1
1167	4 (plus general other mums at groups)	1	3	2	2		1	2
1173	2 (plus baby)		2	1		1		1
1176	1	1		1				1
1188	4	1	3			4	4	
1208	1 (P)	1		1				
1210	baby							
1226	1 (P plus self)		1	1				
2003	self							
2020	2 (plus self & internet)	1	1	1		1	1	
2037	1 (P)	1		1				
2039	2 (plus self)		2				1	1
2047	1 (P)	1		1				
2056	1 (P plus self)	1		1				
2057	baby							
2061	1 (P plus self)	1		1				
2103	2 (plus BF group members)	2				2	2	
2128	2 (plus self & Netmums)	1	1	2			1	
2169	self & baby							
2181								
2192	1 (P plus self)	1		1				
2203								
2255								
2287	1 (P plus self)	1		1				
2294	baby (plus BF group members)							
2295								