

## **The Challenges of Breastfeeding in a Complex World**

A critical review of the qualitative literature on women and their partners'/supporters' perceptions about breastfeeding

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## Executive Summary

*“I thought I’d be absolutely fine ... I thought I’d just get on with it and it would be easy really ... (but) people were really shocked by the fact that you’re breastfeeding in public. I kind of felt like I didn’t care, but I did care a lot, and it was really difficult ... I just found it really stressful, really embarrassing, really horrible” (Boyer, 2012, p557).*

### **Introduction, purpose and methods**

Breastfeeding is universally acknowledged as providing health benefits for mothers and infants, decreasing infant mortality and morbidity particularly in developing countries, but also in more affluent societies like Canada. Despite strong recommendations from the World Health Organization and many national health bodies in the Western world, breastfeeding rates, and in particular exclusive breastfeeding rates at six months, remain lower than recommended and can be highly variable across cultures and communities. In Canada, for example, community health survey data for 2009-2010 found a breastfeeding initiation rate of 87.3% and a six month exclusive breastfeeding rate of 25.9%.

This critical review of the literature was commissioned by Alberta Health Services to inform the development of initiatives to improve breastfeeding initiation and duration rates in Alberta, and was planned and undertaken in response to the following question:

What are the perceptions of women and their partners/supporters of the barriers/challenges and enablers to the initiation and duration of breastfeeding?

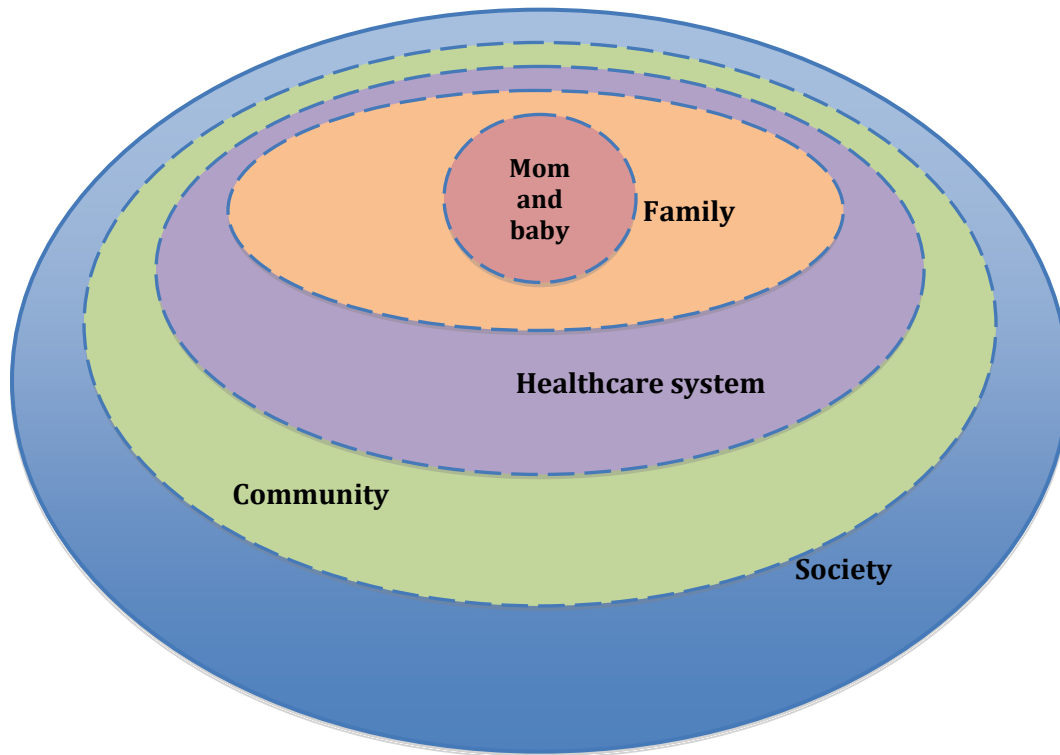
The purpose of this review was to capture firsthand the breastfeeding perceptions, attitudes and experiences of today’s modern mothers and their partners and supporters through reviewing qualitative research from the past ten years. The search strategy was developed to specifically target qualitative research. Review articles and single qualitative studies were the primary focus of interest, but mixed method research studies were considered if they included a strong qualitative component through the use of focus groups, interviews or open-ended surveys.

### **Findings**

A major crosscutting theme identified from the literature is the challenges of breastfeeding in a complex world. This theme cut across all groups of women regardless of age, ethnicity or socioeconomic status. Many of the studies highlight the importance of viewing breastfeeding not simply as a technical task but rather as an important part of the transition to motherhood. An individual's personal and social context is described as integral to the discussion of breastfeeding, with a woman’s breastfeeding decisions best understood and supported in relation to the circumstances of her life, her immediate sociocultural context and her individual experience.

We frame our findings from this review within a five-layer human ecology model comprised of: the mother-infant dyad; the family; the healthcare delivery system; the community; and society (see Figure 1). These levels blend into each other as indicated in our model through the use of dotted lines between the circles.

**Figure 1: Ecological Frame - Perceptions of breastfeeding in a complex world**



#### Mom and baby

Maternal confidence in the ability to initiate and keep breastfeeding results from a dynamic interaction between each woman's expectations, the physical aspects of breastfeeding, her baby's breastfeeding behaviour, sources of support, and the complex social context within which breastfeeding and motherhood is embedded. Going into breastfeeding with more realistic than idealistic expectations contributes to more maternal confidence, self-efficacy and ultimately breastfeeding success. Useful information about breastfeeding, intention to breastfeed, and early positive experiences and satisfaction with breastfeeding are also positive contributing factors.

#### Family

Family, for the purposes of this review, transcends the traditional concept of the nuclear family. Adopting a woman-centred approach, family is simply defined as anyone identified by a mother as someone with whom she has a close relationship and relies on for support (i.e., those

individuals that she is closest to and most influenced by). An overarching theme captured here is that the attitudes, beliefs and expectations of family are a major contributing factor to a woman's infant feeding decisions. Women describe the support of their partner as having a positive impact on the initiation and duration of breastfeeding, and this finding appears to cut across ethnicity, socioeconomic status and the age of the mother. Women highly value and rely on support from the people they are closest to. Support from family members contributes to a woman's confidence in and ability to breastfeed.

#### Healthcare system

Women frequently describe looking to health professionals for support in getting breastfeeding established. This is particularly true of women with little family support. Confidence and self-efficacy with breastfeeding are critical enablers of breastfeeding success. Yet the healthcare culture within which health professionals practice contributes to support being provided in a way that undermines rather than builds on women's confidence in breastfeeding. Developing a healthcare system culture that can support health professionals to practice patient- and family-centred care is important if the healthcare system is to do more good than harm. Taking a patient- and family-centred approach to care involves working collaboratively with moms and babies within the context of their individual families and lives.

#### Community

A major theme that emerged here is the importance of creating spaces within different kinds of communities where women feel truly comfortable breastfeeding. Women who are breastfeeding consistently describe feeling isolated and excluded from society, primarily because of the social disapproval around breastfeeding in public places. In particular, workplaces and schools are described as settings where women feel a lot of discomfort both with breastfeeding and pumping. Young people in particular express a lot of disapproval about breastfeeding in public. As a result, many young women stop breastfeeding sooner than they intended to because of the sense of isolation that results from this reluctance to breastfeed in public places. Developing workplace and school policies and practices that actively support breastfeeding, as well as peer support initiatives can positively contribute to breastfeeding rates.

#### Society

The dominant theme woven throughout this entire findings section is that breastfeeding is a culturally embedded activity that occurs in an increasingly complex world. As Stewart-Knox et al (2003) stated almost a decade ago, "*culture profoundly influences health knowledge, attitudes and behaviour; and this is particularly true of infant feeding practices*" (p265). Ultimately, as the roles of women in modern societies change, there is tension between motherhood and the various other roles that women play. Mothering in today's society is characterized as a complex balancing act. Women describe trying to achieve some kind of balance between ensuring the health of their babies and the reality of their daily lives. Although society has changed,

breastfeeding is expected to continue in the same way as always. Yet many women have to return to work and/or school soon after their children are born and trying to juggle this with breastfeeding can be hugely challenging. Overall, women describe struggling with trying to integrate breastfeeding into their lives.

*“The perfect mother can do everything. She can breastfeed while holding down a full-time professional job, earning truckloads of money, can manage a household, drives the perfect car, has great skin every day, lovely shiny hair, and goes to the gym, eats the perfect diet, and does all this and can still be having a good sex life, and be a gourmet chef [laugh]. It’s just expectation that we build up in ourselves to do with breastfeeding, natural birth, perfect career, and the perfect marriage. I don’t know why we do it to ourselves, because we’re constantly disappointed” (McBride & Henry, 2010, p771).*

## 1.0 Introduction and background

Breastfeeding is universally acknowledged as providing health benefits for mothers and infants, decreasing infant mortality and morbidity particularly in developing countries, but also in more affluent societies like Canada (Burn et al, 2010; Gatti, 2008; Johnson & Esposito, 2007; Larsen, Hall & Aagaard, 2008; McGregor & Hughes, 2010; Schmied, Beake, Sheehan, McCourt & Dykes, 2011; Stolzer, 2010). The World Health Organization (WHO) “strongly recommends exclusive breastfeeding for the first six months of life” (WHO, Online). Health Canada supports this WHO recommendation, stating that: “exclusive breastfeeding is recommended for the first six months of life for healthy term infants” (Health Canada, Online).

Despite these strong recommendations, breastfeeding rates, and in particular exclusive breastfeeding rates at six months, remain lower than recommended across the industrialized world and are highly variable across settings (Gatti, 2008; Schmied et al, 2011). U.S. data show that although an increasing number of women are initiating breastfeeding, the majority do not exclusively breastfeed, with the highest drop-off occurring in the first few weeks after birth (Gatti, 2008). Known demographic factors that influence breastfeeding duration rates are race, age, marital status and socioeconomic status (Grassley, 2010; McGregor & Hughes, 2010; Thulier & Mercer, 2009).

The WHO states that: “even in industrialized countries, breastfeeding rates are typically low, and only slowly improving” (WHO, Online). At the global level, “less than 40% of infants under six months of age are exclusively breastfed” (WHO, Online). Here in Canada, the percentage of mothers who initiate breastfeeding slowly improved between 2001 and 2008, increasing from 81.5% in 2001, to 84.9% in 2003, to 87.9% in 2007-2008. This was followed by a slight dip to 87.3% in 2009-2010 (Health Canada, Online). The Canadian rates for exclusive breastfeeding at six months are much lower, although they have been slowly increasing over the past decade. In 2003, the percentage of mothers who exclusively breastfed for six months or more was 17.3%. This increased to 20.3% in 2005, to 23.1% in 2007-2008, and was 25.9% in 2009-2010 (Health Canada, Online).

Statistics from Alberta indicate that the breastfeeding initiation rates have been gradually dropping over the past seven years. In 2005, the initiation rate was 92.7%; in 2007-2008, the rate was 92%; and in 2009-2010, the rate had dipped down to 90.8%. The exclusive breastfeeding rate at six months is quite low in Alberta as well, although higher than the Canadian average, with 29% of mothers exclusively breastfeeding at six months (Breastfeeding Alberta, Online).

### 1.1 Purpose of the literature review

This critical review of the literature was commissioned by Alberta Health Services to inform the development of initiatives to improve breastfeeding initiation and duration rates in Alberta, and was planned and undertaken in response to the following question:



What are the perceptions of women and their partners/supporters of the barriers/challenges and enablers to the initiation and duration of breastfeeding?

The purpose of this review was to capture firsthand the breastfeeding perceptions, attitudes and experiences of today's modern mothers and their partners and supporters through reviewing qualitative research from the past ten years.

A separate systematic quantitative review of the effectiveness of public health strategies to increase breastfeeding rates is also underway. In tandem these two critical reviews of the literature should capture what the research has to say about this important issue and help to inform and better enable future supports and services to strengthen breastfeeding initiation and duration rates here in Alberta, in Canada and abroad.

## **2.0 Literature search strategy**

The search strategy for this review was developed to specifically target qualitative research. Review articles and single qualitative studies were the primary focus of interest, but mixed method research studies were considered if they included a strong qualitative component through the use of focus groups, interviews or open-ended surveys.

The search strategy was created in consultation with a Health Librarian using Medline OVID then adjusted as required while searching other databases. A total of nine electronic peer reviewed databases were searched: Medline, PubMed, EMBASE, CINAHL, Family and Society Studies Worldwide, SocINDEX, Social Services Abstracts, Social Work Abstracts and Sociological Abstracts. The search was limited to English language literature published after 2001.

The review was limited to literature related to pregnant or postpartum women or women of childbearing age and their partners, and healthy term infants and singleton births. Studies were excluded if they addressed: women with serious illness; the perceptions of healthcare providers alone; the implementation or evaluation of breastfeeding initiatives; or demographic or medical epidemiological research.

The tables related to high-income economies and high-income OECD members, and the Center for European and Eurasian Studies' listing of Western European Countries were used in combination to develop a geographic filter that would limit the search to women and their partners from Canada and countries comparable to Canada (World Bank, Online; UCLA Center for European and Eurasian Studies, Online).

Please see Appendix 1 for a comprehensive outline of the search strategy used in this critical review of the qualitative literature.

### **2.1 Selection and critical appraisal of articles**

Searches of electronic databases captured 2,327 citations in total, post duplication deletion. A preliminary review of the titles and abstracts determined that 1,892 of the citations were not relevant. The remaining 435 articles were pulled and further screened for relevance, with 249

articles identified for possible inclusion. These articles were passed on to a second reviewer for a more thorough screening for relevance. An additional 108 articles were excluded at this stage leaving 141 articles. The reference lists of all key articles uncovered during this process were checked and cross-referenced to ensure relevant articles were not missed.

The final grouping of 141 full text articles were read through and critically appraised for quality using recent guidelines for “Critically appraising qualitative research” published in the BMJ (Kuper, Lindgard & Levinson, 2008). The overarching questions considered through the critical appraisal process are included in Box 1.

**Box 1 Key questions to ask when reading qualitative research studies**

- ✚ Was the sample used in the study appropriate to its research question?
- ✚ Were the data collected appropriately?
- ✚ Were the data analysed appropriately?
- ✚ Can I transfer the results of this study to my own setting?
- ✚ Does the study adequately address potential ethical issues, including reflexivity?
- ✚ Overall: Is what the researchers did clear?

*From: Kuper, Lindgard & Levinson, 2008, p687*

Articles describing survey results were only included if rigorous qualitative analysis techniques were used to analyze responses from open-ended questions. An initial critical appraisal phase excluded 29 articles and a further, more rigorous screen that incorporated consideration of both saturation and quality eliminated another 22 articles. The remaining 90 articles are included in this literature review.

Please refer to Appendix 2 for a detailed schematic of the results from the literature search and screening process.

## 2.2 Thematic analysis

A review of titles and abstracts prior to the second round of critical appraisal of quality resulted in a loose grouping of the articles into ten categories: sociocultural focus; ethno-cultural groups; socioeconomic status; young moms; role of fathers and other family; returning to work or school; healthcare professionals and the healthcare system; general; and other. Many of the articles contain information pertinent to more than one category but most do focus on a particular area of interest. Please refer to Appendix 3 for a bibliography that lists the articles included in this review by category of interest.

These articles were then reviewed to identify key themes related to women’s and their supporters’ perceptions of barriers and enablers to breastfeeding. A key guiding question during this read through of the articles was whether there were more commonalities than differences

across cultures and countries. As key themes were identified within each article, they were compared to themes identified in other articles. This identification of themes as the analysis progressed was facilitated through the use of mind-mapping software, which supported the constant comparison of these emerging themes as well as the mapping of relationships between them. Through this analysis it was determined that these themes could be best captured using a human ecology framework. This is described in more depth at the start of the findings section.

### **2.3 Strengths and limitations of this review**

This critical review of the literature was initiated to capture the perceptions of women and their partners or supporters of the barriers, challenges and enablers to the initiation and duration of breastfeeding. Qualitative research was specifically targeted in order to best get at firsthand perceptions, attitudes and experiences. The review identified a large volume of reasonable to good quality published qualitative research in this area. There is, however, a lack of research related to Canadian moms and their partners. Much of the research captured in this review is from the United States, but there are also sizeable bodies of literature from the U.K. and from Australia and New Zealand.

Both the United States and the U.K. appear to have considerable variability across groups of women with respect to breastfeeding initiation and duration. Both countries have some communities with strong bottle-feeding cultures. There seems to be a strong breastfeeding culture across Australia and New Zealand. As well, the majority of the studies regardless of country are specific to particular sub-populations of women such as low socioeconomic status, younger moms, working moms and/or particular ethno-cultural groups.

A major strength to this critical review of the qualitative research is the volume of literature reviewed that enabled the identification of key themes related to the barriers and enablers of breastfeeding that cut across boundaries related to SES, age, ethno-cultural experience, family situation, and professional or working status. In other words, women and their supporters' perceptions, experiences and needs cut across these boundaries. Although strategies for increasing breastfeeding rates still need to be tailored for different sub-groups and individualized for women within these sub-groups, the broad strategies are more the same than different.

## **3.0 Findings and discussion**

Once again, the question addressed in this review of the qualitative literature was: What are the perceptions of women and their partners/supporters of the barriers/challenges and enablers to the initiation and duration of breastfeeding? A major cross-cutting theme identified from the literature is the challenges of breastfeeding in a complex world (Dykes, 2005a; Marshall, Godfrey & Renfrew, 2007; Palmer, Carlsson, Mollberg & Nystrom, 2012; Sheehan, Schmied & Barclay, 2010; Schmied et al, 2011; Steinman, Doescher, Keppel, Pak-Gorstein, Graham, Haq et

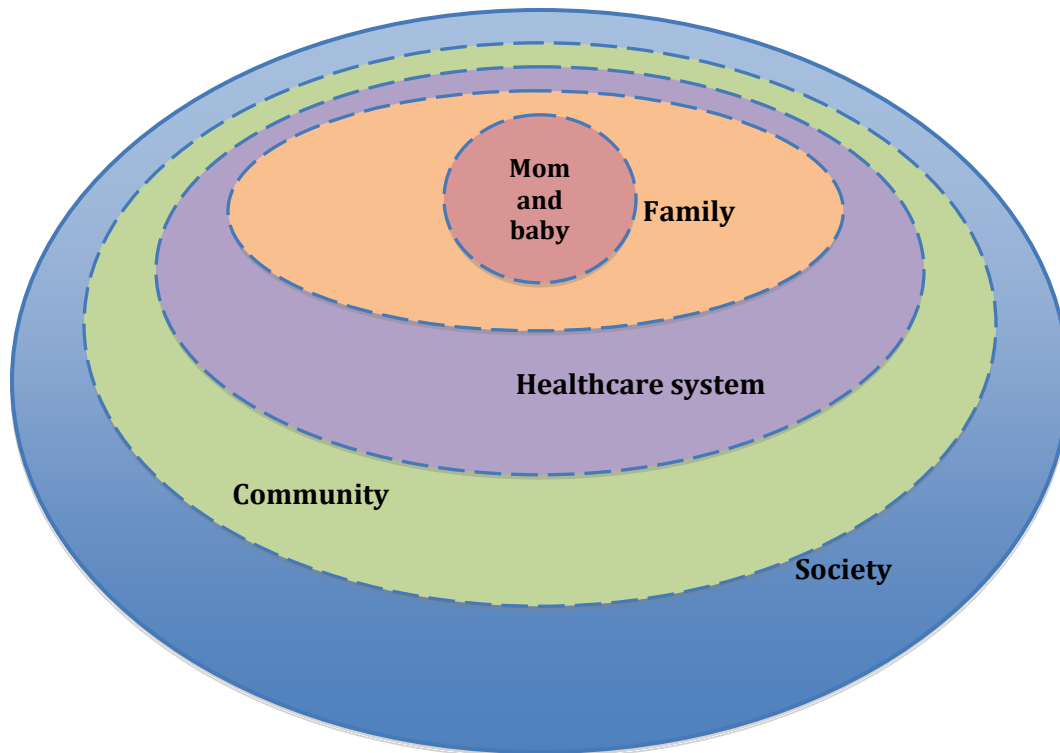
al, 2010; Stewart-Knox, Gardiner & Wright, 2003). This theme cut across all groups of women regardless of age, ethnicity or socioeconomic status.

Many of the studies highlight the importance of viewing breastfeeding not simply as a technical task but rather as an important part of the transition to motherhood. An individual's personal and social context is described as integral to the discussion of breastfeeding (Marshall et al, 2007), with a woman's breastfeeding decisions best understood and supported in relation to the circumstances of her life, her immediate sociocultural context and her individual experience (Sheehan et al, 2010). Given that breastfeeding is clearly a deeply culturally imbedded phenomenon, any discussion of the barriers and enablers to breastfeeding must go beyond individual behaviour and the role of the healthcare system in shaping behaviour.

It became apparent early on in the analysis that the emergent themes aligned well with an ecological framework. In fact, two studies were identified that explicitly tested the utility of using an ecological model to frame their findings: a review of the literature on barriers and facilitators for breastfeeding among working women (Johnston & Esposito, 2007); and a qualitative study of post-partum women in the U.S. (Tiedje, 2002). By using an ecological frame, or a framework of human ecology, one can consider the individual within the context of his or her immediate and broader environment. An ecological frame best captures the challenges of breastfeeding in a complex world and also provides a good fit with health promotion and the social determinants of health.

We frame our findings from this review within a five-layer human ecology model comprised of: the mother-infant dyad; the family; the healthcare delivery system; the community; and society (see Figure 1). These levels blend into each other as indicated in our model through the use of dotted lines between the circles.

**Figure 1: Ecological Frame - Perceptions of breastfeeding in a complex world**



Within each of these five levels we describe the key themes coming out of the literature with respect to both the barriers and enablers of breastfeeding, identifying subtle differences across sub-groups of women, for example: low SES; adolescent/'young' moms; specific ethno-cultural groups; and professional women.

### **3.1 The mother-infant dyad**

An overarching theme that emerged at this level is that no one course of action would work for all women and their babies. The journey women take through the early months of breastfeeding and motherhood in modern Western society is often complex and challenging. As Grassley and Nelms (2008) note, women: *"coped with their experiences in different ways, and ultimately had to find their own way"* (p27). This is an important finding when considering the context of the healthcare system where there is a tendency to develop 'one-size-fits-all' processes and programs.

#### ***Barriers/challenges***

The main barriers to breastfeeding at the mother-infant level can be grouped into five broad categories as summarized here in Table 1.

**Table 1: Barriers/challenges to breastfeeding at the mother-infant level**

Barrier/challenge	Description	Authors
Attitudes, beliefs and knowledge <sup>1</sup> about breastfeeding	<ul style="list-style-type: none"> <li>- Idealized notion of breastfeeding not fitting with real world experiences</li> <li>- Some women are repulsed by the idea of breastfeeding</li> <li>- Disapproval of breastfeeding in public</li> </ul>	Avery & Magnus (2011); Bailey (2007); Forster et al (2010); Grassley & Nelms (2008); Kelleher (2006); Hall & Hauck (2007); Sheehan, Schmied & Barclay (2010)
Physical feeding difficulties	<ul style="list-style-type: none"> <li>- Baby rejecting the breast</li> <li>- Insufficient milk supply</li> <li>- Latching problems and nipple pain</li> <li>- Mastitis</li> </ul>	Bailey (2007); Flower et al (2008); Harris, Nayda & Summers (2003); Heinig et al (2009); Lewallen, Dick, Flowers, Powell, Zickefoose & Wall (2006); Manhire, Hagan & Floyd (2007); Redshaw & Henderson (2012); Twamley, Puthussery, Harding, Baron & Macfarlane (2011)
Pumping difficulties	<ul style="list-style-type: none"> <li>- Time consuming</li> <li>- Lack of access to effective breast pumps</li> <li>- Finding places to pump at work/school</li> </ul>	Avishai (2007); Holmes, Chin, Kaczorowski & Howard (2009); Johnson, Williamson, Lyttle & Leeming (2009)
Other difficulties	<ul style="list-style-type: none"> <li>- Lack of confidence and self-efficacy</li> <li>- Breastfeeding perceived as time-consuming</li> <li>- Fatigue, exhaustion</li> <li>- Impractical when going out, leaking breasts</li> </ul>	Cloherly, Alexander & Holloway (2004); Forster & McLachlan (2010); Forster et al (2012); Gatrelli (2007); Larsen et al (2008); Lewallen et al (2006); Twamley et al (2011)
Mother's health	<ul style="list-style-type: none"> <li>- Smoking and other addictions</li> <li>- Poor diet</li> <li>- Hepatitis B</li> <li>- Post C-section pain and recovery</li> </ul>	Flower et al (2008); Goldade, Nichter, Nichter, Adrian, Tesler & Muramoto (2008); Lewallen et al (2006); Sutton, He, Despard & Evans (2007).
Infant's health	<ul style="list-style-type: none"> <li>- Weight loss, or failure to gain sufficient weight</li> </ul>	Flower et al (2008); Lewallen et al (2006)

The major theme that emerged related to attitudes, beliefs and knowledge about breastfeeding is that many women have unrealistic expectations about the experience. A large survey conducted in Australia concluded that: "breastfeeding was held out as a natural, romanticized, problem-free experience" (Hall & Hauck, 2007, p794). Key findings from this survey of middle-class, married, older, well-educated women show that these women struggle with many of the same problems described by more vulnerable women such as a lack of support from family

<sup>1</sup> Attitudes, beliefs and knowledge about breastfeeding are particularly strongly influenced by all the other levels (i.e., family through society).

members and discomfort with breastfeeding in public. The authors conclude that the factors that undermine breastfeeding in general do cut across groups of women regardless of age, SES, education or culture (Hall & Hauck, 2007).

A potential unintentional consequence to describing breastfeeding as natural is the conspiracy of silence that then arises around any difficulties such as latching on, cracked and painful nipples or mastitis (Grassley & Nelms, 2008). This can contribute to a woman's loss of confidence in her ability to breastfeed, early cessation and even the feeling of being a failure as a mother (Harris et al, 2003; Larsen et al, 2008). Kelleher (2006) notes that openly acknowledging that physical pain and vulnerability may be a part of the early breastfeeding experience for some women, would help to validate women's early experiences with breastfeeding rather than causing them to feel abnormal in any way or, worse yet, a failure.

In their meta-synthesis of seven qualitative studies, Larsen et al (2008) explore what affects a mother's confidence in breastfeeding. They were trying to understand why, in Denmark, where the benefits of breastfeeding are widely known and almost all new mothers initiate breastfeeding, 41% of women stop before their infants are four months old. The major emergent theme from this study is that women's confidence in breastfeeding is affected when both expectations of breastfeeding and motherhood are shattered. A major contributing factor here is the expectation that breastfeeding is natural and something every mother can do, an expectation created by the way breastfeeding is promoted to mothers. In reality, however, breastfeeding is also a skill that needs to be learned; it does require knowledge, familiarity and practice (Harris et al, 2003; Larsen et al, 2008). This clash between myth and reality leads to both a lack of confidence and the assumption of sole responsibility by the mother for the success of the breastfeeding experience. The deep connection between breastfeeding and motherhood explains why women often feel that they have failed as mothers when they give up breastfeeding.

Women's descriptions of the physical difficulties they experience with feeding are widely described in the literature. A practicality affecting many women is the problem of getting the baby latching on properly, and then the resulting nipple cracking, bleeding and/or pain (Bailey, 2007; Flower, 2008; Harris et al, 2003; Kelleher, 2006; Manhire et al, 2007). Even women who end up being able to breastfeed successfully often experience problems early on (Bailey, 2007). Many women experience pain and discomfort, and are surprised by the intensity and the duration of the pain. The language women use to describe this includes: "*sore as hell; ...scared of the pain; ...really intimidating*" (Kelleher, 2006).

In addition to painful breasts or nipples, physical feeding issues that are widely described by women as reasons they stop breastfeeding early on are: the baby rejecting the breast or not sucking (Redshaw & Henderson, 2012); and perceived insufficient milk supply (Bailey, 2007; Flower et al, 2008; Gatti, 2008; Heinig et al, 2009; Twamley et al, 2011). Gatti's (2008) review of the literature concluded that many women discontinue breastfeeding during the first few weeks

because of perceived insufficient milk supply. Approximately 35% of women who wean early report this as the primary reason for stopping. Gatti's review also notes that women primarily use infant satisfaction cues as their main indication of sufficient milk supply. They will discontinue breastfeeding if they perceive their infant is still hungry and/or not satisfied without any professional concurrent evaluation of their actual breast milk supply (Gatti, 2008). In response to an open-ended question asked in an Australian survey, the reason most commonly given for stopping breastfeeding in the second week (i.e., once breastfeeding was proceeding well) was that breastfeeding took too long or was too tiring (Redshaw & Henderson, 2012).

It is very common in some ethno-cultural communities, and particularly with more recent immigrants, to top up breastfeeding with formula feeding. Among many of these communities there is a widely held perception that a big baby is a sign of health and breast milk is not enough to sustain a healthy weight (Twamley et al, 2011; Steinman et al, 2010). This belief is particularly prevalent among women who are less educated. Well-educated women across these ethno-cultural communities appear to understand the benefits of breastfeeding and are also more confident standing up to their relatives (Twamley et al, 2011). Many studies highlight how having a happy, healthy baby is equated with lots of weight gain. These perceptions often lead to the introduction of formula as a supplement to breast milk or a change to formula only (Bailey, 2007; Steinman et al, 2010).

Some women also indicate that they are unable to start or have to stop breastfeeding because of their health and the health of their babies. The discussion of infant health is predominantly related to weight loss or insufficient weight gain (Flower et al, 2008). With respect to the mother's own health, the issues they describe include: smoking; other addictions; poor diet; Hepatitis B; and caesarian section (Flower et al, 2008; Goldade et al, 2008; Sutton et al, 2007). With respect to smoking and other addictions, many women believe that the benefits of breastfeeding their baby are outweighed by the negative impact of the nicotine (Goldade et al, 2008) or other drugs in their breast milk. Surgery (i.e., caesarian section) is described as having a negative physical effect on breastfeeding because of the post-op pain and discomfort. Women describe finding it difficult to get their baby in a good position that does not increase their pain (Manhire et al, 2007; Redshaw & Henderson, 2011).

All of these physical difficulties, in combination with the other difficulties noted - the hard work it can take to get breastfeeding established; the perception that breastfeeding and pumping are very time-consuming in comparison with bottle-feeding; fatigue; and the problems associated with breastfeeding, pumping and/or leaking in social situations - can lead to a woman losing confidence in her ability and desire to breastfeed (Cloherty, Alexander & Holloway, 2004; Forster et al, 2012; Gatrelli, 2007; Johnson et al, 2009; Twamley et al, 2011). As well, the practical challenges women face when returning to work or school, such as getting access to effective breast pumps and finding clean, private spaces in which to pump, all contribute to shortened breastfeeding duration (Holmes et al, 2009; Johnson et al, 2009).



## Enablers

The enablers to breastfeeding described most frequently at the mother-infant level can be grouped into four broad categories. These are summarized here in Table 2.

**Table 2: Enablers to breastfeeding at the mother-infant level**

<b>Enabler</b>	<b>Description</b>	<b>Authors</b>
Attitudes, beliefs and knowledge about breastfeeding	Awareness of: <ul style="list-style-type: none"> <li>- Nutritional and immunological benefits of breastfeeding for the baby</li> <li>- Breastfeeding being a positive bonding experience</li> <li>- Breastfeeding as a convenient, low cost feeding option</li> <li>- Potential challenges associated with breastfeeding</li> </ul>	Andrew & Harvey (2011); Bai et al (2007); Bailey (2007); Harris et al (2003); Hegney, Fallon & O'Brien (2008); Koerber, Brice & Tombs (2012); Sheehan et al (2010)
Intention to breastfeed	- Intending to breastfeed is strongly related to breastfeeding success	Twamley et al (2011); Thulier & Mercer (2009)
Early positive experiences, satisfaction with breastfeeding	<ul style="list-style-type: none"> <li>- Mastering the technical aspects of breastfeeding</li> <li>- Perception that baby is satisfied</li> <li>- Satisfaction with maternal identity and lifestyle</li> </ul>	Andrew & Harvey (2011); Manhire et al (2007)
Self-efficacy, confidence in breastfeeding	<ul style="list-style-type: none"> <li>- High levels of confidence, determination and commitment</li> <li>- Previous experiences with breastfeeding influence self-efficacy</li> </ul>	Avery et al (2009); Bailey (2007); Brown & Lee (2011); Burns, Schmied, Sheehan & Fenwick (2010); Burns et al (2011); Entwistle, Kendall & Mead (2010); Grassley & Nelms (2008); Larsen et al (2008); Manhire et al (2007); Robinson & VandeVusse (2011); Thulier & Mercer (2009); Twamley et al (2011)

A key enabler of breastfeeding is the understanding that breastfeeding is best for the baby. In today's modern societies, women's decisions around infant feeding are often formulated against this concept that "breast is best" (Sheehan et al, 2010). In many communities and cultures breastfeeding success has become closely tied to the idea of "good mothering", and this is most pronounced among women of higher SES and their supporters (Koerber et al, 2012).

Many studies report that women and their partners are aware of the benefits of breastfeeding for their babies. They know that breastfeeding can increase bonding with the baby; make the baby healthier; build up the baby's immunity; and provide overall good nutrition to the baby.

Women also believe that breastfeeding is an easier, more convenient option; one that can also save them money (Bai et al, 2007; Bailey, 2007).

Although an enabler, awareness of the benefits of breastfeeding is not sufficient on its own to support the initiation and continued duration of breastfeeding. In some studies there is discussion about the need for balance between the promotion of the benefits of breastfeeding and the provision of practical information about the common challenges women experience in getting breastfeeding established. As described previously, it definitely helps if women go into breastfeeding with realistic rather than overly idealistic notions (Harris et al, 2003; Hegney et al, 2008).

Mothers describe how breastfeeding is a skill made easier with practice. The longer a mother breastfeeds, the easier she believes it is. Breastfeeding does require some technical skill, the development of which can be facilitated through support from others who have had experience with breastfeeding (Andrew & Harvey, 2011). Support can come from family members, peers and health professionals. Being able to master the technical aspects of breastfeeding contributes to early positive experiences and satisfaction. Satisfaction with breastfeeding encompasses maternal, baby and lifestyle satisfaction. Having a positive bonding experience, as well as a positive transition to the maternal identity and lifestyle, particularly for first-time moms, all contribute to a positive and satisfying experience with breastfeeding (Manhire et al, 2007).

These enablers all assist in the development of self-efficacy and confidence, which are widely described in this body of literature as important enablers of breastfeeding. This finding cuts across SES and ethnicity. High levels of confidence, and the commitment and determination to carry on with their decision to breastfeed despite any difficulties they might encounter all enable women to continue to breastfeed (Avery et al, 2009; Bailey, 2007; Brown & Lee, 2011; Entwistle et al, 2010; Manhire et al, 2007; Robinson & VandeVusse, 2011; Twamley et al, 2011).

According to Bandura's theory of self-efficacy, "individuals who successfully master a skill are more apt to perform that behaviour again" (Robinson & VandeVusse, 2011, p323). Women who are unsuccessful at establishing breastfeeding with previous children are less likely to try breastfeeding with subsequent children (Robinson & VandeVusse, 2011). Persistence and determination are described as being particularly important through the early weeks of breastfeeding. Women often describe their early experience as a 'struggle'. They talk about how tempting it is to stop when there are other feeding options so readily available. Lots of encouragement from healthcare professionals, family and friends early on is described as being very helpful (Manhire et al, 2007).

In their review of the qualitative literature on women's experiences with breastfeeding, Burns et al (2010) found that confident women are more likely to sustain breastfeeding. They describe

the ways that health professionals can work with women to increase their confidence. This is discussed in more depth under the healthcare delivery system level.

### Summary

Maternal confidence in the ability to initiate and keep breastfeeding results from a dynamic interaction between each woman’s expectations, the physical aspects of breastfeeding, her baby's breastfeeding behaviour, sources of support, and the complex social context within which breastfeeding and motherhood is embedded (Grassley & Nelms, 2008; Larsen et al, 2008). Going into breastfeeding with more realistic than idealistic expectations contributes to more maternal confidence, self-efficacy and ultimately breastfeeding success. Useful information about breastfeeding, intention to breastfeed, and early positive experiences and satisfaction with breastfeeding are also positive contributing factors.

### 3.2 The family

Family, for the purposes of this review, transcends the traditional concept of the nuclear family. Adopting a woman-centred approach, family is simply defined as anyone identified by a mother as someone with whom she has a close relationship and relies on for support (i.e., those individuals that she is closest to and most influenced by). This can include extended family and close friends (Heinig et al, 2009). An overarching theme captured here is that the attitudes, beliefs and expectations of family are a major contributing factor to a woman’s infant feeding decisions. In other words, family can affect breastfeeding initiation and duration both positively and negatively.

### Barriers/challenges

The main barriers to breastfeeding at the family level can be grouped into three broad categories as summarized here in Table 3.

**Table 3: Barriers/challenges to breastfeeding at the family level**

Barrier/challenge	Description	Authors
Attitudes, beliefs and expectations of family members	<ul style="list-style-type: none"> <li>- Family members strongly influence women’s breastfeeding goals</li> <li>- Grandmothers’ and partners’ views are particularly influential</li> </ul>	Andrew & Harvey (2011); Bailey (2007); Grassley & Eschiti (2008); Manhire et al (2007); Morrison, Reza, Cardines, Foutch-Chew & Severance (2008); Reid, Schmied & Beale (2010); Tohotoa, Maycock, Hauck, Howat, Burns & Binns (2009); Twamley et al (2011)
Inter-personal factors, family functioning	<ul style="list-style-type: none"> <li>- Dads can feel left out if they cannot feed their babies</li> <li>- Concern about affect of breastfeeding on bonding between the father and baby</li> </ul>	Avery & Magnus (2011); Gisbers (2005); Ludlow, Newhook, Newhook, Bonia, Goodridge & Twells (2012); Twamley et al (2011)

Barrier/challenge	Description	Authors
Other family and household demands	<ul style="list-style-type: none"> <li>- Need to balance breastfeeding with other roles and responsibilities</li> <li>- Breastfeeding can interfere with other household and family tasks</li> </ul>	Ludlow et al (2012); Twamley et al (2011)

The beliefs, attitudes and expectations of family members strongly influence women's breastfeeding goals as well as their breastfeeding experience (Andrew & Harvey, 2011; Bailey, 2007; Datta, Graham & Wellings, 2012; Grassley & Eschiti, 2008; Manhire et al, 2007; Tohotoa et al, 2009; Twamley et al, 2011). The decision to breastfeed is often made early in a pregnancy, before contact with health professionals or even prior to conception. Family is, therefore, strongly influential around intention to breastfeed (Datta et al, 2012). The views of partners and grandmothers are described as being particularly influential (Grassley & Eschiti, 2008; Reid et al, 2010).

Mothers speak about how myths and outdated knowledge related to breastfeeding can create barriers. An example of a family myth is illustrated by the following quote:

*“I know my mother-in-law, my husband was born in '62, was taught that breastmilk is bad and it's not going to be nutritionally enough for your child and that was just how she was raised and how she raised her children”* (Grassley & Eschiti, 2008, p332).

In a New Zealand study, Manhire et al (2007) found that family members' perspectives often contributed to women stopping breastfeeding sooner than they would have chosen. Once the baby reached six months of age, family support for breastfeeding began to decrease, with little tolerance for breastfeeding after a year (Grassley & Eschiti, 2008).

In a study looking at the breastfeeding experiences of women in Indian and Pakistani households in the U.K., many women describe breastfeeding as interfering with other household tasks as well as movement outside of the house (Twamley et al, 2011). These issues link both to how time-consuming breastfeeding is and the difficulty often experienced around breastfeeding in front of others. It is also much easier for others in the family to care for the baby if the baby is being bottle-fed. This is hugely important in households where multiple generations are living together. In many of these households there is a lot of grandparental preference for bottle-feeding (Twamley et al, 2011).

Infant feeding decisions require considerations around a number of factors, including balancing the needs of other children and the relationship with one's partner (Ludlow et al, 2012). For example, breastfeeding can be seen as incompatible with sexual relations or with a partner's wish to share in the feeding of the baby (Bailey, 2007; Ludlow et al, 2012). There were mixed findings about the perspectives of partners on breastfeeding and the impact that breastfeeding

had on the relationship between the woman and her partner, with some studies reporting that breastfeeding could create some jealousy. It appears that, overall, women may be more sensitive to this than the fathers are (Avery & Magnus, 2011; Bailey, 2007). Avery and Magnus (2011) found that expectant moms in the U.S. express more concern about the effect of breastfeeding on bonding between the father and the infant than do the expectant fathers.

In a study conducted in Newfoundland and Labrador, Ludlow et al (2012) conclude that feeding decisions are firmly embedded in the family context:

*“It is interesting to consider that individual infant feeding decisions made by mothers could be viewed as being on a continuum of ‘confident commitment’ (Avery et al, 2009) to that choice. Mothers who firmly believe that formula feeding their infants is the only method for them and their families are on one end. At the opposite pole are those who believe that breastfeeding is the only option worth considering. Between the two extremes lie all others who believe that breastfeeding is the best nutritional option for their child but, due to environmental and personal issues, they need to strike a balance and make the best choice possible. In fact, ‘an individual family ... has a perspective on breast feeding that is very different from the population at large and of the policy makers who monitor public concerns’ (Meyers 2009, p. S13). The role of both policy makers and health care providers is to empower, encourage and then support people in their decisions about health; yet ultimately the choice is the individual’s” (p304).*

### **Enablers**

The enablers to breastfeeding at the family level described by women most frequently relate to support from their partners, family and friends. This finding cuts across ethnicity, socioeconomic status and age. These enablers are summarized here in Table 4.

**Table 4: Enablers to breastfeeding at the family level**

<b>Enabler</b>	<b>Description</b>	<b>Authors</b>
Support from partner	- Support from partner strongly influences both initiation and duration of breastfeeding	Clifford & McIntrye (2008); Datta, Graham & Wellings (2012); Morrison et al (2008); Rempel & Rempel (2011); Sherriff & Hall (2011); Thulier & Mercer (2009); Tohotoa et al (2009); Tucket et al (2011)
Support from family and friends	- Women frequently highly value breastfeeding advice from their own mother - Grandmothers can play an important role in supporting new moms’ breastfeeding - Women describe seeking and valuing breastfeeding advice from friends	Andrew & Harvey (2011); Clifford & McIntrye (2008); Grassley & Eschiti (2008); Heinig et al (2009); Reid et al (2010); Thulier & Mercer, 2009

A key theme here is that women describe their partner's/boyfriend's support as having a positive impact on the initiation and duration of breastfeeding, and this finding appears to cut across ethnicity, socioeconomic status and the age of the mother (Alexander, Dowling & Furman, 2010; Datta et al, 2012; Morrison et al, 2008; Rempel & Rempel, 2011; Sherriff & Hall, 2011; Tohotoa et al, 2009). In other words, *"Dads do make a difference"* (Tohotoa et al, 2009, p1).

Many partners defer the ultimate decision around breastfeeding to the woman, describing their role as providing support to the woman's decision (Datta et al, 2012). Women, however, indicate that they value the perspectives of their partners, describing the decision as a joint one (Rempel & Rempel, 2011). Fathers do want to be involved and to actively support and care for their partners (Datta et al, 2012; Tohotoa et al, 2009), with a major role being to "protect and defend" their decision to breastfeed their baby (Tohotoa et al, 2009, p6). In their U.K.-based research, Datta et al (2012) found that fathers face a dilemma in supporting their partners when they are experiencing breastfeeding difficulties. They do not want to undermine the mother's efforts but at the same time wish to protect her from pain and exhaustion.

The kinds of support that partners can provide include: becoming knowledgeable about breastfeeding and using this knowledge to encourage and assist mothers in breastfeeding; valuing and providing encouragement to breastfeeding mothers; and sharing housework and childcare (Datta et al, 2012; Rempel & Rempel, 2011; Sherriff & Hall, 2011). Given the important role that partners play in preparing for and supporting breastfeeding, and their desire for more relevant and accessible information on both the benefits of breastfeeding as well as how to more practically support their partner, it is important to actively invite them to and involve them in both pre and postnatal learning sessions (Clifford & McIntyre, 2008; Rempel & Rempel, 2011; Sherriff & Hall, 2011; Tohotoa et al, 2009). Specific recommendations around ways that healthcare and healthcare professionals can more directly engage and involve dads is also discussed at the healthcare system level.

Breastfeeding takes place within the context of an extended family within which grandmothers often bring their own infant breeding practices and beliefs to their support of new mothers (Grassley & Eschiti, 2008). Grandmothers, and most particularly maternal grandmothers, are an important source of support for new mothers (Grassley & Eschiti, 2008; Heinig et al, 2009; Reid et al, 2010). Women frequently value the advice they get from their own mothers more so than from health professionals. In a study carried out in Texas, the essence of what individual mothers need and want from their mothers is to support and advocate for their decision to breastfeed by truly valuing breastfeeding and providing loving encouragement (Grassley & Eschiti, 2008). When experiencing difficulties, women are more likely to turn to their mothers and other informal sources of support, including their friends, for help (Grassley & Eschiti, 2008; Heinig et al, 2009). This quote from a woman participating in a study exploring low-income women's sources of breastfeeding advice illustrates this point:

*“When I first had a problem nursing, I didn’t think to call here [WIC]. And that was an emergency, I mean she wasn’t eating. I just called a friend who I know had similar issues and asked her what I was supposed to do. . . .So, just calling someone I know has been in a similar situation” (Heinig et al, 2009, p166).*

Other research has found that in fast-paced urban environments, and in particular those where extended family is far away, new mothers may rely heavily on information from peers, professionals and the media (Reid et al, 2010). Reid et al (2010) also acknowledge that the relationship between grandmothers and new mothers is complex. Grandmothers are often acutely aware of how challenging it is to balance potential risks and rewards in their interactions with the new family. In general, the grandmothers interviewed in this Australian study were very positive about wanting to provide support to the new mothers but they also recognized that it was important not to be too intrusive.

### **Summary**

Women highly value and rely on support from the people they are closest to, and most particularly their partners. Support from family members contributes to a woman’s confidence in and ability to breastfeed. Taking a patient- and family-centred approach to care in the health system is important to allowing family members to be actively engaged in, and promoting and supporting breastfeeding within their families. This is described in more depth under enablers in the next section related to the healthcare system level.

### **3.3 The healthcare system**

The overarching theme captured from the literature here is that the culture of the healthcare system acts as a barrier to effectively supporting breastfeeding and yet it is to health professionals that many women look for expert advice and support for breastfeeding. In the healthcare system, breastfeeding, like childbirth, is often medicalized. Many health professionals view breastfeeding as a health issue rather than as an activity that is deeply embedded in culture and strongly influenced by a variety of sociocultural factors. Taking a patient- and family-centred approach to care - one that includes working collaboratively with moms and babies within the context of their individual families and lives - is described as the way for health professionals to best support breastfeeding.

### **Barriers/challenges**

The main barriers to breastfeeding in the healthcare system can be grouped into five broad categories as summarized here in Table 5.

**Table 5: Barriers/challenges to breastfeeding at the healthcare system level**

Barrier/challenge	Description	Authors
Healthcare culture	<ul style="list-style-type: none"> <li>- Being treated in a condescending manner</li> <li>- Judgmental attitudes from some health professionals</li> <li>- Ideological push for breastfeeding from health professionals</li> <li>- Medicalization of breastfeeding</li> </ul>	Archabald et al (2011); Baker, Choi, Henshaw & Tree (2005); Burns et al (2010); Dykes (2005b); Hauck, Graham-Smith, McInerney & Kay (2011); Hall & Hauck (2007); Manhire et al (2007); McInnes & Chambers (2008); Redshaw & Henderson (2012); Schmidt et al (2011); Sheehan, Schmied & Barclay 2010; Sheehan et al (2009)
Lack of time in medical environment	- Lack of time in medical environment to address issues at individual/family level – feelings of being rushed	Dykes (2005b); McInnes & Chambers (2008)
Conflicting advice	- Conflicting advice from healthcare professionals negatively affects women’s confidence and self-esteem	Dykes (2005b); Manhire et al (2007); McInnes & Chambers (2008)
Little consideration of needs of partner	- Little or no consideration around the knowledge and other support needs of the women’s partners	Sherriff & Hall (2011); Tohotoa et al (2009)
Promotion of formula	- Promotion of formula in hospitals and other health and human services settings	Holmes et al (2011); McInnes & Chambers (2008); Stolzer (2010)

The culture of the healthcare system is widely described as a barrier to breastfeeding across much of the literature reviewed. Women describe an overall lack of individualized or personalized care. Hospital organizational factors described as being not helpful include: rules that prevent the partner from staying with the new mom and baby; staff shortages; conflicting advice and information; the judgmental attitudes of some health professionals; and even rude, impatient or unprofessional behaviour exhibited by health professionals (Archabald et al, 2011; Baker et al, 2005; Burns et al, 2010; Dykes, 2005b; Hauck et al, 2011; Hall & Hauck, 2007; Hauck et al, 2011; Manhire et al, 2007; McInnes & Chambers, 2008; Redshaw & Henderson, 2012).

Women describe feeling like “naughty children” when they try to breastfeed and fail, and are “reprimanded” for not doing what is expected. *“No one offered to show me how to breastfeed, bath or change my baby, and I was shouted at for falling asleep and not feeding the baby although he hadn’t woken up either”* (Redshaw & Henderson, 2012, p25). Other women describe being afraid to ask for help from health professionals because of the way they are made to feel, as this quote illustrates: *“Some doctors, midwives, and nurses made me feel stupid when I asked a question or talked down to me, though it was my second child”* (Redshaw & Henderson, 2012, p26).

Other issues are described in the literature related to the healthcare culture. A specific issue



related to hospital-based care is the lack of time nurses and midwives have to establish helpful relationships with new mothers - relationships that enable them to provide the kind of support that women require to get breastfeeding started (Dykes, 2005b; McInnes & Chambers, 2008). As one woman states:

*“It would be nice if somebody could just come and spend 10 minutes with you to talk about breast feeding. If they did that they could learn about your concerns and anything you feel you need help with...I’m not very confident at all” (Dykes, 2005b, p246).*

The way hospital wards are staffed can prevent nurses and midwives from spending very much time at all with individual women, and create huge challenges to providing continuity of care. This contributes to the conflicting advice many women describe receiving (Dykes et al, 2005; Manhire et al, 2007; McInnes & Chambers, 2008) as illustrated by this quote: *“I’ve seen different people this morning and they have all had a different approach” (Dykes, 2005b, p247).*

Another barrier to breastfeeding is the promotion of formula in hospitals and in other health and human services settings. This is a contributing factor to the development of a bottle-feeding culture and it has been shown to decrease the rates of exclusive breastfeeding (Holmes et al, 2009; Stolzer, 2010). Hospitals across North America often provide formula advertising and free samples as part of the packages they routinely give to new moms (Holmes et al, 2009; Stolzer, 2010).

Another challenge, given the importance of partner support to successful breastfeeding, is the lack of consideration of partners’ needs for informational and other kinds of support (Alexander, Dowling & Furman, 2010; Sherriff & Hall, 2011; Tohotoa et al, 2009). This involves thinking through whether existing policies and ways of delivering services, both antenatally and postnatally, negatively affect partners’ involvement. For example, antenatal classes or postnatal home visits are often done at times when it is difficult for partners to participate because of work commitments. Hospital visiting policies that place restrictions around when the partner can be with the new mom and baby also create barriers. The literature clearly indicates that providing new fathers with emotional, practical and physical supports is important to promoting successful breastfeeding, and also enriches the experience for both the mother and father (Tohotoa et al, 2009).

The tension between idealism and realism is also evident within the healthcare setting and women are often on the receiving end of mixed messages. Breastfeeding is portrayed as natural - something every woman can do - and yet instruction on breastfeeding is often perceived by women to be overly technical and rules-based. This can undermine a woman’s confidence in her ability to breastfeed (Burns et al, 2010). Women describe how some health professionals exert a lot of pressure to breastfeed and again this undermines their confidence and self-esteem, and makes them feel like failures if they are unsuccessful (Baker et al, 2005; Hall & Hauck, 2007; Redshaw & Henderson, 2012).

*"Messages like, if you really want to breastfeed you can succeed, created a climate where women felt personally responsible for problems that resulted in breastfeeding cessation"* (Hall & Hauck, 2007, p794).

Overall the literature indicates that poor support from health professionals can decrease women's confidence in breastfeeding and result in the early cessation of breastfeeding (Schmidt et al, 2011; Sheehan, Schmied & Barclay, 2010; Sheehan et al, 2009). The concept that "breast is best" and the way that this is pushed by health professionals contribute to women feeling judged and failures as mothers if they switch to bottle-feeding. There is the overarching sense, based on women's descriptions, that the kind of support currently provided by healthcare professionals, particularly in the hospital setting, is often doing more harm than good.

### **Enablers**

The enablers to breastfeeding in the healthcare system described most frequently are effective support from health professionals and patient- and family-centred care. These are summarized here in Table 6.

**Table 6: Enablers to breastfeeding at the healthcare system level**

<b>Enabler</b>	<b>Description</b>	<b>Authors</b>
Support from health professionals	<ul style="list-style-type: none"> <li>- Providing effective pre and postnatal support (i.e., emotional, tangible, informational) from healthcare providers</li> <li>- Providing information both on the benefits of breastfeeding, and the common challenges and ways of overcoming them</li> </ul>	Bailey et al (2004); Barona-Vilar, Escriba-Aguir & Ferrero-Gandia (2009); Burns et al (2010); Clifford & McIntrye (2008); Graffy & Taylor (2005); Grassley (2010); Hall & Hauck (2007); Hegney et al (2008); Twamley et al (2011)
Patient- and family-centred care	<ul style="list-style-type: none"> <li>- Working collaboratively with moms, partners/dads and babies in the context of their families and lives</li> <li>- Providing support in a facilitating manner</li> <li>- Focusing on strengths</li> <li>- Providing individualized advice in an effective and timely manner</li> </ul>	McInnes & Chambers (2008); Grassley & Eschiti (2008); Hall & Hauck (2007); Hoddinott, Craig, Britten & McInnes (2012); Lavender, McFadden & Toole (2006); Reid et al (2010); Sheehan et al (2010)

Women describe the importance of effective support from health professionals. They need and appreciate: practical help with positioning; effective, timely and individualized advice and

suggestions; acknowledgement of their experiences and feelings; and reassurance and encouragement (Graffy & Taylor, 2005). These kinds of supports contribute to the establishment of pain-free, successful breastfeeding. Effective support in the first few weeks is critical to getting breastfeeding established (Bailey et al, 2004; Sheehan et al, 2009) and will increase the chances that breastfeeding will be a positive experience and one that will be able to be sustained.

Women talk about wanting reassurance from health professionals that they are breastfeeding 'right' and their infants are getting enough milk (Twamley et al, 2011). This is particularly true for younger moms with no previous breastfeeding experience or no tangible support from their own mothers (Barona-Vilar et al, 2009; Grassley, 2010). Health professionals can best support women by being non-judgmental and avoiding generalizations about breastfeeding success, difficulties or experiences. It does not help to say, for example: *"If you really want to, you'll be able to breastfeed"*. Women talk about how valuable it is to hear from healthcare professionals that they are doing a great job (Hall & Hauck, 2007). It is also critical for women to have a health professional they can trust for support (Hegney et al, 2008).

The kind of care and support that women and their families want from the healthcare system aligns with the concept of patient- and family-centered care (i.e., working collaboratively with moms and babies in the context of their families and lives; providing support in a facilitating manner; focusing on strengths; and providing individualized advice). Women talk about needing care that is sensitive, individualized and meets their particular needs. In their study, Sheehan et al (2009) demonstrate that this type of support can increase women's confidence to breastfeed. The scientific-bureaucratic approach to breastfeeding is not in a woman's best interest (Sheehan, Schmied & Barclay, 2010).

Hoddinott et al (2012) describe family-centred discussions as being more highly valued by women and their partners than breastfeeding-centred checklists. They encourage health professionals to "...ask open questions about experiences, values, priorities and goals with discussion about how feeding will fit into family life" (p 9). Such a pro-active family-centred approach to feeding care would be helpful in anticipating and resolving challenges at pivotal points along the way (Hoddinott et al, 2012).

In their meta-ethnographic synthesis of women's experience of breastfeeding, Burns et al (2010) describe the cultural shift in authority that has taken place around breastfeeding knowledge, from women's own shared and embodied knowledge towards a biomedical narrative. They note that historically this knowledge was shared by women in communities and families, and passed down from one generation to the next, and how now in Western societies knowledge about breastfeeding is delivered predominantly by health professional experts. They describe a *"need for health professionals to move away from biomedical discourses towards more holistic language where the mind and body are viewed as 'inseparably intertwined' and the embodied reality of breastfeeding is more clearly articulated"* (Burns et al, 2010, p215).

Given the importance of family support in initiating and sustaining breastfeeding, actively supporting and involving family members is necessary. Women's partners want to be involved in the care of their babies and in supporting breastfeeding in whatever way they can (Sherriff & Hall, 2011; Tohotoa et al, 2009). Health professionals can support fathers by giving them more information about breastfeeding and its benefits, and providing them with suggestions about how they can help their partners both emotionally and practically. Recognizing that breastfeeding is a family issue benefits everyone (Sherriff & Hall, 2011; Tohotoa et al, 2009).

Another important source of support for new moms is grandmothers. Reid et al (2010) describe the importance of recognizing the challenges and dilemmas faced by grandmothers in trying to support new mothers in their early parenting and breastfeeding experiences. They note that grandmothers are often highly motivated and so it might be helpful to include them in parenting education sessions (i.e., in home or in other settings), if the mothers so wish. This would allow for their knowledge and expertise to be acknowledged while at the same time ensuring that they are aware of current recommendations around the care of infants. Inviting all of the new mother's identified key supporters to be involved in these learning events would help to ensure that consistent, evidence-based strategies are supported and promoted by everyone (Grassley & Eschiti, 2008; Lavender et al, 2006; Reid et al, 2010).

### *Summary*

Women frequently describe looking to health professionals for support in getting breastfeeding established. Confidence and self-efficacy with breastfeeding are critical enablers of breastfeeding success. Yet the healthcare culture within which health professionals practice contributes to support being provided in a way that undermines rather than builds on women's confidence in breastfeeding. Developing a healthcare system culture that can help support health professionals to practice patient- and family-centred care is important if the healthcare system is to do more good than harm.

### **3.4 The community**

A major theme that emerged through this review of the literature is the importance of creating spaces within different kinds of communities where women feel truly comfortable breastfeeding. Women who are breastfeeding consistently describe feeling isolated and excluded from society, primarily because of the social disapproval around breastfeeding in public places. In particular, workplaces and schools are described as settings where women feel a lot of discomfort both with breastfeeding and pumping.

### *Barriers/challenges*

The main barriers to breastfeeding at the community level can be grouped into two broad categories as summarized here in Table 7.

**Table 7: Barriers/challenges to breastfeeding at the community level**

Barrier/challenge	Description	Authors
Disapproval of and discomfort with breastfeeding in public spaces	<ul style="list-style-type: none"> <li>- Many people disapprove of breastfeeding in public spaces, and this perspective may be more prevalent among young people</li> <li>- Many women express feeling embarrassed and uncomfortable breastfeeding in public places, and this contributes to feeling socially isolated</li> <li>- These public spaces include workplaces and schools</li> </ul>	Avery & Magnus (2011); Bai et al (2009); Boyer (2012); Bailey (2007); Forster & McLachlan (2010); Goldade et al (2008); Henderson et al (2011); Spurles & Babineau (2011); Wallace & Chason (2007)
Lack of more private places to breastfeed and pump in public areas	<ul style="list-style-type: none"> <li>- Many women describe breastfeeding and/or pumping in uncomfortable settings in public places (e.g., public toilet stalls; closets; cars)</li> </ul>	Boswell-Penc & Boyer (2007); Boyer (2012); Forster & McLachlan (2010)

A major emergent theme from this literature review is the level of discomfort and even disapproval around breastfeeding in public places (Avery & Magnus, 2011; Bailey, 2007; Boyer, 2012; Spurles & Babineau, 2011). A key finding from focus groups conducted with young men and women in Eastern Canada, for example, was that they want to see their future children breastfed but at the same time have restrictive attitudes toward breastfeeding in public (Spurles & Babineau, 2011). Interviews with men and women in the U.K. also found that both moms and dads feel that woman need to be discrete. "You don't know what people might do once you start showing your breast in public? You just don't know and also other people might find it offensive" (Bailey, 2007, p150).

Men's disapproval of breastfeeding in public is well documented in the literature, with some studies illustrating that men are more likely to disapprove than women (Avery & Magnus, 2011). A key finding from focus groups conducted in three large U.S. cities is that women and men, both Caucasian and African American, disapprove of breastfeeding in public. Some of the men did acknowledge the contradictions between the public exposure of breasts in a cultural context versus public exposure while breastfeeding, as this next quote illustrates:

*"To see a baby under there is like oh, man, that's wrong. She got her breasts out. But then you go to the club, if she is standing there with the same bra, you like hey, you know, look at her" (Avery & Magnus, 2011, p151).*

A number of studies with pregnant women have found that they anticipate experiencing difficulties with breastfeeding in public. In one study many women spoke about breastfeeding in public with great modesty and discretion, and how "there was a general sense of disapproval of obvious public breastfeeding" (Avery & Magnus, 2011, p152). Avery and Magnus note that none of the 121 men or women participating in their 2011 study mentioned any knowledge about laws supporting public breastfeeding. It seems that informal cultural norms have a far greater influence on public attitudes and behaviours.

Women describe discomfort and embarrassment around breastfeeding and/or pumping in public spaces, with many women reporting that they do not want to breastfeed outside of their homes. This is clearly an issue that cuts across all groups of women. Some women describe being uncomfortable breastfeeding in public even while using a cover or while sitting in their cars (Bai et al, 2009; Wallace & Chason, 2007; Hauck, 2004). It seems far less acceptable among young people of lower socioeconomic status to breastfeed in many Western societies, making breastfeeding in public difficult (Dyson, Green, Renfrew, McMillan & Woolridge, 2010). Moms with higher levels of confidence and self-esteem (i.e., usually older moms of higher SES), along with lots of support from peers and family can overcome this discomfort and keep breastfeeding.

A large survey conducted in Australia that includes a strong qualitative component also identifies breastfeeding in public as a prominent theme in Australian society, with 19% of women commenting on it even though they were not specifically asked about it. Many women describe the lack of more private spaces to breastfeed in public settings. Some women simply bottle-feed when they go out. "*Feeding in public was an issue, [I] wouldn't go out if a feed was due*" (Forster & McLachlan, 2010, p121). Some women never overcome their discomfort about breastfeeding in public, whereas others become more comfortable over time (Forster & McLachlan, 2010).

The embarrassment and discomfort associated with breastfeeding in public is a contributing factor for some women not beginning breastfeeding or stopping early if they need to return to work or school (Flower et al, 2008; Stolzer, 2010). Returning to work is described as a key factor underlying the lower breastfeeding rates seen in low-income women. These women are less likely to have access to paid or unpaid maternity leave or jobs that allow them the time and space to pump milk (Stolzer, 2010). Gatrell (2007) notes that many women may not take the full maternity leaves available to them, and breastfeeding and/or pumping is "taboo" in the workplace.

### **Enablers**

The enablers to breastfeeding in the community described most frequently in the literature can be grouped into two broad categories. These are summarized here in Table 8.

**Table 8: Enablers to breastfeeding at the community level**

Enabler	Description	Authors
Workplace and school policies and cultures that support breastfeeding	<ul style="list-style-type: none"> <li>- Supportive workplace supervisors</li> <li>- Maternity leave</li> <li>- Flexible scheduling at work</li> <li>- Developing workplace breastfeeding support groups</li> <li>- On-site childcare</li> <li>- On-site lactation rooms with high quality breast pumps, and places to store breast milk</li> <li>- Breastfeeding policies</li> </ul>	Gatrell (2007); Johnson & Esposito (2007); Morrison et al (2008); Payne & James (2008); Payne & Nicholls (2010); Rojjanasrirat (2004); Rojjanasrirat & Sousa (2010)
Peer support	- Peer support has been shown to be helpful for increasing breastfeeding in a variety of community settings, including schools, workplaces and healthcare organizations	Bai et al (2009); Clifford & McIntyre (2008); Johnson & Esposito (2007); Hegney et al (2008); Grassley (2010); Ingram, Cann, Peacock & Potter (2008); Redshaw & Henderson (2012); Scott, Mostyn & Greater Glasgow Breastfeeding Initiative Management Team (2003); Vaughn, Ireton, Geraghty, Diers, Nino, Falciglia et al (2010)

Returning to work or school is widely described as a contributing factor to low breastfeeding rates, with longer maternity leaves contributing to increased breastfeeding duration (Johnson & Esposito, 2007; Morrison et al, 2008; Stolzer, 2010). Women returning to full-time work breastfeed for shorter durations than women returning to work part-time (Johnson & Esposito, 2007). Many workplaces do not support breastfeeding. Women describe having to hide any evidence that they are pumping and/or breastfeeding at work (Gatrell, 2007; Payne & James, 2008). Women also describe the need for support, space and time (Payne & James, 2008). Putting policies and practices in place that support breastfeeding in workplaces and schools has the potential to positively influence breastfeeding rates.

Many authors and a number of policy documents identify that breastfeeding workers require time, space and support (Payne & James, 2008). Johnson and Esposito’s (2007) review of the literature related to breastfeeding among working women in the U.S. describes a number of facilitations to breastfeeding continuation, some of which relate directly to the workplace environment. Recognizing that the workplace is an influential social environment; both informal peer support and more formalized breastfeeding support groups in the workplace; and supportive supervisors all enable breastfeeding (Johnson & Esposito, 2007; Payne & James, 2008; Rojjanasrirat, 2004). The opinions of other people at work can influence a woman’s

decision to keep breastfeeding, making workplace support very important (Payne & James, 2008).

Instrumental support can also facilitate ongoing breastfeeding. Some workplaces, for example, offer on-site childcare and/or access to on-site lactation rooms with high quality breast pumps, making it much easier for working mothers to continue to breastfeed (Gatrell, 2007; Johnson & Esposito, 2007; Rojjanasrirat, 2004). Organizations can also develop operational policies that support breastfeeding such as allowing women to have their infants brought to them for breastfeeding and allowing women to take extra time after lunch to breastfeed (Johnson & Esposito, 2007; Rojjanasrirat & Sousa, 2010).

Providing maternity leave and flexible scheduling at work both positively influence breastfeeding duration (Johnson & Esposito, 2007; Rojjanasrirat, 2004). Flexible scheduling makes it easier for women to take breaks to feed their babies and/or to pump. This is easier to do in some professions than others. Examples of low flexibility jobs include physician residencies, jobs in security, the military and jobs with 12-hour rotating shifts (Johnson & Esposito, 2007).

A key finding across a number of studies is that peer support groups might be helpful to women in a variety of community settings and may be a particularly important strategy in those communities where there is a strong bottle-feeding culture (Scott et al, 2003). This also applies to women from particular ethno-cultural groups (Ingram et al, 2008; Vaughn et al, 2010), as well as young moms (Grassley, 2010). Attending workplace support groups has been shown to be a significant predictor of breastfeeding duration (Johnson & Esposito, 2007). Some authors specifically comment that peer support has the potential to make a difference in the healthcare system context, particularly when targeted (Redshaw & Henderson, 2012). Studies find that women who continue to breastfeed are more likely to report having peers to share breastfeeding experiences with (Hegney et al, 2008).

### *Summary*

A major barrier to breastfeeding at the community level is the discomfort and embarrassment many women feel about breastfeeding in public, including at work or at school. Young people in particular express a lot of disapproval about breastfeeding in public. Many young women decide not to breastfeed or stop breastfeeding sooner than they intend to because of the sense of isolation that results from this reluctance to breastfeed in public places. A number of women talk about how returning to work and/or school is a major reason why they stop breastfeeding or decide not to start. Developing workplace and school policies and practices that actively support breastfeeding, as well as peer support initiatives can positively contribute to breastfeeding rates.



### 3.5 Society

The dominant theme woven throughout this entire findings section is that breastfeeding is a culturally embedded activity that occurs in an increasingly complex world. As Stewart-Knox et al (2003) stated almost a decade ago, "culture profoundly influences health knowledge, attitudes and behaviour; and this is particularly true of infant feeding practices" (p265). Because of the accumulating evidence that a major contributing factor to early cessation of breastfeeding is negative influences within the sociocultural environment (Stewart-Knox et al, 2003), the sociocultural influences on breastfeeding and how these might be mitigated has been the focus of a growing body of research. The emergent findings from this research are discussed in this section, beginning with a description of the barriers and challenges to breastfeeding at a sociocultural level.

#### *Barriers/challenges*

The main barriers to breastfeeding in society can be grouped into three broad categories as summarized here in Table 9.

**Table 9: Barriers/challenges to breastfeeding at the societal level**

Barrier/challenge	Description	Authors
Bottle-feeding culture	<ul style="list-style-type: none"> <li>- Breastfeeding not the norm in many societies and cultures</li> <li>- Restrictive attitudes toward breastfeeding in public</li> <li>- Embarrassment and discomfort</li> <li>- Promotion of formula</li> </ul>	Bailey, Pain & Aarvold (2004); Flower et al (2008); Stewart-Knox et al (2003); Lee (2007); Lewallen & Street (2010); McFadden & Toole (2006); Nelson (2009); Nelson & Sethi (2007); Stolzer (2010)
Body image	<ul style="list-style-type: none"> <li>- Sexualization of breasts</li> <li>- Concern about body image (e.g., leaking breasts; sagging breasts)</li> <li>- This seems to be a particularly important issue for adolescents and young people</li> </ul>	Dyson et al (2010); Gatrell (2007); McFadden & Toole (2006); Nelson & Sethi (2007); Wambach & Cohen (2009)
Integrating breastfeeding into modern, daily living	<ul style="list-style-type: none"> <li>- Returning to work, school and other activities in the community</li> </ul>	Callaghan & Lazard (2012); Dykes (2005b); Lavender et al (2006); Marshall et al (2007); McBride & Henry 2010; McFadden & Toole (2006); Reid et al (2010); Thulier & Mercer (2009); Tucket et al (2011)

A common statement made by many mothers in this body of literature is that we live in a bottle-feeding culture. The ready availability of formula in Western societies is widely described as a key contributing factor to this focus on bottle-feeding (Callaghan & Lazard, 2012; Holmes et al, 2009; Stolzer, 2010; Sutton et al, 2007; Vaughn et al, 2010). The distribution of formula samples in hospitals and in related health and human services programs is described as still widely practiced at least in North America (Holmes et al, 2009). The U.S.-based Women, Infants and Children (WIC) program, for example, provides free formula to low-income breastfeeding women, a group of U.S. women that traditionally have lower breastfeeding rates and should be strongly encouraged to breastfeed (Holmes et al; 2009; Stolzer, 2010).

The reality in which new mothers often find themselves is even more complicated than this. Mothering in today's society is portrayed as a complex balancing act. Women describe trying to achieve some kind of balance between ensuring the health of their babies and the reality of their daily lives (Dykes, 2005a; McBride & Henry, 2010; Marshall et al, 2007). In doing so, "women negotiate the moral minefield that defines good mothering and the diverse conceptions and influences that shape it..."(Marshall et al, 2007, p2147). Lavender et al (2006) state that, although society has changed, breastfeeding is expected to continue in the same way as always. Many women have to return to work soon after their children are born, and trying to juggle a job and breastfeeding can be hugely challenging (Rojjanasrirat, 2004, Rojjanasrirat & Sousa, 2010; Vaughn et al, 2010). Overall, women describe struggling with trying to integrate breastfeeding into modern life (Dykes, 2005a; Lavender et al, 2006; Marshall et al, 2007; McFadden & Toole, 2006; Stewart-Knox et al, 2003; Thulier & Mercer, 2009).

Mixed images of the breast in modern Western society and, in particular, the emphasis perpetuated by the mass media of breasts as sexual objects can lead to breastfeeding being viewed as a sexual rather than a feeding activity. This is described in a number of studies as an additional obstacle to breastfeeding related to perceptions around breastfeeding in public (Gatrell, 2007; Harris et al, 2003; Henderson et al, 2011; Mahon-Daly & Andrews, 2002; Reid et al, 2010). Based on what they learned through their focus groups with grandmothers, Reid et al (2010) conclude that "breasts are seen as having more of a sexual function today" (p78).

Related to this emphasis on breasts as sexual objects is the fact that body image, and in particular the concern about leaky breasts in the short term and saggy breasts in the longer term, is described frequently by women as a contributing factor to both the decision not to breastfeed and the decision to stop breastfeeding early. Embarrassment about leaking milk is frequently noted as a major barrier to breastfeeding when a woman returns to work or school (Flower et al, 2008; Gatrell, 2007). Many women report the belief that breastfeeding will make their breasts sag (Reid et al, 2010; Vaughn et al, 2010). Body image issues are clearly important.

Embarrassment because of the sexual nature of breasts and concerns about body image may be more significant barriers for young people (Henderson et al, 2011; Nelson & Sethi, 2005). Authors of a study that involved conducting focus groups with young, lower SES men in Scotland

conclude that, as this topic was raised spontaneously by the younger participants, it was perhaps more salient for teenagers who are likely to be extremely body conscious. As one young man declared: "You would end up with flat paps"; and another went even further by saying that "breastfeeding makes the woman look deformed and then she is ugly for the rest of her life" (Henderson et al, 2011, p67).

Embarrassment and discomfort with the whole idea of breastfeeding because of a lack of social acceptability is widely described in the literature (Flower et al, 2008; Forster & McLachlan, 2010). In many modern societies, the perceived taboos around breastfeeding in public spaces are a contributing factor to a major finding across studies; that is, that breastfeeding just does not fit with a modern woman's lifestyle and that exclusive breastfeeding limits a woman's flexibility to do other things thereby placing a burden on the mother (Goldade et al, 2008; Ludlow et al, 2012; Nelson, 2009). Sheehan et al (2010) conclude from their research that some women do not like breastfeeding. They do not feel comfortable with it and some are even repulsed by the idea. Harris et al (2003) discuss the unrelenting nature of motherhood and breastfeeding, and describe how this can be a challenging transition in our goal-oriented modern world. Because of this, many women and their partners describe bottle-feeding as being easier (Bailey, Pain & Aarvold, 2004; Flower et al, 2008; Stewart-Knox et al, 2003; Lee, 2007; Lewallen & Street, 2010; McFadden & Toole, 2006; Nelson, 2009; Nelson & Sethi, 2007; Stolzer, 2010).

It is not surprising then that a dominant theme in much of the qualitative research is social exclusion (Stewart-Knox et al, 2003). A qualitative study conducted in Ireland where breastfeeding rates are known to be low concludes that the main barriers to breastfeeding related to social exclusion are: "restricted freedom and independence associated with family issues, return to work, societal embarrassment and perceived social isolation" (Stewart-Knox et al, 2003, p265). Paradoxically, although many women describe living in a bottle-feeding culture, they also feel considerable societal pressure to breastfeed their babies. Based on their research in New Zealand, McBride and Henry (2010) describe a number of negative, unintended consequences of this, as follows:

*"...women who struggle to breastfeed might do so in silence, as they can be unwilling to discuss their experience with others for fear they will be perceived to be failures. This undermines women's confidence when facing unexpected breastfeeding difficulties, and might lead them to believe they are isolated, especially when peers seem to have "perfect" infants. The belief that they are not measuring up to the ideal mother silences them, the end result being an inability to seek the help they need" (p175).*

Although much of the research does talk about a bottle-feeding culture existing in many Western countries, there are a variety of sub-cultures that exist within any society. These sub-cultures can be divided along a number of lines, including class, age and/or ethnicity. Research suggests that women of lower SES and young moms have lower rates of breastfeeding initiation and breastfeed for shorter durations (Brown, Raynor & Lee, 2011; Stolzer, 2010; Holmes et al, 2009; Nelson, 2009; Nelson & Sethi, 2005; Wambach & Cohen, 2009). There is a common

impression among teenage moms that breastfeeding is not a normal part of teen culture. Both this lack of breastfeeding among teens and peers' negative experiences with breastfeeding are influential barriers to breastfeeding (Tucket et al, 2011). Tucket et al (2011) found that in the U.S., bottle-feeding is more pronounced in black and white teen moms in comparison with Hispanic teen moms. Young people describe returning to school as a challenge to breastfeeding, in part because pumping at school is difficult to do (Tucket et al, 2011).

Breastfeeding rates vary across ethno-cultural groups. There is a sizeable body of literature that focuses on understanding why women in these particular groups do and do not breastfeed, and the unique strategies that may be effective in increasing breastfeeding rates in particular ethno-cultural groups (Bartick & Reyes, 2012; Bunick et al, 2006; Choudry & Wallace, 2012; Cricco-Lizza, 2004; Gill et al, 2004; Groleau et al, 2006; Ingram et al, 2008; Lewallen & Street, 2010; Robinson & VandeVusse, 2011; Steinman et al, 2010; Sutton et al, 2007; Twamley et al, 2011; Vaughn et al, 2010). A key finding from this literature review is that there are more similarities than differences in the barriers to breastfeeding that women describe. Given the culturally embedded nature of breastfeeding, however, a woman's stage in life, her social circumstances and her ethnicity do contribute to the particular challenges she experiences and how she is able to respond to these.

It is beyond the scope of this literature review to explore in any depth how ethnicity and acculturation contribute to women's breastfeeding decisions in particular ethno-cultural groups. There is a large body of literature on breastfeeding in a variety of ethno-cultural groups within Western cultures (e.g., North America; Australia and New Zealand; the United Kingdom; other European countries) and the literature does often include a description of how breastfeeding rates vary from national norms and why. In the U.S., for example, breastfeeding is more acceptable in white than in African-American communities (Cricco-Lizza, 2004; Flower et al, 2008; Vaughn et al, 2010). Non-exclusive breastfeeding is also common among Latina women in the U.S. (Bartick & Reyes, 2012; Bunick, Clark, Zimmer, Jimenez, O'Connor & Crane, 2006), with non-breastfeeding increasing with acculturation (Vaughn et al, 2010). This decline in breastfeeding among some recent immigrants as they become acculturated cuts across a number of different ethno-cultural groups. In many of these studies it is difficult to disentangle the contributions of ethnicity, acculturation and socioeconomic status (Bunick et al, 2006; Choudhry & Wallace, 2012; Cricco-Lizza, 2004; Gill, Reifsnider, Mann, Villarreal & Tinkle, 2004).

In a Canadian study of recent immigrants from Vietnam, Groleau, Souliere and Kirmayer (2006) found that although there is a high rate of breastfeeding in Vietnam and many of the women interviewed had breastfed previous children in refugee camps, very few of them breastfeed their babies born in Canada. Their situations in Canada do not seem as conducive to breastfeeding, with fatigue cited as a major contributing factor to the discontinuation of exclusive breastfeeding.

So how does the role of the healthcare system fit into the reality of breastfeeding in modern Western society as it is expressed by women across socioeconomic status, ethno-cultural groups and age groups? Ludlow et al (2012) note that concerns are being expressed in the research community about whether promoting breastfeeding may be doing more harm than good. "There are concerns that public health breastfeeding messages have contributed to a dominant, medicalised dialogue that focuses on fear and risk, that promotes an ideology of 'intensive mothering' and unlimited self-sacrifice, and ultimately adds a considerable burden of guilt, stress and regret to decisions about feeding infants" (p292).

### *Enablers*

As the rich description of the sociocultural barriers to breastfeeding provided by women and their supporters outlined in the previous section illustrates, if we are to increase breastfeeding initiation and duration rates it is necessary to explore the broader context of breastfeeding. Cultural norms deeply affect breastfeeding outcomes. In Scandinavian countries, for example, the cultural norm is to breastfeed (Larsen et al, 2008). Breastfeeding rates have been so high for so long that women having babies now have grown up seeing women breastfeed (Forster et al, 2010). Scandinavian countries also have strong social policies, including generous maternity and paternity leaves that support parents to stay at home with their infants. Strategies that work to influence cultural norms in social-democratic societies, however, may be difficult to transfer to the Canadian context.

Even in Scandinavian countries, although there is close to a 100% breastfeeding initiation rate, the percentage of women still breastfeeding at six months is low. For example, in Denmark where almost all mothers initiate breastfeeding, 41% of women stop before the baby is four months old (Larsen et al, 2008). The tension between breastfeeding and lifestyle, independence and self-identify is still an issue (Andrew & Harvey, 2011; Bailey, 2007). In studies involving professional women, there is clearly a tension between a woman's role as a professional and her role as a mother (Bailey, 2007). As a professional woman in the U.K. stated: "I want to keep my own identify and independence" (Bailey, 2007, p150). Social policies can be enabling but are clearly not enough on their own to increase breastfeeding duration.

### *Summary*

Ultimately, as the roles of women in modern societies change, there is tension between motherhood and the various other roles that women play. Increasingly, both men and women work outside of the home and parenting of children is becoming more of a shared responsibility both between a woman and her partner as well as with extended family. Increasingly, having two incomes is a necessity for many families. This, in combination with the reality that many women cannot afford to take extended maternity leaves for either financial or career reasons, can make breastfeeding a challenge. Given the prevalence of this theme in the literature, the opening up of a public discourse into how breastfeeding fits in the real world with all its complexities seems very important. This is discussed in more depth in the next section of the report.

## 4.0 Implications for the health sector using a health promotion frame

Breastfeeding is an important public health issue with increasingly strong evidence mounting in support of the benefits of breastfeeding for both the infant and the mother. As such, increasing breastfeeding rates is a social responsibility. As described previously, the main theme emerging from this review of the literature is that breastfeeding is a culturally embedded activity that takes place in a complex world. Many women describe struggling to integrate breastfeeding into modern life, meaning that many more women initiate breastfeeding than continue to breastfeed exclusively at six months. This is evident in the breastfeeding rates reported at the beginning of this report.

Like many public health issues, the contributing factors to initiating and sustaining breastfeeding as a 'healthy behaviour' go far beyond the healthcare system. The crux of the challenge is to continue to work on shifting culture(s) from bottle-feeding to breastfeeding. Given this, we highlight below some key issues and implications for the health sector framed within the five health promotion strategies from the Ottawa Charter for Health Promotion model (Public Health Agency of Canada, Online).

### 4.1 Build healthy public policy

*“Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.”*

(Public Health Agency of Canada, Online)

There are a range of public policies that could be developed to support more of a shift to a breastfeeding culture. Some of these have already been alluded to throughout the findings section of this report based on women and their supporters' in-depth descriptions of the barriers and enablers to breastfeeding. A few examples, highlighted again here for illustrative purposes, are:

- Policies that limit the promotion of formula, and particularly in health and human services settings;
- Maternity and paternity leave policies that enable women to initiate and sustain breastfeeding, and their partners to support them in doing so;
- Policies that enable and support breastfeeding in the workplace and at school;
- Policies that increase awareness of the right to breastfeed in any public place; and,
- Policies that increase the access to private spaces to breastfeed in public settings.

## 4.2 Create supportive environments

*“Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.”*

(Public Health Agency of Canada, Online)

Creating supportive environments is a critically important area to take action on given that cultural norms are a major contributing factor to breastfeeding rates. As was described in the findings section, creating work and school environments that support breastfeeding is instrumental (e.g., access to private places to breastfeed with high quality pumps; on-site childcare). As well, creating psychosocial supports (e.g., workplace support groups) would help to increase breastfeeding rates. Many women describe the need to return to work and/or school as a major contributing factor to their discontinuing breastfeeding.

Although it is important to ensure that there are legislation and policies in place to protect women’s rights to breastfeed in a variety of public spaces, this is not enough. Many women describe how uncomfortable and embarrassed they feel breastfeeding in public. They want access to more private, appropriate breastfeeding spaces in public areas.

## 4.3 Strengthen community action

*“Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters.”*

(Public Health Agency of Canada, Online)

The development of formal peer support groups in a variety of settings (e.g., work, school, healthcare organizations), as well as the nurturing of informal support networks is an area worthy of action. Many women, and particularly women in more disadvantaged situations, highly value support from peers and credit this support for enabling them to keep breastfeeding.

#### 4.4 Develop personal skills

*“Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.”*

(Public Health Agency of Canada, Online)

Evidence about the benefits of breastfeeding for babies and mothers is highly valued by women, their partners and their families. In addition to this evidence about the ‘why’ of breastfeeding, women also very much appreciate information about the ‘how’ of breastfeeding. Women want someone with breastfeeding expertise (i.e., health professionals and/or peers) to spend time with them early on passing along technical tips on getting breastfeeding established. Expanding the ‘how’ of breastfeeding to include honest and open discussion on the practical integration of breastfeeding into real life is also highly valued. Women want health professionals and others to consider both their physical and mental health as important, and support them in making infant feeding decisions that are going to work for them.

Staying away from a ‘breastfeeding is natural’ focus in public health messages and instead providing honest information about the realities of breastfeeding is also critical. Women who are aware of the potential challenges - both the physical difficulties and the sociocultural difficulties - and are provided with good support are more likely to develop the confidence and self-efficacy necessary to sustain breastfeeding.

#### 4.5 Reorient health services

*“Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.”*

(Public Health Agency of Canada, Online)

Reorienting health services to consider the whole person in the context of their family and their lives is particularly important with breastfeeding, in part because breastfeeding is such a culturally embedded phenomenon. This builds on what is previously described under developing personal skills. Women appreciate health professionals who work with and support them in a facilitative manner rather than in a task-oriented and/or judgmental way. Developing healthcare systems and cultures that support health professionals to practice patient- and family-centred care is an important first step.

Finally, a guiding principle for health services, whether this be healthcare delivery or public health, is to “do no harm”. Recognizing that there are multiple dimensions to health and that physical and mental health are equally important, supporting women to make infant feeding



choices that will work in the context of their lives should be the aim. There are some women who will not be able to begin or to sustain breastfeeding and they should not be made to feel like they are bad mothers because they are bottle-feeding their babies. Public health messaging that describes breastfeeding as natural and equates good mothers to breastfeeding, for example, can do more harm than good.

## 5.0 Concluding remarks

We return to the question addressed through this literature review: What are the perceptions of women and their partners/supporters of the barriers/challenges and enablers to the initiation and duration of breastfeeding? The main theme that emerged in response to this question is reflected in the title of this report: *“The Challenges of Breastfeeding in a Complex World”*.

Many women intend to breastfeed, and the majority of women in Canada and other Western countries do initiate breastfeeding. Some women struggle early on with the physical challenges associated with breastfeeding such as latching issues that result in painful nipples and bad feeding experiences. Other women may overcome these physical issues but continue to struggle trying to integrate breastfeeding into modern life, with a major challenge here being the discomfort many women experience with breastfeeding in public places. The result is that far fewer women are breastfeeding exclusively at six months than who successfully initiated breastfeeding.

The majority of women do understand the benefits of breastfeeding, but knowledge of the health benefits of breastfeeding alone is clearly not enough to enable women to breastfeed. One key challenge is the mixed messages that women get. Many women describe receiving conflicting advice early in the postnatal period about mastering the technical nuances of breastfeeding. A number of societal-level mixed messages seem to be even more problematic with respect to their influence on women who are trying to integrate breastfeeding into their lives. Some of the mixed messages we identified through this review of the literature are summarized below.

- Breastfeeding is natural, something every woman can easily do, but it does require a lot of persistence, commitment, practice and technical support.
- Breastfeed because it is best for your baby, but do not do so in public because it makes people uncomfortable.
- Your breasts are made to feed babies, but in many of our modern societies breasts are predominantly viewed and ‘advertised’ as sexual objects.
- Fathers should be playing a bigger role in their children’s lives and it is important that they bond with and share in the care of their baby, but the mother should breastfeed.
- To be a modern woman it is important to take your career seriously, but if you are a good mother you will breastfeed your baby - but not at work.
- If you are a young mom we really want you to stay in school, but breastfeeding is not part of the teen culture so you might not want to breastfeed at school.

To conclude, although breastfeeding may be a health issue it is also very much a societal one. Health professionals who work directly with women and their partners to support them in their infant feeding decisions, and public health professionals working on initiatives to increase breastfeeding rates should be mindful about viewing breastfeeding within this broader context. Like many health issues, infant feeding choices are not made by individuals based solely on research evidence about what is best for the baby's and the mother's short and long term health. Rather, these are decisions embedded in real lives that are informed and influenced by many factors, including societal structures, norms, values, attitudes and beliefs. The health sector has an important role to play in contributing to the development of a society that truly supports women to breastfeed their babies. This includes the development of healthcare cultures that support health professionals to practice patient- and family-centred care, but goes far beyond this to contributing to an opening up of public discourse into how breastfeeding fits in the real world.

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## **Appendices**

Appendix 1: Literature Search Strategy

Appendix 2: Search and Screening Process Results

Appendix 3: Bibliography Organized by Category

## Appendix 1: Literature Search Strategy

### Breastfeeding Perceptions: Systematic Review Protocol

Developed by Diane Lorenzetti, Health Librarian – July 27, 2012

#### Research Question:

What are the perceptions of women and their partners or supporters of the barriers and facilitators to initiating or continuing to breastfeed?

#### Inclusion Criteria

1. Pregnant/postpartum women or women of childbearing age and their partners
2. Healthy term infants
3. Singleton births
4. Qualitative or mixed/methods research (e.g., focus groups, interviews, open-ended surveys)
5. Studies based in high income countries (see World Bank Tables of High-income economies and high-income OECD members, and UCLA Center for European and Eurasian Studies listing of Western European Countries)
6. English language literature published after 2001

#### Exclusion Criteria

1. Animal studies
2. Women with serious illness
3. Infants with congenital abnormalities
4. Infants admitted to NICU (i.e., preterm)
5. Non-singleton births
6. Perceptions of healthcare providers
7. Perceptions of women not of childbearing age
8. Studies focusing on implementing/evaluating breastfeeding initiatives
9. Studies based in non-high income/developing countries
10. Epidemiological studies (e.g., demographic, medical)
11. Quantitative research studies
12. Close-ended survey results
13. Non-systematic literature reviews

#### Study Identification

##### A. Electronic Peer Reviewed Databases:

MEDLINE  
PubMed  
EMBASE  
CINAHL (nursing and allied health database)  
Family and Society Studies Worldwide  
SocINDEX  
Social Services Abstracts  
Social Work Abstracts  
Sociological Abstracts

## B. Reference Lists of Key Studies

### Search Terms

Search strategies for each electronic peer reviewed database will be derived from common sets of keywords based on the following four themes:

- Theme 1: Breastfeeding
- Theme 2: Attitudes, behaviors, barriers and facilitators
- Theme 3: Qualitative studies
- Theme 4: High income countries including only Western European countries as defined by World Bank and UCLA Center for European and Eurasian Studies

Subject headings and keywords (title/abstract words) relevant to these four themes will be combined in each database to generate search results.

Search results will be imported into Reference Manager and duplicates will be removed before abstract screening begins.

### Subject Headings/Keywords (incorporates MeSH terms)

Themes	Subject Headings/Keywords
Breastfeeding	Breast feeding[MeSH] breastfeed* breast-feed* breast milk infant feeding
Attitudes	Breastfeeding/psychology[MeSH] Decision making[MeSH] Health knowledge, attitudes, practice[MeSH] attitude* barriers behavior/behaviour challenges continuation discontinuing experience* facilitators influences initiating initiation intentions perception* perceived benefits perspective* practices preference*

Qualitative Studies	Focus groups[MeSH] Interview[MeSH] Qualitative research[MeSH] focus group* interview* mixed methods qualitative questionnaire* survey*
High Income Countries Western European Countries	Andorra Australia Austria Belgium Canada Denmark European Union Finland France Germany Greece Greenland Iceland Northern Ireland Ireland Great Britain Italy Liechtenstein Luxembourg Monaco Netherlands New Zealand North America Norway Portugal Scotland Spain Sweden Switzerland United Kingdom United States Wales Western Europe

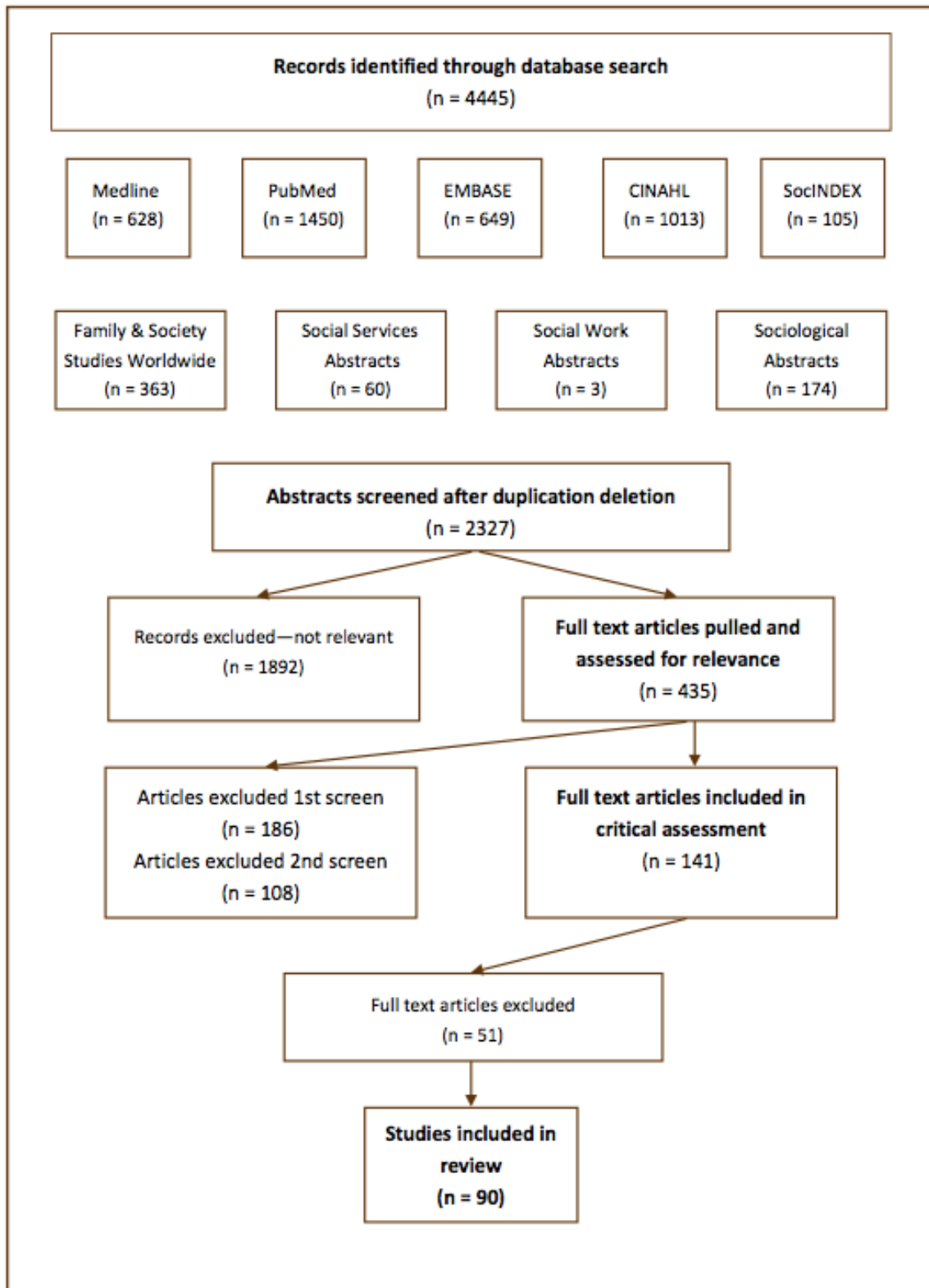
**MEDLINE (OVID) Draft Search    MEDLINE Total 634 abstracts (July 27 2012)**

1. Breast Feeding/
2. Breast Feeding/px [Psychology]
3. decision making/ or choice behavior/
4. Attitude/
5. Health Knowledge, Attitudes, Practice/
6. Attitude to Health/
7. 2 or 3 or 4 or 5 or 6
8. 1 and 7
9. ((breastfeed\* or breast feed\* or breast milk or infant feeding) adj10 (attitude\* or barriers to behavior\* or behaviour\* or challenges or continuing or continuation or discontinu\* or experience\* or facilitate or facilitators or influences or initiating or initiation or intentions or perception\* or perspective\* or perceived benefits or practices or preference\*)).tw.
10. 8 or 9
11. Focus Groups/
12. interview/
13. qualitative research/
14. (focus group\* or interview\* or mixed method\* or qualitative or questionnaire\* or survey\*).tw.
15. 11 or 12 or 13 or 14
16. 10 and 15
17. Andorra/
18. exp Australia/
19. Austria/
20. Belgium/
21. exp Canada/
22. Denmark/
23. Finland/
24. exp France/
25. exp Germany/
26. Greece/
27. Greenland/
28. Iceland/
29. exp Northern Ireland/ or exp Ireland/
30. exp Great Britain/
31. exp Italy/

32. Liechtenstein/
33. Luxembourg/
34. Monaco/
35. exp Netherlands/
36. New Zealand/
37. exp Norway/
38. Portugal/
39. Spain/
40. Sweden/
41. Switzerland/
42. exp United States/
43. north america/ or exp cities/ or europe/
44. European Union/
45. (andorra\* or australia\* or austria\* or belgium or belgian or canada or canadian\* or denmark or dutch or finland\* or france or germany or greece or iceland or ireland or irish or great britain or england or italy or italians or liechtenstein\* or luxembourg or monaco or netherlands or new zealand\* or Norway or portugal or portuguese or spain or spanish or sweden or swedish or switzerland or swiss or united kingdom or UK or scotland or wales or united states or US or USA or north america or western europ\* or european).tw.
46. (alberta or british columbia or saskatchewan or manitoba or ontario or quebec or new brunswick or nova scotia or newfoundland or prince edward island or nunavut or northwest territories or yukon).tw.
47. 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46
48. 16 and 47
49. limit 48 to animals
50. limit 48 to (animals and humans)
51. 49 not 50
52. 48 not 51
53. limit 52 to (english language and yr="2002 -Current")
54. limit 53 to clinical trial, all
55. 53 not 54



## Appendix 2: Search and Screening Process Results



## Appendix 3: Bibliography Organized by Category

### Review articles

- Burns, E., Schmied, V., Sheehan, A., & Fenwick, J. (2010). A meta-ethnographic synthesis of women's experience of breastfeeding. [Review]. *Maternal & Child Nutrition*, 6, 201-219.
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### Ethno-cultural groups

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### Sociocultural focus

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