Original Article

Exploring women's views of breastfeeding: a focus group study within an area with high levels of socio-economic deprivation

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Abstract

There is ample evidence of the short- and long-term health benefits of breastfeeding for mothers and infants, yet breastfeeding rates remain low in the UK, particularly in areas of high social deprivation. It is imperative that appropriate strategies are utilized to support more women to initiate and continue breastfeeding. This study used focus group methodology to explore women's views in relation to breastfeeding. The study was conducted within an area with high levels of socio-economic deprivation in the north-east of England and aimed to identify local barriers to breastfeeding, influences on choice of infant-feeding method and strategies which might improve breastfeeding rates. Focus group discussions were conducted with low-income women, adolescent women and women from a minority ethnic group. The five key themes that emerged from the data were: society's negative attitudes towards breastfeeding; the influence of family and friends and the experience on choice of method of infant feeding; lack of knowledge of some aspects of infant feeding; perceptions of professional support; and women's positive and negative experiences of breastfeeding. Recommendations for promoting and supporting breastfeeding include improving facilities to breastfeed in public, enhancing the provision of information, addressing conflicting advice and poor professional practice and implementing support mechanisms. The findings and recommendations have been used to develop a breastfeeding strategy to meet local needs. This project was funded by the English Department of Health Infant Feeding Initiative.

Keywords: breastfeed, focus groups, low income, adolescent, ethnic minority.

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Introduction

There is ample evidence of the short- and long-term health benefits of breastfeeding for mothers and babies (Howie *et al*. 1990; British Paediatric Associa-

tion 1994; Wilson *et al*. 1998; Kramer *et al*. 2001) and the significant role it has in improving public health. This is recognized by the UK government in the Department of Health's Priorities and Planning Framework, which has set the target of increasing breastfeeding initiation rates annually by two percentage points (Department of Health 2002a). The role of breastfeeding in public health is also emphasized in the National Service Framework for Children, Young People and Maternity Services (Department of Health 2004). Globally, the World Health Organization (2003) recommends exclusive breastfeeding for the first 6 months of life to achieve optimal growth, development and health.

Breastfeeding also has a vital contribution to make to reducing inequalities in health as identified in the UK in *the Acheson Report* (Department of Health 1998). The UK government has identified a target of reducing inequalities in health outcomes by 10% by the year 2010, as measured by infant mortality and life expectancy at birth (Department of Health 2002b). National surveys of breastfeeding rates in the UK have shown inequalities in breastfeeding rates (Foster *et al*. 1997; Hamlyn *et al*. 2002). In the latest national survey, only 28% of women in lower socio-economic occupational groups breastfeed up to 6 weeks compared with 60% of women in higher socio-economic occupational groups (Hamlyn *et al*. 2002). Previous research has suggested that young mothers, women from low-income communities and those leaving full-time education at an early age have low rates of breastfeeding (Scott & Binns 1999; Hamlyn *et al*. 2002; Dubois & Girard 2003). The evidence concerning breastfeeding and ethnicity is less clear. Hamlyn *et al*. (2002) found that in the UK, Asian women had higher initiation rates than white women (87% compared with 67%), but by 4 months the prevalence of breastfeeding was the same for both groups at 28%.

The context for this study was a town in the north-east of England where breastfeeding rates were improving but remained well below national targets for initiation and continuation of breastfeeding. In this region, two hospitals and one Sure Start local programme have achieved UNICEF UK Baby Friendly Initiative (BFI) accreditation. However, the local maternity unit where all the women in this study gave birth or intended to give birth was not UNICEF UK BFI accredited, nor was the Sure Start local programme within which this study took place. Sure Start is a UK government programme that is part of a national strategy to tackle child poverty and social exclusion. Sure Start local programmes are situated in localities with a high proportion of children living in poverty, with the aim of improving the health and well-being of families and children from birth to 4 years of age (Sure Start 2005).

In 1999, a multi-professional breastfeeding strategy group was formed to address breastfeeding rates in the local area and, over a 2-year period, witnessed an increase in initiation rates from 49% in 1999 to 52% in 2001. During this period, strategies were utilized which may have contributed to this modest increase in breastfeeding rates. The strategies consisted of the formation of a post-natal breastfeeding support group, which attracted women from more affluent areas of the town; training for healthcare assistants; and local events with media coverage during National Breastfeeding Awareness Week (an annual health campaign coordinated by the UK Department of Health to promote breastfeeding).

The breastfeeding strategy group was unsure of how to target its efforts towards communities with low breastfeeding rates, and the recent formation of a Sure Start project seemed an ideal opportunity to explore how this might be achieved. Within this context, a small qualitative study using focus group methodology was carried out to explore women's views. The aims of the project were to discover what women perceived to be the barriers to breastfeeding, what influenced them when choosing their method of infant feeding and what healthcare interventions might have encouraged them to breastfeed. The findings of the project were used to ensure that the ensuing breastfeeding strategy was based on local needs.

Materials and methods

This was a qualitative, exploratory study using focus groups with women living in a Sure Start area in the north-east of England. Focus groups were chosen as the most appropriate data collection method for this

study because they are said to be well suited to health research that explores complex issues (Carey 1994) and to collect a richness of data at a reasonable cost (Kreuger 1988). Seven focus groups were conducted with a total of 35 women. Inclusion criteria for participation in the study were women living in, or accessing services in the defined Sure Start area, who had one or more children under 4 years old or who were pregnant at the time of the study. It was hoped that women with recent experiences of infant feeding or who were in the process of decision making regarding method of infant feeding would have an interest in the topic and be willing to participate in the study. The women were recruited through existing groups for pregnant teenagers, Bangladeshi women, mother and baby groups and a nursery school.

The resulting sample comprised two groups of adolescent women, one group of women from a minority ethnic group and four groups accessed through the nursery school and mother and baby groups. It was felt that this range of groups represented the diverse population within the Sure Start area. Within each group, there were some women who had or intended to breastfeed and some who had or intended to bottle-feed. Thus, a multiple category design (Krueger & Casey 2000) was used to allow comparisons to be made within groups (e.g. between breastfeeding and bottle-feeding) and between groups (e.g. adolescent women and women from an ethnic minority group).

Within these groups, the women knew each other to varying degrees. Using pre-existing groups has the advantage of making the focus group as natural a setting as possible, which can enhance the quality of the data (Kitzinger 1994), but may have the disadvantage that such groups operate with taken-for-granted assumptions (Morgan 1998). Women were initially contacted through the group coordinators who were sent copies of the participant information sheet and consent form to distribute to potential participants. If there was interest expressed by some women, an appointment was made through the group coordinator, to hold a focus group. The numbers of participants in the focus groups ranged from 3 to 10. Although the ideal size for a focus group is reported to be 6 to 10 participants (Morgan 1998), it is more usual for studies to report fewer participants, often due to people agreeing to take part but failing to attend on the day (Bryman 2001). Morgan (1998), however, suggests that smaller groups may be preferable where participants may have a lot to say on the topic and when personal experiences are likely to be included, which was the experience in this study.

The ages of the 35 women ranged from 17 to 40 years, over three-quarters ($n = 27$) had partners, and 69% ($n = 24$) were Caucasian, with the remainder coming from the Bangladeshi community. Twelve (34%) of the women were employed, of whom nine worked part-time. Twenty-two (63%) of the women had breastfed or intended to breastfeed, and 13 (37%) had or intended to bottle-feed. The length of time that women had breastfed ranged from 1 day to over 1 year.

Each focus group took place at the venue normally used by that particular group of women. The same question guide, derived from the aims of the study and relevant literature, was used to facilitate each group. This ensured some comparability between the groups while the questions were open-ended to encourage general discussion and to allow the facilitator flexibility to explore specific issues raised within a group (Bryman 2001). Each group was audio-taped and moderated by the same two researchers, one to facilitate the discussion and the other to make field notes. The field notes were invaluable in the analysis of the data in identifying speakers, identifying non-verbal communication and external stimuli. An interpreter was also in attendance for the focus group with the Bangladeshi women. Prior to the commencement of each focus group, the consent form and information sheets were distributed, and women were given the opportunity to ask questions about the study prior to giving written consent. Participants were also asked to complete a short written demographic questionnaire. Following the conclusion of each discussion, participants were asked to verify a verbal summary of key points as validity check, as suggested by Krueger & Casey (2000).

The recordings of the discussions were transcribed verbatim and analysed for common themes and issues. Both researchers listened to each tape and cross-checked the transcripts and field notes for accuracy. The transcripts were coded, labelling each phe-

nomenon as it occurred and noting the context, frequency, specificity and extensiveness of responses (Krueger & Casey 2000). In this way, patterns, themes and contradictions within each focus group were highlighted and then comparisons made between the groups. Quotations that best illustrated the main themes were selected for inclusion in the report. An academic colleague independently read the transcripts and identified the themes which were similar to those identified by the researchers. This provided a validity check for the data analysis.

Ethical approval for the study was gained from the local research ethics committee. Procedures followed to maintain confidentiality included restricted access to the data, safe storage and timescales for destruction of the data. Names were not attached to the transcripts or any reports or publications. A summary of the report was sent to all participating groups. All of these procedures were made explicit to the women before they consented to participate in the study.

Results

The themes that emerged from the data were remarkably consistent across the focus groups. The key areas discussed were: society's attitudes to breastfeeding; influences on the choice of feeding method; knowledge of infant feeding; perceptions of professional support and experiences of breastfeeding. Each theme has been summarized, and illustrative quotes are included within the narrative. In addition to the five key themes, changes in practice to encourage breastfeeding that the participants themselves suggested are included.

Society's attitudes to breastfeeding

The major issue for many of the women was breastfeeding in public and the way others respond to this. One breastfeeding woman said:

I just think that because people get embarrassed when they see someone breastfeeding, women in general think 'it is not acceptable so I am not going to do it.' Everyone wants to be accepted in society.

Most of the women stated that they were embarrassed when breastfeeding in public and felt uncomfortable because of the perceived reaction of others. Some responded to this by feeding in toilets or sitting in a discreet corner. One young woman described how she had been asked to sit out of sight in a bar and another had been asked to leave a café. A 17-year-old pregnant woman who was intending to bottle-feed, described a friend's experience of breastfeeding in public:

My friend, she goes into the toilet in the café we usually go to because everyone stared. She didn't like to keep going into the toilet. It is a nice café and nice people, but staring puts you off.

In most of the groups, women discussed the lack of comfortable and accessible facilities for breastfeeding in the local town centre. For many women, this restricted their activity and was given as a reason for choosing to formula feed or for giving up breastfeeding. One woman said:

I haven't ever used any of the places in the town because I always make sure if I went out anywhere, I fed him before I went and came back before he was due again because I knew there wasn't ideal facilities in the town to do it.

This comment raised discussion within the focus group that this would be very difficult to achieve as babies are unpredictable in their feeding needs. Facilities for feeding in public places were not an issue for the Bangladeshi women, as they stated categorically that they only breastfeed in the home.

We didn't do it in public . . . never.

This restriction on their activities was cited as a reason for giving up breastfeeding for these women. In contrast with the problems of breastfeeding in public, the majority opinion was that bottle-feeding is accepted everywhere.

For many women, the embarrassment of breastfeeding extended into their own homes, and the responses of family and friends, especially male relatives, were highlighted. One breastfeeding mother said:

My father-in-law will not come in the house if I'm feeding, honestly, he won't come in the house. He won't even sit in a different room.

And another said:

My dad used to call breast milk muck. He'd say, 'what are you giving them that muck for?'

Specific aspects of breastfeeding which were stated to be embarrassing included leaking breastmilk and feeding an older child who is actively seeking the breast.

Influences on the choice of infant-feeding method

Some of the women expressed passionate attitudes towards breastfeeding, ranging from those who were avidly in favour of it to those who were disgusted by it. It appeared that these women were unlikely to be swayed by other factors. It was noted that within the groups, when a bottle-feeding mother said that she found the idea of breastfeeding repulsive, the breast-feeding women were empathetic and accepting of this attitude.

Those women who chose to breastfeed often reported having been breastfed themselves, or having siblings who had been breastfed. Many of the women had never seen anyone breastfeed and for those that had, this was not necessarily a positive experience. For example, having friends who had difficulties in breastfeeding influenced some women to choose bottle-feeding.

Family and friends were cited most frequently as being influential in the women's decision of infant-feeding method. Examples emerged of relatives or friends describing their own negative experiences of breastfeeding to persuade the women to choose bottle-feeding.

When I first became pregnant I said 'Oh yes, I'm definitely breastfeeding.' But as it wore on and on, everybody's answer to that was 'Oh well, you might not be able to you know' and I got brought down and down. By the time I had her I was saying 'Oh well, I will if I can' because I felt it was hard saying I was going to.

Some grandparents were said to have felt that breastfeeding excluded them.

I think my partner's parents thought I was breastfeeding the babies so they couldn't have them, basically. They wanted to be active grandparents and be hands on all the time, which drives me 'round the twist'. I felt that they were very offish on breastfeeding because it meant that they couldn't have them (the infants) at their house.

The women's partners also had a strong influence on most of the women; however, partners were not mentioned in the discussions with the adolescent or Bangladeshi women.

Women's opinions differed when asked whether media campaigns had any impact. It was suggested by one group that media campaigns have little effect in persuading women to breastfeed, whereas another group felt that advertisements suggesting that infant formula is as good as breastmilk do have an impact.

Knowledge of infant feeding

Women appeared to lack knowledge about some aspects of infant feeding. The source of knowledge of bottle-feeding tended to be experiential, whereas information about breastfeeding was mainly from books, leaflets and antenatal classes. Not all of the women had received information from health professionals. Most of the women seemed to have awareness that breastfeeding is best for the baby, but had little knowledge of the specific benefits. Only one woman, an adolescent, said that she had gained knowledge from school. It was generally felt that there was not enough information or preparation given antenatally for either method of infant feeding. One breastfeeding mother said:

I felt parentcraft classes seemed rather obsessed with the pain of childbirth and never seemed to talk about little else. I thought they could have concentrated on how to hold the baby and that kind of thing.

One woman mentioned that she had attended breastfeeding workshops antenatally in a different locality and had found these very helpful. Some of the women who had chosen to bottle-feed expressed the opinion that information of the benefits of breast-feeding was not sufficiently convincing.

I mean you do hear that breast is best and it is promoted but it doesn't actually tell you why.

Another woman said:

I think that if it was proven positive that the breastfed babies thrived a lot better than on the bottle, I think a lot of people would try it (breastfeeding) before they went on the bottle.

As the focus groups progressed and women described their positive experiences of breastfeeding, including the health of their babies, one or two of the bottle-feeding women seemed to re-appraise their attitude towards breastfeeding. One asked

Do you think it is true then, that bottle fed tend to get asthma and things and they're more prone to it? Really?

Perceptions of professional support

Many women were distressed by the inappropriate attitudes of some health professionals and their conflicting information regarding aspects of breastfeeding. The following woman described her upsetting experience in hospital:

One midwife came and whispered to me 'Not all the midwives would do this and they don't agree with it, but I'm going to give you a shield' and the next one came on was very stroppy with me and she told me flatly that she didn't agree that I was doing that and had me in tears.

Midwives were observed by some women to be more helpful to breastfeeding mothers than to those bottle-feeding, while others felt that midwives assumed they had knowledge of infant feeding.

They were more helpful if you wanted to breastfeed and I did sort of notice that the girls who were bottle-feeding, they just sort of let them get on with it.

In hospital, some of the women were reluctant to ask for help because they felt the midwives were too busy. Within all of the focus groups, this point had strong agreement from the participants, although some were keen to highlight positive support:

Most of the midwives used to come in and say 'hello I'm such and such I'm your midwife for this shift'. They used to walk back out of the door and then you never used to see them again until the next midwife came on shift. But this particular one just used to keep popping back in and say 'are you alright?' The fact that you didn't feel awkward to buzz for her either . . .

Support and help from the hospital staff in initiating breastfeeding was valued, although some women had difficulties once they had returned home. Other health professionals mentioned were general practitioners, who had given two women inappropriate advice concerning mastitis, and health visitors, who were said by some women to be overly concerned about weight gain:

But the health visitors were panicking like mad and 'Oh he doesn't weigh enough', which had me quite worried with my first.

Contradictory opinions were expressed regarding the promotion of breastfeeding by health professionals. Some felt that pressure from professionals to breastfeed made bottle-feeding women feel guilty, whereas others thought breastfeeding was not promoted enough.

Experiences of breastfeeding

There was a general perception, especially notable among those who had chosen to bottle-feed and those who had discontinued breastfeeding after a short time, that breastfeeding is difficult. Some women had actually experienced difficulties themselves, whereas others just held this belief. Frequent feeding and concerns that the baby was not getting enough milk were the most common themes. Problems with latching on, soreness and sleeping difficulties were also commonly mentioned. In contrast, bottle-feeding was perceived to be easier, incurring fewer problems and resulting in infants that were more settled, chubbier and needing less frequent feeds. Many of the women appeared tentative in their decision to breastfeed because they anticipated problems and lacked confidence in their ability.

We decided that we were going to give breast feeding a try and, like you, I had all the bottles and formula at home in case it didn't work or she wouldn't do it.

One woman reported that a midwife had advised her to have a supply of bottles and formula in case of problems.

The impact of breastfeeding on their lifestyle was significant for some of the women. Examples included the lack of freedom to travel, socialize and continue education and work. These issues were particularly significant for the adolescent women and were quoted as a reason for choosing bottle-feeding.

Women felt that there were insufficient support mechanisms available, and some were unaware of existing support groups and helplines. Many breastfeeding women appeared to have contradictory views and, while they discussed their associated problems at length, they also highlighted many benefits. These included that it is convenient, cheaper, easier at night, with a toddler, and on holiday, and that breastfed babies are healthier. Women also emphasized the emotional rewards of breastfeeding.

When she came into bed with me on a morning and she would just lie there and feed, you feel it's just like your mind clears, your body is just relaxed and I've never been so relaxed and I haven't got that relaxation back since I stopped.

Although in all the groups, problems with breastfeeding were discussed at length, only the breastfeeding mothers identified any disadvantages of bottle-feeding.

My sister's got a new-born baby and initially she was having fourteen bottles a day. You see, every couple of hours she was wanting a couple of ounces. She said, 'In the morning when you walk in the kitchen there's all this . . . mess.'

Within the focus group with the Bangladeshi women, there appeared to be an age divide, with the younger women holding the attitude that breastfeeding is difficult. One 18-year-old woman from this group, referring to breastfeeding, stated:

Yeah, I come from the younger generation so I think that not wanting to breastfeed was a bit of shyness. I thought that bottle-feeding was easy.

In contrast, the older women spoke of how much easier and more convenient breastfeeding is. The 39-year-old woman who had breastfed seven children and was still feeding the youngest, said:

I don't have to make anything, it's ready there and then for the baby. I don't have to warm it up or clean the bottle or things like that.

Women's suggestions

In most of the discussions, the women made suggestions that they felt may encourage breastfeeding. They wanted more comfortable facilities for breastfeeding mothers in public places. It was also suggested that breastfeeding-friendly shops and cafes could be positively identified.

I think the only thing is for there to be more places out and about that you can use, comfortable places. Because if you've got a new baby, or even one this age, you've still got to go out and do your day to day things and when a baby wants feeding it wants feeding.

Most of the women would have liked more information, practical advice and preparation in the antenatal period, in the form of workshops, videos and discussions.

But you know that there was that one day where I just could not leave the house. I could not put him down or anything. You're a novice and everything and you don't understand. I think if someone could've just prepared me for that, I probably might have got through it.

Some women felt that opportunities should be provided to discuss infant feeding with the midwife, rather than being asked to make a choice between breastfeeding and bottle-feeding in early pregnancy.

Especially like at the booking in, like we were just saying. Instead of saying 'how are you going to feed?', the midwives could say, 'lets talk about feeding your baby, and the benefits of breast feeding are . . . over a bottle. You need to read this information and then think about it and we'll discuss it at a later date.'

One woman thought that all women who have chosen to bottle-feed should be offered the opportunity to try breastfeeding following birth as they experience skin-to-skin contact.

I mean J was put straight onto my tummy straight away and then, fair enough, he's took away and washed and brought back. But if he'd been maybe left a little bit longer then you

know so those who decide they want to do the bottle – it might give them a chance to maybe change their mind.

Some women would have liked professional support to have been offered rather than having to ask. The Bangladeshi women would have appreciated support from someone from their own culture.

Discussion

The findings of this study have potential relevance for all health professionals concerned with increasing breastfeeding in communities with low rates. There was significant agreement among the participants about the key issues that hinder women from initiating and continuing breastfeeding.

Consistent with other research, women's concerns related to feeding in public and the response of others were a major barrier to breastfeeding (Ineichen *et al*. 1997; Raisler 2000; Barton 2001). In our study, embarrassment at feeding in public was a theme in all of the focus groups, but appeared to be a particular issue for the adolescent women. Hannon *et al*. (2000) also suggest that teenagers find breastfeeding in public embarrassing and unacceptable to others. In part, these attitudes may originate from the conflict between the role of the breast as sexual object and its nurturing function. Linked to this is the notion that breastmilk, like other bodily fluids, is disgusting, or, as referred to by the father of one woman in this study, 'muck'. While this may be an extreme example, it does highlight the challenges that some women face.

As a consequence of these attitudes, the question of where it is appropriate to breastfeed was a very real dilemma for the women in our study. This may be even more so for low-income women who are more likely to travel by public transport than for women who can breastfeed in their cars. Hamlyn *et al*. (2002) found that 39% of women with babies aged 4 to 5 months had problems finding a place to breastfeed in public, while 8% had never breastfed in public. In our study, the experience described by one adolescent woman of being asked to leave a café and another of feeding in a toilet to avoid being stared at, demonstrates the problems and humiliations faced by breastfeeding women as they go about their daily lives. Some feminist writers discuss this issue in terms of boundaries between private and public space in which women's nurturing and mothering activities are confined to the private arena, while men dominate the public one (Carter 1995; Rose 1999). This may explain why women feel the need to conceal breastfeeding, or at the very least, to do it discreetly. However, as Carter (1995) elaborates and as demonstrated in our study, even in the privacy of their own homes, women are not free to do as they please. Women find themselves excluded from social interactions during breastfeeding because others refuse to be in the same room, or even the same house. Any efforts to promote breastfeeding among disadvantaged groups are likely to be undermined if these issues are not addressed. The women in our study wanted better facilities for breastfeeding in public and positive identification of public places that welcome breastfeeding. Health professionals have a role to play in working with local businesses and councils to improve facilities for breastfeeding women.

The second major theme in our study was factors that influence women in their choice of infant-feeding method. The main issues were a bottle-feeding culture in the local community and the influence of families and friends. Factors that influence women in their choice of infant-feeding method have been well documented. Protheroe *et al*. (2003) acknowledge that the attitudes of partners, mothers and peer groups are among some of the factors that influence the initiation of breastfeeding. This supports the findings from our study that male partners and other friends and relatives had a strong influence on the women's decisions regarding infant feeding. A difference between cultural groups noted in our study was that, in the focus group with Bangladeshi women, female relatives rather than male partners were mentioned as having influence over decisions of method of infant feeding. This has also been noted in other studies. Ingram *et al*. (2003) found that, in Bristol, South Asian grandmothers have a key role in supporting and influencing women to breastfeed. These differences have implications for strategies to increase breastfeeding rates which need to target grandmothers as well as partners.

As in many studies, the women in our study displayed deeply held views which were unlikely to be influenced by health professionals. It is frequently reported that women who have the experience of breastfeeding, especially within the family, are more likely to choose to breastfeed their babies (Hoddinott & Pill 1999). Further research exploring the opinions and attitudes of significant others is needed to inform practice. As in our study, Barton (2001) found that family members used negative experiences to discourage breastfeeding. A challenge facing midwives is to overcome the legacy of previous harmful practices and advice. Given the influential role of grandparents, partners and friends in most of the women's decisions, strategies to promote and support breastfeeding may be more effective if directed at the whole community.

Discussion of the role of the media in promoting or inhibiting breastfeeding aroused a variety of opinions in the focus groups. There appeared to be general agreement that media campaigns to promote breastfeeding have little effect. As there has never been a national campaign in England to promote breastfeeding, it would have been interesting to explore what promotional material these women had been exposed to, e.g. parenting magazines, hospital discharge packs, and how influential these were. These women participating in our study believed that they had seen advertisements for formula milk, although, as this is illegal in the UK, they had probably been exposed to advertising of other products, such as follow-on milks. Similarly, in a MORI survey of 1000 new mothers, 60% thought they had seen an advert for infant formula in the preceding year (UNICEF UK & the National Childbirth Trust 2005). While this is not a reliable form of evidence, it demonstrates the importance of this issue and the need for high-quality research on the influence of advertising by formula companies.

Another key theme in our study was that women appeared to lack knowledge about the specific benefits of breastfeeding. This is consistent with the latest national infant-feeding survey (Hamlyn *et al*. 2002), in which a majority of women (89%) said they were aware of the health benefits of breastfeeding, but a significant number of women from lower occupations (27%) and those who have never worked (46%) were unable to give specific reasons. However, Hannon *et al*. (2000), in a study of teenagers in Chicago, found that those who were bottle-feeding questioned the validity of the benefits of breastfeeding. This can be seen in the focus group data in our study, where women were not sufficiently convinced of the benefits of breastfeeding. Health professionals have a significant role in addressing the lack of knowledge about many aspects of infant feeding (Ineichen *et al*. 1997), and the findings of our study suggest that midwives could influence more women to breastfeed by providing information about its benefits during the antenatal period. Rather than being asked to make a choice in early pregnancy, some women in our study would have liked to discuss infant feeding with health professionals throughout pregnancy.

The differences in the sources of knowledge for both methods of feeding seem to suggest that, within a predominantly bottle-feeding culture, collective knowledge about breastfeeding has been lost (Dykes 2003) and many women have to rely on books and antenatal education classes. However, these methods of gaining knowledge have been shown to be less effective with women from low-income groups who are likely to learn more successfully from role models through apprenticeship (Hoddinott & Pill 1999).

A further key finding of this study is that many women did not receive the level of professional support that they would have liked. However, some women valued support from midwives and felt that one supportive midwife could make a significant difference to their experience. In their systematic review of breastfeeding support, Sikorski *et al*. (2004) found evidence that professional support is effective in increasing the duration of breastfeeding. There is also evidence in our study of midwives' dissent, for example, advocating the use of nipple shields and advising a woman to have bottles at home in case of problems. Conflicting advice remains a real issue for practice and can have a devastating impact on women. For midwives to overcome these challenges, they need good-quality training and education. This is supported by Renfrew *et al*. (2005), who suggest that one of the factors contributing to low breastfeeding rates in the UK is the lack of education and preparation of health

practitioners. The introduction of the UNICEF UK BFI (2002) best practice standards for breastfeeding education for student midwives and health visitors will hopefully provide a framework for those delivering pre-registration education to address this issue.

A further major barrier to initiating and continuing breastfeeding, discussed in all of the focus groups, was the perception that it is difficult. The women in our study commonly mentioned concerns that the baby was not getting enough milk, frequent feeding, soreness and difficulties with latching on. Others have found these factors to be associated with early cessation of breastfeeding (Hannon *et al*. 2000; McIntyre *et al.* 2001). Mahon-Daly & Andrews (2002) propose that the idea of insufficient milk has become a cultural belief rather than fact. This can be reinforced, unwittingly, by health professionals who focus on weight gain. The emotional rewards of breastfeeding, which were significant for some women in this study, appear not to receive as much emphasis in scientific literature. This may be because, as Smale (1998) suggests, we lack the language to describe the extent of the pleasure that is possible from breastfeeding.

In attempting to address the many barriers to breastfeeding highlighted in our study, the UK could learn lessons from experiences in Scandinavian countries. Breastfeeding rates in Scandinavia were very low in the 1960s and 1970s (Endressen & Helsing 1995; Greve 2003), but successful action has been taken to reverse this trend. In the late 1990s, Sweden and Norway had almost 100% initiation rates, and at 6 months almost 70% of babies in Sweden and 80% in Norway were still being breastfed (Yngve & Sjostrum 2001; Lande *et al*. 2003). The reasons for these impressive success stories are complex but include changes in hospital ward practices underpinned by he UNICEF BFI (Endressen & Helsing 1995; Ekstrom *et al*. 2003), early introduction of lay groups for breastfeeding support with active government support (Nyqvist & Kylberg 2000; Yngve & Sjostrum 2001), generous and flexible parental leave policies (Galtry 2003) and less infiltration by formula companies (Gerrard 2001).

In our study, we listened to the views and suggestions of local women and used them to formulate a breastfeeding strategy to address local needs. While this research illustrates some key issues related to women's views of breastfeeding, there are difficulties in drawing general conclusions from such small groups, and the findings should be interpreted in the light of the methodological flaws. Limitations include the small, self-selected convenience sample and the possibility that the enthusiasm of the group coordinators may have influenced the decision of some women to participate in the study. As there was only one group of adolescent women and one of Bangladeshi women, the findings from these groups need to be interpreted with caution. Further research focusing independently on these groups of women might have revealed additional issues. A further limitation of this study is the inclusion of both pregnant women and new mothers in the same focus groups. It is possible that the views of the new mothers who had the experience of infant feeding may have dominated the discussion at the expense of the prospective views of pregnant women, especially those pregnant with their first child. This may have affected the validity of the findings. Similarly, having both women who had or intended to breastfeed in the same group as those who had or intended to bottle-feed may have influenced how some women responded to questions. The design of this study, while ascertaining the views of women with a wide-range of perspectives that were important for the aims, may have concealed important differences between these groups. There is always the risk, in this type of research, that the values and beliefs of the researchers have influenced the findings. One of the researchers (G.T.) was known to some of the women who may have been aware of her enthusiasm for breastfeeding. While conscious efforts were made not to influence the discussion and to ask open questions, it can never be assumed that this was wholly achieved.

Information from this study indicates that there are significant barriers to breastfeeding for the local population. These barriers include issues surrounding breastfeeding in public in an area with a predominantly bottle-feeding culture, poor knowledge about the benefits and practicalities of breastfeeding, negative influences from family and friends, inappropriate professional attitudes and the perception that breastfeeding is difficult.

Based on the conclusions of this study, a local breastfeeding strategy has been formulated addressing the themes identified in this research, namely: improving facilities for breastfeeding in public, increasing knowledge of infant feeding for women and their families, professional development for healthcare professionals and the implementation of support mechanisms to meet the needs of women least likely to access existing services. The local authority Health Scrutiny Committee, the health sector and the voluntary sector have formed a partnership to improve breastfeeding facilities in the town centre. As a result of this, the Health Scrutiny Committee was successful in a bid for the Centre for Public Scrutiny money and was awarded a grant of £20 000 to make the town breastfeeding friendly. It is envisaged that this money will be spent on developing a breastfeeding-friendly award scheme for local businesses. Monthly antenatal workshops for women who intend to breastfeed have been implemented at the local hospital. Breastfeeding support groups have been set up in each of the town's two Sure Start projects, and training for peer supporters has commenced. Breastfeeding education has now been included in the annual mandatory training for all midwives. As a result of the findings of this study, the Sure Start area in which it was conducted is working towards the UNICEF UK (2006) Baby-Friendly seven-point community plan. The seven-point community plan was developed by UNICEF UK BFI to protect, promote and support breastfeeding in community healthcare settings (see Appendix 1 for details). While it is recognized that there are examples of the above strategies being implemented across the UK, this study has demonstrated how local findings can spearhead appropriate collaborative action.

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Appendix 1

The seven-point plan for the protection, promotion and support of breastfeeding in Community Healthcare Settings

Community facilities which adopt the plan can apply to be accredited as 'Baby Friendly'.

All providers of community health care should:

1. Have a written breastfeeding policy that is routinely communicated to staff
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy
3. Inform all pregnant women about the benefits and management of breastfeeding
4. Support mothers to initiate and maintain breastfeeding
5. Encourage exclusive and continued breastfeeding, with appropriate introduction of complementary foods
6. Provide a welcoming atmosphere for breastfeeding families
7. Promote co-operation between healthcare staff, breastfeeding support groups and the local community